** *SAMPLE* **

ACORD CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 01/30/2009

PRODUCER

NAME OF INSURANCE BROKER

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

INSURERS AFFORDING COVERAGE	NAIC #
INSURER A: REQUIRED	
INSURER B:	
INSURER C:	
INSURER D:	
INSURER E:	

INSURED

NAME OF CONTRACTOR

COVERAGES

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	ADD'L INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS	
A		GENERAL LIABILITY [X] COMMERCIAL GENERAL LIABILITY [ ] CLAIMS MADE [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: [ ] POLICY [X] PRO-JECT [ ] LOC	REQUIRED	REQUIRED	REQUIRED	EACH OCCURRENCE	$ 1,000,000
						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 100,000
						MED EXP (Any one person)	$ 5,000
						PERSONAL & ADV INJURY	$ 1,000,000
						GENERAL AGGREGATE	$ 2,000,000
						PRODUCTS - COMP/OP AGG	$ 1,000,000
		AUTOMOBILE LIABILITY [X] ANY AUTO [ ] ALL OWNED AUTOS [ ] SCHEDULED AUTOS [X] HIRED AUTOS [X] NON-OWNED AUTOS	REQUIRED	REQUIRED	REQUIRED	COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
						BODILY INJURY (Per person)	$
						BODILY INJURY (Per accident)	$
						PROPERTY DAMAGE (Per accident)	$
		GARAGE LIABILITY [ ] ANY AUTO				AUTO ONLY - EA ACCIDENT	$
						OTHER THAN AUTO ONLY: EA ACC	$
						AGG	$
A		EXCESS/UMBRELLA LIABILITY [ ] OCCUR [ ] CLAIMS MADE [ ] DEDUCTIBLE [ ] RETENTION $				EACH OCCURRENCE	$
						AGGREGATE	$
							$
							$
							$
A		WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below	MUST BE ON: C105.2, U26.3, CE-200, SI-12			[ ] WC STATU-TORY LIMITS [ ] OTH-ER	
						E.L. EACH ACCIDENT	$
						E.L. DISEASE - EA EMPLOYEE	$
						E.L. DISEASE - POLICY LIMIT	$
		DISABILITY	MUST BE ON: CE-200, DB-120.1, DB-155				

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS

THE CERTIFICATE HOLDER IS LISTED AS ADDITIONALLY INSURED

INSURERS ARE ALL LICENSED TO DO BUSINESS IN THE STATE OF NEW YORK

CERTIFICATE HOLDER

TOWN/VILLAGE OF HARRISON
1 HEINEMAN PL
HARRISON, NY 10528

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL *30 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO MAIL SUCH NOTICE SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE

WORKERS' COMPENSATION REQUIREMENTS UNDER WORKERS' COMPENSATION LAW §57

To comply with coverage provisions of the Workers' Compensation Law ("WCL"), businesses must:

A) be legally exempt from obtaining workers' compensation insurance coverage; or
B) obtain such coverage from insurance carriers; or
C) be a Board-approved self-insured employer or participate in an authorized group self-insurance plan.

To assist State and municipal entities in enforcing WCL Section 57, businesses requesting permits or seeking to enter into contracts **MUST** provide **ONE** of the following forms to the government entity issuing the permit or entering into a contract:

A) CE-200., Certificate of Attestation For New York Entities With No Employees And Certain Out Of State Entities, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage Is Not Required;

Starting December 1, 2008, Form CE-200 can be filled out electronically on the Board's website, www.wcb.state.ny.us., under the heading "Forms." Applicants filing electronically are able to print a finished Form CE-200 immediately upon, completion of the electronic application. Applicants without access to a computer may obtain a paper application for the CE-200 by writing or visiting the Customer Service Center at any District Office of the Workers' Compensation Board. Applicants using the manual process may wait up to four weeks before receiving a CE-200. Once the applicant receives the CE-200, the applicant can then submit that CE-200 to the government agency from which he/she is getting the permit, license or contract.
OR

B) C-105.2. -- Certificate of Workers' Compensation Insurance (the business's insurance carrier will send this form to the government entity upon request) **PLEASE NOTE**: The State Insurance Fund provides its own version of this form, the U-26.3; **OR**

C) SI-12. -- Certificate of Workers' Compensation Self-Insurance (the business calls the Board's Self-Insurance Office at 518-402-0247), **OR** GSI-105.2 -- Certificate of Participation in Worker's Compensation Group Self-Insurance (the business's Group Self-Insurance Administrator will send this form to the government entity upon request).

DISABILITY BENEFITS REQUIREMENTS UNDER WORKERS' COMPENSATION LAW §220(8)

To comply with coverage provisions of the WCL regarding disability benefits, businesses may:

A) be legally exempt from obtaining disability benefits insurance coverage; or
B) obtain such coverage from insurance carriers; or
C) be a Board-approved self-insured employer.

Accordingly, to assist State and municipal entities in enforcing WCL Section 220(8), businesses requesting permits or seeking to enter into contracts **MUST** provide **ONE** of the following forms to the entity issuing the permit or entering into a contract:

A) CE-200., Certificate of Attestation For New York Entities With No Employees And Certain Out Of State Entities, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage Is Not Required;

Starting December 1, 2008, Form CE-200 can be filled out electronically on the Board's website, www.wcb.state.ny.us., under the heading "Forms." Applicants filing electronically are able to print a finished Form CE-200 immediately upon, completion of the electronic application. Applicants without access to a computer may obtain a paper application for the CE-200 by writing or visiting the Customer Service Center at any District Office of the Workers' Compensation Board. Applicants using the manual process may wait up to four weeks before receiving a CE-200. Once the applicant receives the CE-200, the applicant can then submit that CE-200 to the government agency from which he/she is getting the permit, license or contract.
OR

B) DB-120.1. -- Certificate of Disability Benefits Insurance (the business's insurance carrier will send this form to the government entity upon request); **OR**

C) DB-155. -- Certificate of Disability Benefits Self-Insurance (the business calls the Board's Self-Insurance Office at 518-402-0247).

Please note that **for building permits ONLY**, certain homeowners of 1, 2, 3 or 4 family owner-occupied residences serving as their own General Contractor may be eligible to file Form BP-1. (The homeowner obtains this form from either the Building Department or on the Board's website, www.wcb.state.ny.us., under the heading "Forms.")

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

1a. Legal Name & Address of Insured (Use street address only)	1b. Business Telephone Number of Insured
Company name	1c. NYS Unemployment Insurance Employer Registration Number of Insured
Work Location of Insured *(Only required if coverage is specifically limited to certain locations in New York State, i.e., a Wrap-Up Policy)*	1d. Federal Employer Identification Number of Insured or Social Security Number
2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) Town / Village of Harrison 1 Heineman Place Harrison, ny 10528	3a. Name of Insurance Carrier 3b. Policy Number of entity listed in box "2" 3c. Policy effective period 3d. The Proprietor, Partners or Executive Officers are included. (Only check box if all partners/officers included) excluded or certain partners/officers excluded.

SAMPLE

This certifies that the insurance carrier listed above in box "3" insures the business referenced above in box "1a" for workers' compensation under the New York State Workers' Compensation Law. (To be valid this form, New York (NY) must be listed under Item 3A on the INFORMATION PAGE of the workers' compensation insurance policy). The Insurance Carrier or its licensed agent will send this Certificate of Insurance to the entity listed above as the certificate holder in box "2".

The Insurance Carrier will also notify the above certificate holder within 10 days IF a policy is canceled due to nonpayment of premiums or within 30 days IF there are changes other than nonpayment of premiums that cancel the policy or eliminate the insured from the coverage indicated on this Certificate. (Those notices may be sent by regular mail.) ***Otherwise, this Certificate is valid for one year after this form is approved by the insurance carrier or its licensed agent, or until the policy expiration date listed in box "3c", whichever is earlier.***

Please Note: Upon the cancellation of the workers' compensation policy indicated on this form, if the business continues to be named on a permit, license or contract issued by a certificate holder, the business must provide that certificate holder with a new Certificate of Workers' Compensation Coverage or other authorized proof that the business is complying with the mandatory coverage requirements of New York State Workers' Compensation Law.

Under penalty of perjury, I certify that I am an authorized representative or licensed agent of the insurance carrier referenced above and that the named insured has the coverage as depicted on this form.

Approved by: _____
(Print name of authorized representative or licensed agent of insurance carrier)

Approved by: _____
(Signature) (Date)

Title: _____

Telephone Number of authorized representative or licensed agent of insurance carrier: _____

Please Note: Only insurance carriers and their licensed agents are authorized to issue Form C-105.2. Insurance brokers are NOT authorized to issue it.

C-105.2 (9-07) www.wcb.state.ny.us

New York State Insurance Fund

Workers Compensation & Disability Benefits Specialists Since 1914

199 CHURCH STREET, NEW YORK, N.Y. 10007-1100
Phone: (212) 587-3976

CERTIFICATE OF WORKERS' COMPENSATION INSURANCE

POLICYHOLDER

Company name
Address

CERTIFICATE HOLDER

Town/Village OF Harrison
1 Heineman Place
Harrison, N.Y. 10528

POLICY NUMBER	CERTIFICATE NUMBER	PERIOD COVERED BY THIS CERTIFICATE	DATE

THIS IS TO CERTIFY THAT THE POLICYHOLDER NAMED ABOVE IS INSURED WITH THE NEW YORK STATE INSURANCE FUND UNDER POLICY NO. 1195 111-8 UNTIL 04/16/200[illegible], COVERING THE ENTIRE OBLIGATION OF THIS POLICYHOLDER FOR WORKERS' COMPENSATION UNDER THE NEW YORK WORKERS' COMPENSATION LAW WITH RESPECT TO ALL OPERATIONS IN THE STATE OF NEW YORK, EXCEPT AS INDICATED BELOW.

IF SAID POLICY IS CANCELLED, OR CHANGED PRIOR TO IN SUCH MANNER AS TO AFFECT THIS CERTIFICATE, 10 DAYS WRITTEN NOTICE OF SUCH CANCELLATION WILL BE GIVEN TO THE CERTIFICATE HOLDER ABOVE. NOTICE BY REGULAR MAIL ADDRESSED SHALL BE SUFFICIENT COMPLIANCE WITH THIS PROVISION. THE NEW YORK STATE INSURANCE FUND DOES NOT ASSUME ANY LIABILITY IN THE EVENT OF FAILURE TO GIVE SUCH NOTICE.

THIS CERTIFICATE DOES NOT APPLY TO BUILDING DEMOLITION.

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS NOR INSURANCE COVERAGE UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICY.

THIS POLICY IS CANCELLED EFFECTIVE

NEW YORK STATE INSURANCE F

Vincent M. Iacovello

DIRECTOR, INSURANCE FUND UNDERWRIT

This certificate can be validated on our web site at https://www.nysif.com/cert/certval.asp
VALIDATION NUMBER: 37185

U-26.3

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
SELF-INSURANCE OFFICE
20 PARK STREET - ROOM 201
ALBANY, NY 12207

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

ROBERT R. SNASHALL
CHAIRMAN

COMPLIANCE WITH DISABILITY BENEFITS LAW

(Pursuant To Section 220, subd. 3 of the Disability Benefits Law)

EMPLOYER	EMPLOYER REGISTRATION NUMBER
	LOCATION OF OPERATIONS
ADDRESS (HOME OR MAIN OFFICE)	OPERATIONS TO BEGIN ON OR ABOUT:

There are on file with the Workers' Compensation Board, documents indicating that the above-named employer has complied with the Disability Benefits Law with respect to all his or her employees, in the following manner:

___ By application for insurance pursuant to Sec. 210, subd. 1 of the Disability Benefits Law.

___ By a combination of approved self-insurance pursuant to Sec. 211, subd. 3 of the Disability Benefits Law and insurance with authorized insurance carrier(s).

Date: _____ By _____

Title W.C. Examiner

DB-155 (1/98)

FORM DB-120.1

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

CERTIFICATE OF INSURANCE COVERAGE UNDER THE NYS DISABILITY BENEFITS LAW

PART 1. To be completed by Disability Benefits [illegible]ier or Licensed Insurance Agent of that Carrier

1a. Legal Name and Address of Insured (Use street address on[illegible] Company name and address	1b. Bus[illegible]phone Number of Insured [illegible] NYS [illegible]mplo[illegible]t Insurance Employer Registration Num[illegible] Insur[illegible] 1d. [illegible]al [illegible]oyer Id[illegible]ation Number of Insured or So[illegible] Sec[illegible] Nu[illegible]
2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) Town/Village of Harrison 1 Heineman Place Harrison, NY 10528	3[illegible] [illegible]e [illegible]er [illegible]b. Polic[illegible] [illegible]listed in [illegible]"1a": 3[illegible] [illegible]olicy eff[illegible] p[illegible]: [illegible] to ______

4. Policy cov[illegible]

[illegible] of the emplo[illegible] [illegible]ploy[illegible] [illegible]igible [illegible]er the [illegible] Yo[illegible] [illegible]sability [illegible]efit[illegible] [illegible]w

[illegible] he follo[illegible] [illegible]cla[illegible] f the e[illegible]yer's [illegible]oye[illegible]

Under penalty of [illegible]ry, I certify that I a[illegible] author[illegible] [illegible]tive o[illegible] [illegible]nsed a[illegible] f t[illegible] [illegible]urance carrier referenced above and that the named ins[illegible] has NYS Disability [illegible]efits [illegible]e c[illegible]age as [illegible]ibed a[illegible]

Date Signed______________ By______________________
[illegible]ture of [illegible] ca[illegible] [illegible] representa[illegible] or NYS Licensed [illegible]nce Agent of that insurance carrier)

Telephone Number______________ [illegible]itle______________________

IMPORTANT: If box "4a" is checked, and this form [illegible] insur[illegible] [illegible]ier['s] [illegible]orized representative or NYS [illegible]sed Insurance Agent of that carrier, this certificate is COMPLETE[illegible] [illegible] [illegible]ly to [illegible] [illegible]ur.
If box "4b" is checked, this certificate is NO[illegible] [illegible]E for p[illegible] [illegible]f Section 220, Subd. 8 of the Disability Benefits Law. It must be mailed for completion to the Workers' Compens[illegible] [illegible] Plan[illegible] [illegible] Unit, 20 Park Street, Albany, New York 12207.

PART 2. To be completed by NYS Workers' [illegible]rd (Only if box "4b" of Part 1 has been checked)

[illegible] ork
Worke[illegible] [illegible]ion Board

According to information maintained by the NY[illegible] [illegible]ers' Co[illegible]ation Board, the above-named employer has complied with the NYS Disability Benefits Law with respect to all of his/[illegible]

Date Signed______________ B[illegible]______________________
[illegible] of NYS Workers' Compensation Board Employee)

Telephone Number______________ Title______________________

Please Note: Only insurance carriers licensed to write NYS disability benefits insurance policies and NYS licensed insurance agents of those insurance carriers are authorized to issue Form DB-120.1. Insurance brokers are NOT authorized to issue this form.

DB-120.1 (5-06)