NOTICE REGARDING COMPLIANCE WITH WORKERS' COMPENSATION LAW AND DISABILITY BENEFITS LAW

Under Workers' Compensation Law § 57(1) and § 220(8), applicants must provide proof that they are in compliance with applicable workers' compensation and disability benefits insurance coverage provisions.

All certificates noted below must show as the certificate holder:

New York State Office of General Services
Dulles State Office Building
317 Washington St, Watertown, NY 13601

If Workers Compensation and/or Disability Insurance Coverage IS Required:

WORKERS' COMPENSATION INSURANCE

To comply with workers' compensation coverage provisions of the Workers' Compensation Law, submit one of the following forms with your application:

- C-105.2 (NOT C-105) — Certificate of Workers' Compensation Insurance (issued by the applicant's insurance carrier); OR
- U-26.3 – Certificate of Workers' Compensation Insurance (issued by The State Insurance Fund); OR
- SI-12 — Certificate of Workers' Compensation Self-Insurance (The applicant should call the Workers' Compensation Board's Self- Insurance Office at 518-402-0247 to request this form); OR
- GSI-105.2 — Certificate of Group Workers' Compensation Self-Insurance (issued by applicant's Group Self-Insurance Administrator).

Please note: ACORD forms are NOT acceptable proof of New York State Workers' Compensation coverage!

AND

DISABILITY BENEFITS INSURANCE

To comply with disability benefits coverage provisions of the Disability Benefits Law (Article 9 of the Workers' Compensation Law), submit one of the following forms with your application:

- DB-120.1 (NOT DB-120) — Certificate of Disability Benefits Insurance (issued by the applicant's insurance carrier); OR
- DB-155 — Certificate of Disability Benefits Self-Insurance (The applicant should call the Workers' Compensation Board's Self- Insurance Office at 518-402-0247 to request this form).

Please note: ACORD forms are NOT acceptable proof of New York State Disability Benefits coverage!

If Workers Compensation and/or Disability Insurance Coverage IS NOT Required:

- CE-200 — Certificate of Attestation of Exemption from New York State Workers' Compensation and/or Disability Benefits Insurance Coverage. (The web-based application to this form is on the Workers' Compensation Board's website http://www.wcb.state.ny.us (WC/DB Exemptions). Upon completion, a hard copy of the form can be printed, must be signed by the applicant [or a representative of the applicant] and submitted with your application.

Please call the Workers' Compensation Board's Bureau of Compliance at (518) 486-6307 with any general questions regarding WCL §57 Workers' Compensation Law or Disability Benefits Law § 220 (8)

New York State Insurance Fund

Workers' Compensation & Disability Benefits Specialists Since 1914

1045 SEVENTH NORTH STREET, LIVERPOOL, NEW YORK 13088-6186

CERTIFICATE OF WORKERS' COMPENSATION INSURANCE

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SCAN TO VALIDATE AND SUBSCRIBE

POLICYHOLDER	CERTIFICATE HOLDER
(Must be exactly the same as name on other documents for the same business)	THE NYS OFFICE OF GENERAL SERVICES DULLES STATE OFFICE B 317 WASHINGTON ST WATERTOWN NY 13601

POLICY NUMBER	CERTIFICATE NUMBER	POLICY PERIOD	DATE
		01/01/2018 TO 01/01/2019	1/10/2018

THIS IS TO CERTIFY THAT THE POLICYHOLDER NAMED ABOVE IS INSURED WITH THE NEW YORK STATE INSURANCE FUND UNDER POLICY NO. 2009 286-2, 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, AND, WITH RESPECT TO OPERATIONS OUTSIDE OF NEW YORK, TO THE POLICYHOLDER'S REGULAR NEW YORK STATE EMPLOYEES ONLY.

IF YOU WISH TO RECEIVE NOTIFICATIONS REGARDING SAID POLICY, INCLUDING ANY NOTIFICATION OF CANCELLATIONS, OR TO VALIDATE THIS CERTIFICATE, VISIT OUR WEBSITE AT HTTPS://WWW.NYSIF.COM/CERT/CERTVAL.ASP. THE NEW YORK STATE INSURANCE FUND IS NOT LIABLE IN THE EVENT OF FAILURE TO GIVE SUCH NOTIFICATIONS.

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.

BY CAUSING THIS CERTIFICATE TO BE ISSUED TO THE CERTIFICATE HOLDER, THE POLICYHOLDER UNDERTAKES TO PROVIDE THE CERTIFICATE HOLDER 30 CALENDAR DAYS' NOTICE OF ANY CANCELLATION OF THE POLICY.

NEW YORK STATE INSURANCE FUND

DIRECTOR, INSURANCE FUND UNDERWRITING

NEW YORK STATE | Workers' Compensation Board

CERTIFICATE OF INSURANCE COVERAGE UNDER THE NYS DISABILITY BENEFITS LAW

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

1a. Legal Name & Address of Insured (use street address only) Work Location of Insured *(Only required if coverage is specifically limited to certain locations in New York State, i.e., a Wrap-Up Policy)*	1b. Business Telephone Number of Insured ( ) 1c. NYS Unemployment Insurance Employer Registration Number of Insured 1d. Federal Employer Identification Number of Insured or Social Security Number
2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) NYS OFFICE OF GENERAL SERVICES DULLES STATE OFFICE BUILDING 317 WASHINGTON ST WATERTOWN, NY 13601	3a. Name of Insurance Carrier **New York State Insurance Fund (NYSIF)** 3b. Policy Number of Entity Listed in Box "1a" DBL 3c. Policy effective period _____ to _____

4. Policy covers:

- ☒ A. All of the employer's employees eligible under the New York Disability Benefits Law
- ☐ B. Only the following class or classes of employer's employees:

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 NYS Disability Benefits insurance coverage as described above.

Date Signed _____ By _____
(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number (866) 697-4332 Title **Director of NYSIF Disability Benefits Insurance**

IMPORTANT: If Box "4a" is checked, and this form is signed by the insurance carrier's authorized representative or NYS Licensed Insurance Agent of that carrier, this certificate is COMPLETE. Mail it directly to the certificate holder.
If Box "4b" is checked, this certificate is NOT COMPLETE for purposes of Section 220, Subd. 8 of the Disability Benefits Law. It must be mailed for completion to the Workers' Compensation Board, DB Plans Acceptance Unit, 328 State Street, Schenectady, NY 12305

PART 2. To be completed by the NYS Workers' Compensation Board (Only if Box "4b" of Part 1 has been checked)

State of New York
Workers' Compensation Board

According to information maintained by the NYS Workers' Compensation Board, the above-named employer has complied with the NYS Disability Benefits Law with respect to all of his/her employees.

Date Signed _____ By _____
Signature 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.***

Certificate Number 450976