INSURANCE REQUIREMENTS

Supplier/vendor agrees to obtain and maintain insurance coverage and shall deliver Certificates of Insurance for the stated coverage upon execution of a contract (i.e. service, commodities, permits, loan agreements, etc.). The policies of insurance set forth below shall be written by companies authorized by the New York Department of Financial Services to issue insurance in the state of New York ("admitted" carriers) with an A.M. Best company rating of "A-" or better.

General Liability Insurance:

Limits no less than Two Million Dollars ($2,000,000) per claim and Four Million dollars ($4,000,000) in the aggregate. Such policy shall name the State University of New York, State University of New York at Buffalo and New York State as an additional insured and shall contain a provision that the State University of New York at Buffalo shall receive at least thirty (30) days written notice prior to material change, cancellation or expiration of such policy.

Workers' Compensation and Disability Benefits Coverage:

The supplier/vendor must submit proof that it has workers' compensation and disability benefits coverage as required by the New York State Workers' Compensation Law, or proof that it is legally exempt from obtaining such coverage in compliance with the New York State Workers' Compensation Law. Proof of compliance must be submitted on one of the forms designated by the New York Workers' Compensation Board.

Workers' Compensation:

An ACORD form is NOT acceptable proof of workers' compensation coverage.

In order to provide proof of compliance with the requirements of the Workers' Compensation Law pertaining to workers' compensation coverage, a supplier/vendor shall:

- Be legally exempt from obtaining Workers' Compensation insurance coverage; or
- Obtain such coverage from an insurance carrier; or
- Be a Workers' Compensation Board-approved self-insured employer or participate in an authorized self-insurance plan.

Workers' Compensation (including occupational disease) and Employer's Liability New York Statutory Endorsement with a minimum limit of $1,000,000 as evidenced by one (1) of the following:

- Form C-105.2 (9/07) if coverage is provided by the contractor's insurance carrier, contractor must request its carrier to send this form to the State University of New York; or
- Form U-26.3 if coverage is provided by the State Insurance Fund, contractor must request that the State Insurance Fund send this form to the State University of New York; or
- Form SI-12, Certificate of Workers' Compensation Self-Insurance available from the New York State Workers' Compensation Board's Self-Insurance Office;
- Form GSI-104.2, Certificate of Participation in Workers' Compensation Group Self-Insurance available from the contractor's Group Self-Insurance Administrator; or
- Form 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, which is available on the Workers' Compensation Board's website http://www.wcb.ny.gov/content/ebiz/wc_db_exemptions/requestExemptionOverview.jsp.

Disability Benefits Coverage:

An ACORD form is NOT acceptable proof of Disability Benefits coverage.

In order to provide proof of compliance with the requirements of the Workers' Compensation Law pertaining to disability benefits, a supplier/vendor shall:

- Be legally exempt from obtaining disability benefits coverage; or
- Obtain such coverage from an insurance carrier; or Be a Board-approved self-insured employer.

New York State Disability Benefits as evidenced by one of the following:

- Form DB-120.1, Certificate of Disability Benefits Insurance. Contractor must request its business insurance carrier to send this form to The State University of New York; or
- Form DB-155, Certificate of Disability Benefits Self-Insurance. The Contractor must call the Board's Self-Insurance Office at 518-402-0247 to obtain this form; or
- Form 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, which is available on the Workers' Compensation Board's website http://www.wcb.ny.gov/content/ebiz/wc_db_exemptions/requestExemptionOverview.jsp.

SEE SAMPLE CERTIFICATES AFTER THIS PAGE

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME:	
Producer's Name	PHONE (A/C, No, Ext):	FAX (A/C, No):
Producer's Address	E-MAIL ADDRESS:	

INSURER(S) AFFORDING COVERAGE		NAIC #
INSURER A :	Carrier A	12345
INSURER B :	Carrier B	12345
INSURER C :	Carrier C	12345
INSURER D :		
INSURER E :		
INSURER F :		

INSURED

Contractor's Name

Contractor's Address

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT 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. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY			Policy Number	01/01/2019	01/01/2020	EACH OCCURRENCE	$ 2,000,000
	CLAIMS-MADE X OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 1,000,000
							MED EXP (Any one person)	$ 10,000
							PERSONAL & ADV INJURY	$ 1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 4,000,000
	X POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG	$ 2,000,000
	OTHER:							$
B	AUTOMOBILE LIABILITY			Policy Number	01/01/2019	01/01/2020	COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
	X ANY AUTO						BODILY INJURY (Per person)	$
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	X HIRED AUTOS / X NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
C	X UMBRELLA LIAB X OCCUR			Policy Number	01/01/2019	01/01/2020	EACH OCCURRENCE	$ 1,000,000
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	$ 1,000,000
	DED RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N			SAMPLE			PER STATUTE OTH-ER	
	ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	N / A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

New York State, State University of New York and State University of New York at Buffalo are named as additional insureds.

30-Day Notice of material changes, cancellation or expiration of policy.

CERTIFICATE HOLDER

State University of New York at Buffalo and
New York State
224 Crofts Hall
Buffalo, New York 14260

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

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
Contractor's name and address **Work Location of Insured** ***(Only required if coverage is specifically limited to certain locations in New York State, i.e., a Wrap-Up Policy)***	Contractor's telephone **1c. NYS Unemployment Insurance Employer Registration Number of Insured** Contractor 's Employer Registration # **1d. Federal Employer Identification Number of Insured or Social Security Number** Contractor's FEIN
2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) State University of New York at Buffalo and New York State 224 Crofts Hall Buffalo, New York 14260	**3a. Name of Insurance Carrier** Contractor's carrier **3b. Policy Number of entity listed in box "1a"** policy # **3c. Policy effective period** 1/1/2019 to 1/1/20 **3d. The Proprietor, Partners or Executive Officers are** ☒ **included.** **(Only check box if all partners/officers included)** ☐ **all excluded or certain partners/officers excluded.**

This certifies that the insurance carrier indicated above in box "3" insures the business referenced above in box "1a" for workers' compensation under the New York State Workers' Compensation Law. **(To use 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".

Will the carrier notify the certificate holder within 10 days of a policy being cancelled for non-payment of premium or within 30 days if cancelled for any other reason or if the insured is otherwise eliminated from the coverage indicated on this certificate prior to the end of the policy effective period? YES X NO ____

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 policy listed, nor does it confer any rights or responsibilities beyond those contained in the referenced policy.

This certificate may be used as evidence of a Workers' Compensation contract of insurance only while the underlying policy is in effect.

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 the 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.*

Workers' Compensation Law

Section 57. Restriction on issue of permits and the entering into contracts unless compensation is secured.

1. The head of a state or municipal department, board, commission or office authorized or required by law to issue any permit for or in connection with any work involving the employment of employees in a hazardous employment defined by this chapter, and notwithstanding any general or special statute requiring or authorizing the issue of such permits, shall not issue such permit unless proof duly subscribed by an insurance carrier is produced in a form satisfactory to the chair, that compensation for all employees has been secured as provided by this chapter. Nothing herein, however, shall be construed as creating any liability on the part of such state or municipal department, board, commission or office to pay any compensation to any such employee if so employed.

2. The head of a state or municipal department, board, commission or office authorized or required by law to enter into any contract for or in connection with any work involving the employment of employees in a hazardous employment defined by this chapter, notwithstanding any general or special statute requiring or authorizing any such contract, shall not enter into any such contract unless proof duly subscribed by an insurance carrier is produced in a form satisfactory to the chair, that compensation for all employees has been secured as provided by this chapter.

New York State Insurance Fund

Workers Compensation & Disability Benefits Specialists Since 1914

199 CHURCH STREET, NEW YORK, N.Y. 10007-1100
Phone: (212) 587-5976

CERTIFICATE OF WORKERS' COMPENSATION INSURANCE

POLICYHOLDER	CERTIFICATE HOLDER

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 04/16/20[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

DIRECTOR, INSURANCE FUND UNDERWRI

This certificate can be validated on our web site at https://www.nysif.com/certverival.asp 15

VALIDATION NUMBER: 37185

U-26.2

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

CERTIFICATE OF PARTICIPATION IN WORKERS' COMPENSATION GROUP SELF-INSURANCE

1a. Legal Name and Address of Business Participating in Group Self-Insurance (Use Street Address Only)	1d. Business Telephone Number of Business referenced in box "1a" 1e. NYS Unemployment Insurance Employer Registration Number of Business referenced in box "1a"
1b. Effective Date of Membership in the Group _____	
1c. The Proprietor, Partners or Executive Officers are ☐ included (only check box if all partners/officers included) ☐ all excluded or certain partners/officers excluded	1f. Federal Employer Identification Number of Business referenced in Box "1a"
2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as Certificate Holder)	3. Name and Address of Group Self-Insurer

This certifies that the business referenced above in box "1a" is complying with the mandatory coverage requirements of the New York State Workers' Compensation Law as a current member of the Group Self-Insurer listed above in box "3" and participation in such group self-insurance is still in force. The Group Self-Insurer's Administrator will send this Certificate of Participation to the entity listed above as the certificate holder in box "2".

The Group Self-Insurer's Administrator will notify the above certificate holder within 10 days IF the membership of the participant listed in box "1a" is terminated. (These notices may be sent by regular mail.) Otherwise, this Certificate is valid for a maximum of one year from the date certified by the group self-insurer.

If this certificate is to be renewed according to the above guidelines and the business referenced in box "1a" continues to be named on a permit, license or contract issued by the certificate holder, the business must provide the certificate holder either with a new certificate or other authorized proof the business is complying with the mandatory coverage requirements of the New York State Workers' Compensation Law.

Under penalty of perjury, I certify that I am an authorized representative of the Group Self-Insurer referenced above and that the business referenced in box "1a" has the coverage as depicted on this form.

Certified by: _____ (Print name of authorized representative of the Group Self-Insurer)

Certified by: _____ (Signature) (Date)

Title: _____

Telephone Number: _____

GSI-105.2 (2-02) 17

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 Carrier or Licensed Insurance Agent of that Carrier

1a. Legal Name and Address of Insured (Use street address only) Contractor's name and address	1b. Business Telephone Number of Insured Contractor's telephone 1c. NYS Unemployment Insurance Employer Registration Number of Insured Contractor's employer registation # 1d. Federal Employer Identification Number of Insured or Social Security Number Contractor's FEIN
2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) State University of New York at Buffalo and New York State 224 Crofts Hall Buffalo, New York 14260	3a. Name of Insurance Carrier Contractor's carrier 3b. Policy Number of entity listed in box "1a": policy # 3c. Policy effective period: 1/1/19 to 1/1/20

4. Policy covers:

a. [X] All of the employer's employees eligible under the New York Disability Benefits Law

b. [ ] Only the following class or classes of the 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_____ Title_____

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, 20 Park Street, Albany, New York 12207.

PART 2. To be completed by 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.***

DB-120.1 (5-06)

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 OPERATION
ADDRESS (HOME OR MAIN OFFICE)	OPERATIONS TO BE INSURED UNDER:

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. 211, 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)

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Certificate of Attestation of Exemption
From New York State Workers' Compensation and/or Disability Benefits Insurance Coverage

This form cannot be used to waive the workers' compensation rights or obligations of any party.

The applicant may use this Certificate of Attestation of Exemption **ONLY** to show a government entity that New York State specific workers' compensation and/or disability benefits insurance is not required. The applicant may **NOT** use this form to show another business or that business's insurance carrier that such insurance is not required.

Please provide this form to the government entity from which you are requesting a permit, license or contract. This Certificate will not be accepted by government officials one year after the date printed on the form.

In the Application of (Legal Entity Name and Address):	Business Applying For:
JOHN SMITH **123 MAIN STREET** **ALBANY, NY 12207** **111-111-1111** **Federal ID Number: XXXXX6789**	**BUILDING PERMIT** **From: CITY OF ALBANY, DEPT OF BUILDING AND CODES** The location of where work will be performed is **123 ACME AVENUE, ALBANY, NY 12203.** Estimated dates necessary to complete work associated with the building permit are from **October 14, 2008 to March 31, 2009.** The estimated dollar amount of project is **$25,001 - $50,000**

Workers' Compensation Exemption Statement:

The above named business is certifying that it is **NOT REQUIRED TO OBTAIN NEW YORK STATE SPECIFIC WORKERS' COMPENSATION INSURANCE COVERAGE** for the following reason:

The business is owned by one individual and is not a corporation. Other than the owner, there are no employees, day labor, leased employees, borrowed employees, part-time employees, unpaid volunteers (including family members) or subcontractors.

Disability Benefits Exemption Statement:

The above named business is certifying that it is **NOT REQUIRED TO OBTAIN NEW YORK STATE STATUTORY DISABILITY BENEFITS INSURANCE COVERAGE** for the following reason:

The business is owned by one individual or is a partnership (LLC, LLP, PLLP or a RLLP) under the laws of New York State and is not a corporation; or is a one or two person owned corporation, with those individuals owning all of the stock and holding all offices of the corporation (in a two person owned corporation, each individual must be an officer and own at least one share of stock) or is a business with no NYS location. In addition, the business does not require disability benefits coverage at this time since it has not employed one or more individuals on at least 30 days in any calendar year in New York State. (Independent contractors are not considered to be employees under the Disability Benefits Law.)

I, JOHN SMITH, am the Sole Proprietor with the above-named legal entity. I affirm that due to my position with the above-named business I have the knowledge, information and authority to make this Certificate of Attestation of Exemption. I hereby affirm that the statements made herein are true, that I have not made any materially false statements and I make this Certificate of Attestation of Exemption under the penalties of perjury. I further affirm that I understand that any false statement, representation or concealment will subject me to felony criminal prosecution, including jail and civil liability in accordance with the Workers' Compensation Law and all other New York State laws. By submitting this Certificate of Attestation of Exemption to the government entity listed above I also hereby affirm that if circumstances change so that workers' compensation insurance and/or disability benefits coverage is required, the above-named legal entity will immediately acquire appropriate New York State specific workers' compensation insurance and/or disability benefits coverage and also immediately furnish proof of that coverage on forms approved by the Chair of the Workers' Compensation Board to the government entity listed above.

SIGN HERE	Signature:	Date:

Exemption Certificate Number
2008-00197

Received
October 2, 2008
NYS Workers' Compensation Board