Audio Video Corp
1236 Main St Ste 1,
Buffalo, New York 14209
(716) 427-2550

Veraview LLC
610 Main Street
Suite 400
Buffalo, New York 14202
(844) 488-3629

Troxell Communications
4675 E Cotton Center Blvd
Suite 155
Phoenix, AZ 85040
Tel. 1-800-352-7912
Fax. 1-800-752-1299

Mary Cheney
Marketing Supervisor
Marketing, VoIP Supply
80 Pineview Drive
Amherst, New York 14226
mcheney@viopsupply.com

Cinema and Sound
3566 North Buffalo Rd
Orchard Park 14127

MOOD
100 Victor Heights Parkway
Victor NY 14564-8934

Sensory Technologies
100 Colvin Woods Parkway
Suite 100
Buffalo NY 14150

Sound Video Solutions
75 Benbro Ste.
200 Buffalo NY 14227

Michael Latvis LLC
2495 Mani #355
Buffalo NY 14214

AVS AVScience
1255 University Ave
Suite 130
Rochester NY 14607

PROJECT NO. 201800163

ERIE COUNTY WATER AUTHORITY

Request for Proposal (RFP)
for
DESIGN, INSTALLATION AND PROGRAMMING OF AUDIO AND VIDEO EQUIPMENT FOR ECWA BOARDROOM

Erie County Water Authority
295 Main Street, Rm. 350
Buffalo NY 14203

Contact:
Terrence D. McCracken
Secretary to the Authority
Telephone No. 716-685-8245
tmccracken@ecwa.org

TABLE OF CONTENTS

Attachments:

Required Forms A, B and C

Sample Contract Termination Provision

Proposer Certification

Erie County Water Authority Insurance Requirements for Professional Services

The Request for Proposal (RFP) for the Design, Installation and Programming of Audio and Video Equipment for ECWA Boardroom is being conducted pursuant to the newly enacted legislation, New York State Finance Law Sections 139j and k and the Erie County Water Authority's Purchasing Guidelines, Policies and Procedures.

I. Purpose:

The Authority is soliciting proposals and qualifications from interested parties for the Audio and Video Equipment for the Erie County Water Authority Boardroom. This RFP is for the equipment and installation of the equipment.

II. Background:

BACKGROUND INFORMATION:

Organizational Information

The Erie County Water Authority is a public benefit corporation formed in 1949 to provide a potable water supply to the residents of Western New York. The Authority was created by an Act of the State Legislature, codified in Sections 1050 through 1073 of Title 3 (the "Erie County Water Authority Act") of Article 5 of the Public Authorities Law of the State of New York (as amended), to, among other things, finance, construct, operate and maintain a water supply and distribution system to benefit the residents of the County of Erie, New York. The Authority became operational in 1953. The Authority is financially self-sustaining, paying all operating expenses from revenues generated from the sale of water to 170,042 customers.

The Erie County Water Authority is not an agency of New York State, nor an agency of Erie County government. The Authority is completely independent with respect to budgeting, bonding authority, debt management and credit rating.

The Erie County Water Authority is governed by a Board of Commissioners. The Board consists of three members appointed by the Chairman of the Legislature of Erie County, subject to confirmation by a majority of said Legislature. Each Board member is appointed for a three-year term and continues to hold office until a successor is confirmed. The three-year terms of office are staggered. The enabling State legislation provides that the officers of the Authority shall consist of a Chairman, a Vice-Chairman and a Treasurer who shall be members of the Authority, and a Secretary, who need not be a member of the Authority. The Board establishes policy and is responsible for the overall operations of the Authority.

III. Proposed Scope of Work:

Ellicott Building Boardroom
Erie County Water Authority

The Erie County Water Authority is looking for a company to design, install and program an upgraded audio video experience for the Erie County Water Authority's Boardroom ("Boardroom") located at 295 Main St. There are two (2) rooms that will need to be interfaced.

In the Boardroom, we would like integrated ceiling microphones that will work with a programmed audio processor to cancel out predictable, repetitive, ambient sound from neighboring duct work and fans. The audio solutions will address issues with transmission of audio from the meeting and allow for transcription of the meetings along with a clear audio and video recorded experience. We will require 7 microphones for speaking, allowing for clear audio from the meeting members that will be preset with the camera for active speaker capabilities.

We also have a need for an updated new projector screen along with a 4,600-lumen projector for displaying video conferencing. This will allow the Authority to video conference with a far end meeting member by video call and audio call at the same time with an easy to use solution. All meetings will be transcribed with the ability to divide meetings into sub meetings for storing and streaming the meetings, whichever we prefer.

Any user should be able to come into the Boardroom and from a touch panel choose which mode to use and which source they would like to use. We would like a wireless presentation system installed for easy connection to the projector and screen that would allow laptop's and portable devices to simultaneously be presented on screen.

In the adjacent "Overflow Room" the Authority has a current television which we would like to have equipment added to allow the live room feed to scale and display on the tv for extra meeting participants to view and hear the meeting.

All the equipment needs to be housed in the Boardroom in one mobile standalone rack. This will keep everything in the room allowing for a clean installation. Everything in the Boardroom will be rack mounted and cleanly installed with minimal visibility.

The goal of this project is to keep things as simple and easy to use as possible in the Boardroom. Many different people utilize the space and it is important for all users to be able to have easy to use control for all the equipment. Ceiling microphones keep things simple by providing seamless interaction as well as maximum coverage.

The audio processing behind the microphones ensures that everyone speaking (even multiple people at once) is heard clearly. The Authority highly recommends coming to the Authority and viewing the two rooms. The Authority is open to any other recommendations for accomplishing the Authority's objective in obtaining a state-of-the-art audio and video system with live feed and archival capabilities.

IV. Proposal Requirements:

All respondents are required to send six (6) complete sets of responses (1 original and 5 copies) which should be submitted to the Authority at the following address:

Terrence D. McCracken, Secretary to the Authority
Erie County Water Authority
295 Main Street, Room 350
Buffalo, New York 14203
(716) 849-8245
tmccracken@ecwa.org

Package should be clearly marked: **2018 RFP Design, Installation and Programming of Audio and Video Equipment for ECWA Boardroom**

Proposals must be delivered via mail or hand delivery to the Authority at the above location no later than August 21, 2018. Proposals delivered prior to the deadline shall remain unopened, so long as the package is properly marked as set forth above. Late proposals will not be accepted and will be marked "TOO LATE" and returned to the sender unopened.

All six (6) copies of the respondent's proposal should be arranged as follows:

1. Title Page: Showing RFP name and respondent's name, address, telephone number and contact person.

2. Letter of Introduction: One page, introducing the respondent and manually signed by the person(s) authorized to sign on behalf of, and bind the company to, statements made in response to this RFP.

3. Company Profile and Respondent Information: The following will be required in a company overview/profile as part of respondent's proposal:

    a. Brief (one or two paragraphs) description of the respondent's business, its history and its ability to provide the requested services, including number of years in business.
    b. Information pertinent to the respondent's background and experience relative to this project
    c. A statement of the respondent's understanding of the scope of services.

d. Identify principals and/or officers of the respondent firm.
e. Firm name.
f. Firm address.
g. Telephone numbers and e-mail addresses.
h. Contact person.
i. Respondent's size and organizational structure.
j. Resumes or bio's of personnel to be assigned to the project.
k. References – provide at least three references with contact name and telephone number.
l. Provide a detailed timetable on the setup and installation of all equipment.

4. Compensation: Please provide quotes for all costs of equipment and services.

5. Certifications and Insurances: All attached required NYS Finance Law Certifications Forms A, B, C, Proposer Certification and Insurance certificates must be submitted.

6. Additional Information: If additional services are provided by your firm that are not specified in the SCOPE OF SERVICES (i.e., graphic design), please include those services in your company's response.

V. Terms and Conditions:

- All proposals become the property of the Authority.
- The Authority shall have no financial responsibility for any costs assumed by the "Proposer" in submitting the RFP.
- Each proposal shall be prepared simply and economically, and should provide straightforward and concise responses that satisfy the requirements of the RFP.
- The Authority reserves the right to request additional information from any and all Proposers to assist in the evaluation process. It is the responsibility of the Proposer to inquire about and clarify any aspect of the RFP that is not understood.

Acceptance/Rejection

The Authority reserves the right to accept or reject any or all of the proposal(s) and to select the proposal(s) which, in the opinion of the Authority, will be in the Authority's best interest. The Authority also reserves the right to reject the response of any respondent who has previously failed in the proper performance of any agreement with the Authority. The Authority specifically may choose other than the lowest cost proposal in order to provide the requisite experience and background which are deemed to be most appropriate for the Authority.

THE ISSUANCE OF THIS RFP CONSTITUTES ONLY AN INVITATION TO PRESENT PROPOSALS. THE AUTHORITY AND THE RFP EVALUATION COMMITTEE RESERVE THE RIGHT TO DETERMINE, IN THEIR SOLE DISCRETION, WHETHER ANY ASPECT OF THE PROPOSAL SATISFACTORILY MEETS THE CRITERIA ESTABLISHED IN THE RFP. THE AUTHORITY AND THE RFP EVALUATION COMMITTEE RESERVE THE RIGHT TO SEEK ADDITIONAL INFORMATION AND/OR CLARIFICATION FROM ANY RESPONDENT, THE RIGHT TO NEGOTIATE WITH ANY RESPONDENT SUBMITTING A RESPONSE, AND THE RIGHT TO REJECT ANY OR ALL RESPONSES, WITH OR WITHOUT CAUSE. IN THE EVENT THAT THE RFP IS WITHDRAWN BY THE AUTHORITY FOR ANY REASON, INCLUDING, BUT NOT LIMITED TO, THE FAILURE TO OCCUR OF ANY OF THOSE THINGS OR EVENTS SET FORTH HEREIN, THE AUTHORITY SHALL HAVE NO LIABILITY TO ANY RESPONDENT FOR ANY COSTS OR EXPENSES INCURRED IN CONNECTION WITH THE RFP OR OTHERWISE.

Selection/Evaluation Process

1. An RFP evaluation committee will review all accepted proposals, and will have the option of selecting firms for possible oral presentations. It is anticipated that this process may be completed by August 22, 2018.

2. The RFP evaluation committee will report to the Board of Commissioners, and it is anticipated that the committee will recommend a firm by August 22, 2018. After acquiring the Board of Commissioners consent, the selected firm will be notified.

3. The Authority will negotiate with the firm deemed in its sole judgment to be the most qualified.

4. The successful firm will be required to enter into a written Professional Services Agreement with the Authority in a form approved by the Authority's legal counsel. The Authority reserves the right to negotiate the terms and conditions of the agreement with the selected firm.

5. All proposals must state the period for which the proposal shall remain in effect, with a minimum of 120 days from the due date of the proposal.

6. The Authority reserves the right to request additional information from any and all respondents to assist in the evaluation process.

7. The Authority reserves the right to reject any and all proposals. The award will be made to the firm whose proposal is deemed to be in the best interest of the Authority at its sole discretion.

8. Respondents, agents and/or associates are prohibited from contacting or soliciting any other Erie County Water Authority official, including Authority members, during the restricted period from August 2, 2018 through the award of contract date.

9. Any changes to the request for proposal will be communicated in writing to all firms who receive this RFP.

10. Should the Authority be unable to negotiate a satisfactory contract with the selected firm, negotiations with that firm will be formally terminated. The Authority will then undertake negotiations with the second most qualified firm.

VI. Additional Information:

It is the sole responsibility of the respondent to inquire about and seek clarification on any aspect of the RFP that is not understood.

All questions and requests for clarification should be addressed in writing to the designated contact person, Terrence D. McCracken, Secretary to the Authority at tmccracken@ecwa.org. All questions and requests for clarifications will be answered and distributed via e-mail to all firms eligible to submit a response to the RFP.

VII. Time Table of Events

August 2, 2018 Distribute Request for Proposal (RFP)

Pre-RFP Meeting: August 6, 2018 – August 8, 2018 at 295 Main Street, Room 350, Buffalo, New York 14203. Any interested party should contact Terry D. McCracken (716-849-8245) and make an appointment to view the two rooms

RFP due date: **August 20, 2018**

Terrence D. McCracken
Secretary to the Authority
Erie County Water Authority
295 Man Street, Rm. 350
Buffalo, New York 14203

FORMS A, B and C

SECTION 139 OF STATE FINANCE LAW

Pursuant to State Finance Law §139-j and §139-k, this Invitation to Bid includes and imposes certain restrictions on communications between a Governmental Entity and an Offerer/bidder during the procurement process. An Offerer/bidder is restricted from making contacts from the earliest notice of intent to solicit offers, through final award and approval of the Procurement Contract by the Governmental Entity. The designated contact is identified in the Notice to Bidders. Governmental Entity employees are also required to obtain certain information when contacted during the restricted period and make a determination of the responsibility of the Offerer/bidder pursuant to these two statutes. Certain findings of non-responsibility can result in rejection for contract award and in the event of two findings within a 4-year period; the Offerer/bidder is debarred from obtaining governmental Procurement Contracts. Further information about these requirements can be found in §139-j and §139-k of the New York State Finance law and the Erie County Water Authority's Procurement Disclosure Policy.

- Form A - Offerer's Affirmation of Understanding of and Agreement pursuant to State Finance Law.
- Form B - Offerer's Certification of Compliance with State Finance Law.
- Form C - Offerer's Disclosure of Prior Non-Responsibility Determinations.
- Contract Termination Provision.

FORM A

Offerer's Affirmation of Understanding of and Agreement pursuant to State Finance Law §139-j (3) and §139-j (6) (b)

Instructions:

A Governmental Entity must obtain the required affirmation of understanding and agreement to comply with procedures on procurement lobbying restrictions regarding permissible Contacts in the restricted period for a procurement contract in accordance with State Finance Law §§139-j and 139-k. It requires that this affirmation be obtained as early as possible in the procurement process, but no later than when the Offerer submits its proposal.

Offerer affirms that it understands and agrees to comply with the procedures of the Government Entity relative to permissible Contacts as required by State Finance Law §139–j (3) and §139–j (6) (b).

By: _____ Date: _____

Name: _____

Title: _____

Contractor Name: _____

Contractor Address: _____

_____

_____

FORM B

Offerer's Certification of Compliance
With State Finance Law §139-k (5)

Instructions:

A Governmental Entity must obtain the required certification that the information is complete, true, and accurate regarding any prior findings of non-responsibility, such as non-responsibility pursuant to State Finance Law §139-j. The Offerer must agree to the certification and provide it to the procuring Governmental Entity. It is required that the certification be obtained as early as possible in the process, but no later than when an Offerer submits its proposal.

Offerer Certification:

I certify that all information provided to the Governmental Entity with respect to State Finance Law §139-k is complete, true, and accurate.

By: _____ Date: _____

Name: _____

Title: _____

Contractor Name: _____

Contractor Address: _____

_____

_____

FORM C

Offerer's Disclosure of Prior Non-Responsibility Determinations

Background:

New York State Finance Law §139-k (2) obligates a Governmental Entity to obtain specific information regarding prior non-responsibility determinations with respect to State Finance Law §139-j. In accordance with State Finance Law §139-k, an Offerer must be asked to disclose whether there has been a finding of non-responsibility made within the previous four (4) years by any Governmental Entity due to: (a) a violation of State Finance Law §139-j or (b) the intentional provision of false or incomplete information to a Governmental Entity. The terms "Offerer" and "Governmental Entity" are defined in State Finance Law §139-k (1). State Finance Law §139-j sets forth detailed requirements about the restrictions on Contacts during the procurement process. A violation of State Finance Law §139-j includes, but is not limited to, an impermissible Contact during the restricted period (for example, contacting a person or entity other than the designated contact person, when such Contact does not fall within one of the exemptions).

As part of its responsibility determination, State Finance Law §139-k (3) mandates consideration of whether an Offerer fails to timely disclose accurate or complete information regarding the above non-responsibility determination. In accordance with law, no Procurement Contract shall be awarded to any Offerer that fails to timely disclose accurate or complete information under this section, unless a finding is made that the award of the Procurement Contract to the Offerer is necessary to protect public property or public health safety, and that the Offerer is the only source capable of supplying the required Article of Procurement within the necessary time frame. See State Finance Law §139-j (10) (b) and §139-k (3).

Instructions:

A Governmental Entity must include a disclosure request regarding prior non-responsibility determinations in accordance with State Finance Law §139-k in its solicitation of proposals or bid documents or specifications or contract documents, as applicable, for procurement contracts. The attached form is to be completed and submitted by the individual or entity seeking to enter into a Procurement Contract. It shall be submitted to the Governmental Entity conducting the Governmental Procurement no later than when an Offerer submits its proposal.

FORM C

Offerer's Disclosure of Prior Non-Responsibility Determinations

Name of Individual or Entity seeking to Enter into the Procurement Contract:

_____

Address: _____

_____

Name and Title of Person Submitting this Form: _____

_____

Contract Procurement Number: _____

Date:_____

1. Has any Governmental Entity made a finding of non-responsibility regarding the individual or entity seeking to enter into the Procurement Contract in the previous four years? (Please circle)

   No Yes

   If yes, please answer the next questions:

2. Was the basis for the finding of non-responsibility due to a violation of State Finance Law §139-j? (Please circle)

   No Yes

3. Was the basis for the finding of non-responsibility due to the intentional provision of false or incomplete information to a Governmental Entity? (Please circle)

   No Yes

4. If you answered yes to any of the above questions, please provide details regarding the finding of non-responsibility below.

Governmental Entity: _____

Date of Finding of Non-Responsibility: _____

Basis of Finding Non-Responsibility: _____

_____

_____

_____

_____

_____

(Add additional pages as necessary)

FORM C

5. Has any Governmental Entity or other governmental agency terminated or withheld a Procurement Contract with the above-named individual or entity due to the intentional provision of false or incomplete information? (Please circle)

No Yes

6. If yes, please provide details below.

Governmental Entity: _____

Date of Termination or Withholding of Contract: _____

Basis of Termination or Withholding: _____

_____

_____

_____

_____

_____

(Add additional pages as necessary)

Offerer certifies that all information provided to the Governmental Entity with respect to State Finance Law §139-k is complete, true, and accurate.

By: _____ Date: _____

Signature

Name: _____

Title: _____

Contract Termination Provision

Instructions:

A Contract Termination Provision will be included in each Procurement Contract governed by State Finance Law §139-k. New York State Finance Law §139-k (5) provides that every procurement contract award subject to the provisions of State Finance Law §139-k and §139-j shall contain a provision authorizing the Governmental Entity to terminate the contract in the event that the certification is found to be intentionally false or intentionally incomplete. This statutory contract language authorizes, but does not mandate, termination. "Government Entity" and "procurement contract" are defined in State Finance Law §139-k (1).

This required clause will be included in a covered procurement contract.

A sample of the Termination Provision is included below. If a contract is terminated in accordance with State Finance Law §139-k (5), the Governmental Entity is required to include a statement in the procurement record describing the basis for any action taken under the termination provision.

Sample Contract Termination Provision

The Governmental Entity reserves right to terminate this contract in the event it is found that the certification filed by the Offerer in accordance with New York State Finance Law §139-k was intentionally false or intentionally incomplete. Upon such finding, the Governmental Entity may exercise its termination right by providing written notification to the Offerer in accordance with the written notification terms of this contract.

Erie County Water Authority Insurance Requirements for Contracting Services

Project Number: 201800163

Description: DESIGN, INSTALLATION AND PROGRAMMING OF AUDIO AND VIDEO FOR ECWA BOARDROOM

The following minimum insurance requirements shall apply to contractors providing services to the Erie County Water Authority (ECWA). If a service or project, in the opinion of ECWA, represents an unusual or exceptional risk, ECWA may establish additional insurance requirements for that service or project. All insurance required herein shall be obtained at the sole cost and expense of the contractor, including deductibles and self-insured retentions, and shall be in full force and effect on the contract commencement date and for the duration of the contract. These requirements include but are not limited to the minimum insurance requirements.

An X indicates insurance coverage is required.

X **Commercial General Liability Insurance**: (including, but not limited to, Bodily (Personal) Injury, Premises Operations, Property Damage Liability (broad form), Contractual Liability, Advertising Injury, Independent Contractors, Product Liability, and Completed Operations Liability in an amount not less than $1,000,000 combined single limit and $2,000,000 in the aggregate:

X **Per Policy**

___ **Per Project or Job**

___ **Per Location**

There should be no exclusions for any claims filed, actual or alleged, for violation of any applicable statute including, but not limited to, the New York State or federal labor laws, ordinances, administrative orders, executive orders, rules, regulations, or decrees of any court of competent jurisdiction.

X **Commercial Business Automobile Insurance** in an amount of not less than $1,000,000 each accident and shall cover liability arising out of any automobile owned, leased, hired, borrowed and non-owned automobiles. Additionally, if vehicles are used for transporting hazardous materials, the contractor shall obtain and maintain the "broadened" coverage (endorsement CA 99 48), as well as proof of MCS 90 04 00.

X **Cyber and Privacy & Security Coverage:**

All vendors with access to confidential records and/or access to any of ECWA's communication networks, servers, etc. must carry Cyber Liability coverage for damages arising from a failure of computer security, or wrongful release of private information including expenses for notification as required by local, state or federal guidelines. Limit of liability must be at least One Million and 00/100 Dollars ($1,000,000.00) per claim and One Million and 00/100 Dollars ($1,000,000.00) in the aggregate. Any retroactive date or prior acts exclusion must predate both the date of this agreement and any earlier commencement of any services. If coverage is on a "claims made basis", a 2 to 5 year extended reporting provision must be included.

X **All-Risk Installation Floater**: Builder's risk completed value form based on the total value of the project, providing coverage for work performed, equipment, supplies and materials at the project location, as well as any off-site storage location.

___ **Pollution Legal Liability Insurance** in an amount of not less than:

___ $1,000,000 in the aggregate

___ $2,000,000 in the aggregate

___ $3,000,000 in the aggregate

___ $4,000,000 in the aggregate

___ $5,000,000 in the aggregate

___ **Per Policy**

___ **Per Project or Job**

___ **Per Location**

And, if disposal of materials is involved, the disposal site operator must carry Pollution Legal Liability Insurance in an amount of not less than:

___ $1,000,000 in the aggregate

___ $2,000,000 in the aggregate

___ $3,000,000 in the aggregate

___ $4,000,000 in the aggregate

___ $5,000,000 in the aggregate

___ **Per Policy**

___ **Per Project or Job**

___ **Per Location**

___ **Excess Umbrella Liability Insurance** in an amount of not less than:

___ $1,000,000 in the aggregate

___ $2,000,000 in the aggregate

___ $3,000,000 in the aggregate

___ $4,000,000 in the aggregate

___ $5,000,000 in the aggregate

___ **Per Policy**

___ **Per Project or Job**

___ **Per Location**

__X__ **Workers' Compensation and Employers' Liability and New York State Disability Benefits Insurances,** as required by New York State statute. If employees of the contractor will be working on or near navigable waters, US Longshore and Harbor Workers Compensation Act endorsement must be included.

Certificates of Insurance, on forms approved by the New York State Department of Insurance, must be submitted to ECWA prior to the award of contract. Renewals of Certificates of Insurance, on forms approved by the New York State Department of Insurance, must be received by ECWA 30 days prior to the expiration of the insurance policy period.

Certificates of Insurance and renewals, on forms approved by the New York State Department of Insurance, must be submitted to ECWA prior to the award of contract. Each insurance carrier issuing a Certificate of Insurance shall be rated by A. M. Best no lower than "A-" with a Financial Strength Code (FSC) of at least VII. The professional service provider shall name ECWA, its officers, agents and employees as additional insured on a Primary and Non-Contributory Basis, including a Waiver of Subrogation endorsement (form CG 20 26 11 85 or equivalent), on all applicable liability policies. Any liability coverage on a "claims made" basis should be designated as such on the Certificate of Insurance.

To avoid confusion with similar insurance company names and to properly identify the insurance company, please make sure that the insurer's National Association of Insurance Commissioners (N.A.I.C.) identifying number or A. M. Best identifying number appears on the Certificate of Insurance. Also, at the top of the Certificate of Insurance, please list the project number.

Acceptance of a Certificate of Insurance and/or approval by ECWA shall not be construed to relieve the outside vendor of any obligations, responsibilities or liabilities.

Certificates of Insurance should be e-mailed to AALESSI@ECWA.ORG. or mailed to Mr. Anthony Alessi, ECWA Claims Representative/Risk Manager, Erie County Water Authority, 295 Main Street – Room 350, Buffalo, New York 14203-2494, or If you have any questions you can contact Mr. Alessi by e-mail or phone (716) 849-8477.

Please refer to the bid and the contract document(s) for additional information regarding insurance requirements.

County Water Authority Insurance Requirements for Contracting Services

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:
	PHONE (A/C, No, Ext): FAX (A/C, No):
	E-MAIL ADDRESS:
	PRODUCER CUSTOMER ID #:

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

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 INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	GENERAL LIABILITY						EACH OCCURRENCE	$ 1,000,000
	X COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 100,000
	CLAIMS-MADE X OCCUR						MED EXP (Any one person)	$ 5,000
	X Blanket Broad Form	X	X				PERSONAL & ADV INJURY	$ 1,000,000
	Contractual						GENERAL AGGREGATE	$ 2,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						PRODUCTS - COMP/OP AGG	$ 2,000,000
	POLICY X PRO-JECT LOC							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
	X ANY AUTO						BODILY INJURY (Per person)	$
	ALL OWNED AUTOS						BODILY INJURY (Per accident)	$
	SCHEDULED AUTOS	X	X				PROPERTY DAMAGE (Per accident)	$
	HIRED AUTOS							$
	NON-OWNED AUTOS							$
	X UMBRELLA LIAB X OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB CLAIMS-MADE	X	X				AGGREGATE	$
	DEDUCTIBLE							$
	X RETENTION $ 10,000			Per Specific Agreement				$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N			SUBMIT proof of Workers			WC STATU-TORY LIMITS / OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	N/A		Compensation and disability			E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below			as per examples attached			E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, If more space is required)

Additional Insured on a Primary and non-contributory basis:Erie County Water Authority
Additional Insured endorsement CG 20 10 11 85 or equivalent

CERTIFICATE HOLDER

Erie County Water Authority
295 Main St, Suite 350
Buffalo, NY 14203

Attn: Anthony Alessi

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

Understanding New York Workers Compensation Board
Workers Compensation and N.Y.S Disability Benefits Liability

This is a brief description for governmental organizations to validate vendor workers compensation and NYS Disability Benefits coverage. These requirements should be used when applying for permits, licenses or secure contracts. Copies should be obtained not only at the initial issuance but at renewal as well. A full instruction manual can be obtained from the Workers Comp Board.

The forms discussed are:

1) Form CE-200- Affidavit of Exemption (obtain at: www.wcb.state.ny.us/content/ebiz/wc_db_exemptions/requestExemptionOverview.jsp)
   - ➢ Acceptable proof that the business listed is exempt from providing workers' compensation and/or disability insurance coverage.

2) Workers Compensation

- Form C-105.2: Certificate of Workers Compensation (WC) (Obtain from your insurance agent)
  - ➢ All private NYS licensed workers' compensation carriers are required to issue the C-105.2.

- Form SI- 12: Certificate of WC when self-insured. (Obtain from workers compensation board)
  - ➢ Only the Self-Insurance Office of the Workers' Compensation Board issues the SI-12. The Self-Insurance Office can be contacted at **518-402-0247**. **Only one legal name and Federal Employer Identification Number can be listed on each Form SI-12. (Multiple legal entities must not be listed.)**

- Form GSI- 105.2: Certificate of WC when participating in a group self-insured program.
  - ➢ The self-insurance administrator of the group completes the form.

- Form U-26.3: Certificate of WC
  - ➢ Acceptable proof that the business has workers' compensation coverage through the New York State Insurance Fund. Only available through (NYSIF).

3) New York State Disability Benefits Law (DBL)

- Form DB-120.1: Certificate of DBL Insurance (obtain from workers compensation board)
  - ➢ The DB-120.1 must be completed by either the NYS statutory disability benefits insurance carrier, or a licensed NYS insurance agent of that carrier. The form can be obtained by contacting the Bureau of Compliance. (certificates@wcb.state.ny.us)

- Form DB-155: Certificate of DBL Self-Insurance
  - ➢ The Self-Insurance Office of the Workers' Compensation Board issues the DB-155. The Board's secretary will approve the DB-155. The Self-Insurance Office can be contacted at **518-402-0247**.

4) Exemption 1, 2, 3, or 4 Family, Owner Occupied residence (http://www.wcb.state.ny.us/content/main/forms/bp-1.pdf)

NOTE: ACORD Certificates of Insurance are not acceptable proof. Must use one of the forms noted above:

Form CE-200

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: BUILDING PERMIT
JOHN SMITH 123 MAIN STREET ALBANY, NY 12207 111-111-1111 Federal ID Number: XXXXX6789	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

CE-200 (Draft 06/02/08)

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** **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)	**3a. Name of Insurance Carrier** **3b. Policy Number of entity listed in box "1a"** **3c. Policy effective period** _____ **to** _____ **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".

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 reasons other than nonpayment of premiums that cancel the policy or eliminate the insured from the coverage indicated on this Certificate. (These notices may be sent by regular mail.) ***Otherwise, this Certificate is valid for one year after this form is approved by the insurance carrier, 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 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.

Form SI-12

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
SELF-INSURANCE OFFICE
20 PARK STREET - ROOM 206
ALBANY, NY 12207

(518) 402-0247
FAX (518) 402-6199

COMPLIANCE WITH DISABILITY BENEFITS LAW
(Pursuant To Section 220, subd. 8 of the Disability Benefits Law)

EMPLOYER	FEDERAL EMPLOYER IDENTIFICATION 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 of his or her employees in the following manner:

☐ By approved self-insurance pursuant to Section 211, subdivision 3 of the Disability Benefits Law.

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

Date:

By:_____
Gina Wagoner
WC Examiner

DB-155 (3/04)

THIS AGENCY EMPLOYS & SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

NYSIF New York State Insurance Fund
Workers' Compensation & Disability Benefits Specialists Since 1914
199 CHURCH STREET, NEW YORK, N Y. 10007-1100
Phone: (888) 997-3863

CERTIFICATE OF WORKERS' COMPENSATION INSURANCE

^^^^^^

POLICYHOLDER	CERTIFICATE HOLDER

POLICY NUMBER	CERTIFICATE NUMBER	PERIOD COVERED BY THIS CERTIFICATE	DATE
		01/01/2009 TO 05/01/2010	1/8/2009

THIS IS TO CERTIFY THAT THE POLICYHOLDER NAMED ABOVE IS INSURED WITH THE NEW YORK STATE INSURANCE FUND UNDER POLICY NO. 2058 840-6 UNTIL 05/01/2010, 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 05/01/2010 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 SO 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.

NEW YORK STATE INSURANCE FUND

John Masetti

DIRECTOR,INSURANCE FUND UNDERWRITING

This certificate can be validated on our web site at https://www.nysif.com/cert/certval.asp or by calling (888) 875-5790
VALIDATION NUMBER: 107031806

U-26.3

0/CD23592-21/94

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 participating 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 no longer valid 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: _____

NEW YORK STATE | Workers' Compensation Board

CERTIFICATE OF INSURANCE COVERAGE
DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

PART 1. To be completed by Disability and Paid Family Leave 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., Wrap-Up Policy)*	1b. Business Telephone Number of Insured 1c. 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)	3a. Name of Insurance Carrier **ShelterPoint Life Insurance Company** 3b. Policy Number of Entity Listed in Box "1a" 3c. Policy effective period _____ to _____

4. Policy provides the following benefits:
   - ☐ A. Both disability and paid family leave benefits
   - ☐ B. Disability benefits only.
   - ☐ C. Paid family leave benefits only.
5. Policy covers:
   - ☐ A. All of the employer's employees eligible under the NYS Disability and Paid Family Leave 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 and/or Paid Family Leave Benefits insurance coverage as described above.

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

Telephone Number _____ Name and Title _____

IMPORTANT: If Boxes 4A and 5A are 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, 4C or 5B is checked, this certificate is NOT COMPLETE for purposes of Section 220, Subd. 8 of the NYS Disability and Paid Family Leave Benefits Law. It must be mailed for completion to the Workers' Compensation Board, Plans Acceptance Unit, PO Box 5200, Binghamton, NY 13902-5200.

PART 2. To be completed by the NYS Workers' Compensation Board (Only if Box 4C or 5B 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 and Paid Family Leave Benefits Law with respect to all of his/her employees.

Date Signed _____ By _____
(Signature of Authorized NYS Workers' Compensation Board Employee)

Telephone Number _____ Name and Title _____

Please Note: Only insurance carriers licensed to write NYS disability and paid family leave 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.

Additional Instructions for Form DB-120.1

By signing this form, the insurance carrier identified in Box 3 on this form is certifying that it is insuring the business referenced in box "1a" for disability and/or paid family leave benefits under the New York State Disability and Paid Family Leave Benefits Law. The Insurance Carrier or its licensed agent will send this Certificate of Insurance to the entity listed as the certificate holder in Box 2.

The insurance carrier must notify the above certificate holder and the Workers' Compensation Board within 10 days IF a policy is cancelled due to nonpayment of premiums or within 30 days IF there are reasons other than nonpayment of premiums that cancel the policy or eliminate the insured from coverage indicated on this Certificate. (These notices my 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

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 Disability and/or Paid Family Leave Benefits contract of insurance only while the underlying policy is in effect.

Please Note: Upon the cancellation of the disability and/or paid family leave benefits 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 NYS Disability and/or Paid Family Leave Benefits Coverage or other authorized proof that the business is complying with the mandatory coverage requirements of the New York State Disability and Paid Family Leave Benefits Law.

DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

§220. Subd. 8

(a) 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 employment as defined in this article, and not withstanding 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 the payment of disability benefits and after January first, two thousand and twenty-one, the payment of family leave benefits for all employees has been secured as provided by this article. 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 disability benefits to any such employee if so employed.

(b) 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 employment as defined in this article and 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 the payment of disability benefits and after January first, two thousand eighteen, the payment of family leave benefits for all employees has been secured as provided by this article.

FORM DB-155

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
SELF-INSURANCE OFFICE
20 PARK STREET - ROOM 206
ALBANY, NY 12207

(518) 402-0247
FAX (518) 402-6199

COMPLIANCE WITH DISABILITY BENEFITS LAW
(Pursuant To Section 220, subd. 8 of the Disability Benefits Law)

EMPLOYER	FEDERAL EMPLOYER IDENTIFICATION 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 of his or her employees in the following manner:

☐ By approved self-insurance pursuant to Section 211, subdivision 3 of the Disability Benefits Law.

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

Date:

By:_____
Gina Wagoner
WC Examiner

DB-155 (3/04)

THIS AGENCY EMPLOYS & SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Affidavit of Exemption to Show Specific Proof of Workers' Compensation Insurance Coverage for a 1, 2, 3 or 4 Family, Owner-occupied Residence

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

Under penalty of perjury, I certify that I am the owner of the 1, 2, 3 or 4 family, **owner-occupied** residence (including condominiums) listed on the building permit that I am applying for, and I am not required to show specific proof of workers' compensation insurance coverage for such residence because (please check the appropriate box):

☐ I am performing all the work for which the building permit was issued.

☐ I am not hiring, paying or compensating in any way, the individual(s) that is(are) performing all the work for which the building permit was issued or helping me perform such work.

☐ I have a homeowners insurance policy that is currently in effect and covers the property listed on the attached building permit AND am hiring or paying individuals a total of less than 40 hours per week (aggregate hours for all paid individuals on the jobsite) for which the building permit was issued.

I also agree to either:

- acquire appropriate workers' compensation coverage and provide appropriate proof of that coverage on forms approved by the Chair of the NYS Workers' Compensation Board to the government entity issuing the building permit if I need to hire or pay individuals a total of 40 hours or more per week (aggregate hours for all paid individuals on the jobsite) for work indicated on the building permit, or if appropriate, file a CE-200 exemption form; OR
- have the general contractor, performing the work on the 1, 2, 3 or 4 family, **owner-occupied** residence (including condominiums) listed on the building permit that I am applying for, provide appropriate proof of workers' compensation coverage or proof of exemption from that coverage on forms approved by the Chair of the NYS Workers' Compensation Board to the government entity issuing the building permit if the project takes a total of 40 hours or more per week (aggregate hours for all paid individuals on the jobsite) for work indicated on the building permit.

_____ _____

(Signature of Homeowner) (Date Signed)

_____ Home Telephone Number _____

(Homeowner's Name Printed)

Property Address that requires the building permit:

_____

_____

_____

_____

Sworn to before me this _____ day of

_____, _____.

(County Clerk or Notary Public)

Once notarized, this BP-1 form serves as an exemption for both workers' compensation and disability benefits insurance coverage.

LAWS OF NEW YORK, 1998
CHAPTER 439

The **general municipal law is amended by adding a new section 125** to read as follows:

. 125. ISSUANCE OF BUILDING PERMITS. NO CITY, TOWN OR VILLAGE SHALL ISSUE A BUILDING PERMIT WITHOUT OBTAINING FROM THE PERMIT APPLICANT EITHER:

1. PROOF DULY SUBSCRIBED THAT WORKERS' COMPENSATION INSURANCE AND DISABILITY BENEFITS COVERAGE ISSUED BY AN INSURANCE CARRIER IN A FORM SATISFACTORY TO THE CHAIR OF THE WORKERS' COMPENSATION BOARD AS PROVIDED FOR IN SECTION FIFTY-SEVEN OF THE WORKERS' COMPENSATION LAW IS EFFECTIVE; OR

2. AN AFFIDAVIT THAT SUCH PERMIT APPLICANT HAS NOT ENGAGED AN EMPLOYER OR ANY EMPLOYEES AS THOSE TERMS ARE DEFINED IN SECTION TWO OF THE WORKERS' COMPENSATION LAW TO PERFORM WORK RELATING TO SUCH BUILDING PERMIT.

Implementing Section 125 of the General Municipal Law

1. General Contractors -- Business Owners and Certain Homeowners

For **businesses and certain homeowners listed as the general contractors on building permits,** proof that they are in compliance with Section 57 of the Workers' Compensation Law (WCL) is **ONE** of the following forms that indicate that they are:

- insured (C-105.2 or U-26.3),
- self-insured (SI-12), or
- are exempt (CE-200),

under the mandatory coverage provisions of the WCL. Any residence that is not a **1, 2, 3 or 4 Family, Owner-occupied Residence** is considered a business (income or potential income property) and must prove compliance by filing one of the above forms.

2. Owner-occupied Residences

For homeowners of a **1, 2, 3 or 4 Family, Owner-occupied Residence,** proof of their exemption from the mandatory coverage provisions of the Workers' Compensation Law when applying for a building permit is to file form BP-1.

- Form BP-1 shall be filed if the homeowner of a **1, 2, 3 or 4 Family, Owner-occupied Residence** is listed as the general contractor on the building permit, and the homeowner:
  - ◊ is performing all the work for which the building permit was issued him/herself,
  - ◊ is not hiring, paying or compensating in any way, the individual(s) that is(are) performing all the work for which the building permit was issued or helping the homeowner perform such work, or
  - ◊ has a homeowner's insurance policy that is currently in effect and covers the property for which the building permit was issued AND the homeowner is hiring or paying individuals a total of less than 40 hours per week (aggregate hours for all paid individuals on the jobsite) for the work for which the building permit was issued.
- If the homeowner of a **1, 2, 3 or 4 Family, Owner-occupied Residence** is hiring or paying individuals a total of **40 hours or MORE** in any week (aggregate hours for all paid individuals on the jobsite) for the work for which the building permit was issued, then the homeowner may not file the "Affidavit of Exemption" form, BP-1(11/04), but shall either:
  - ◊ acquire appropriate workers' compensation coverage and provide appropriate proof of that coverage on forms approved by the Chair of the NYS Workers' Compensation Board to the government entity issuing the building permit (the C-105.2 or U-26.3 form), OR
  - ◊ have the general contractor, (performing the work on the 1, 2, 3 or 4 family, **owner-occupied** residence (including condominiums) listed on the building permit) provide appropriate proof of workers' compensation coverage, or proof of exemption from that coverage on forms approved by the Chair of the NYS Workers' Compensation Board to the government entity issuing the building permit.

STATE OF NEW YORK - WORKERS' COMPENSATION BOARD

ESTADO DE NUEVA YORK - JUNTA DE COMPENSACION OBRERA

NOTICE OF COMPLIANCE
WORKERS' COMPENSATION LAW

TO EMPLOYEES

IMPORTANT INFORMATION FOR EMPLOYEES WHO ARE INJURED OR SUFFER AN OCCUPATIONAL DISEASE WHILE WORKING.

1. By posting this notice and information concerning your rights as an injured worker, your compliance with the Workers' Compensation Law.
2. If you do not notify your employer within 30 days of the date of your injury your claim may be disallowed, so do so immediately.
3. You are entitled to obtain any necessary medical treatment and should do so immediately.
4. You may choose any doctor, podiatrist, chiropractor or psychologist referred by a medical doctor that accepts NY State Workers Compensation patients and is Board authorized. However, if your employer is involved in a certified preferred provider organization (PPO) you must first be treated by a provider chosen by your employer and your employer must give you a written statement of your rights concerning further medical care.
5. You should tell your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and with your employer's insurance company, which is indicated at the bottom of this form.
6. You may be entitled to lost time benefits if your work-related injury keeps you from work for more than seven days, compels you to work at lower wages or results in permanent disability to any part of your body. You may be entitled to rehabilitation services if you need help returning to work.
7. You should not pay any medical providers directly. They should send their bills to your employers insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for the payment of the bills.
8. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire a representative do not pay him/her directly. Any fee will be set by the Board and will be deducted from your award.
9. If you have difficulty in obtaining a claim form or need help in filling it out, or if you have any other questions or problems about a job-related injury, contact any office of the Workers' Compensation Board.

WORKERS' COMPENSATION BOARD OFFICES

Albany, 12241 - 100 Broadway-Menands - (866) 750-5157
• Brooklyn, 11201 - III Livingston St. - Brooklyn - (800) 877-1373
Binghamton, 113901 - State Office Bldg. - 44 Hawley St. - (866) 802-3604
Buffalo, 14202 - Statler Tower, 107 Delaware Ave. - (866) 211-0645
• Hauppauge, 11788 - 220 Rabro Drive - Suite 100 - (866) 681-5354
•Hempstead, 11550 - 175 Fulton Avenue - (866) 805-3630
• New York, 10027 - 215 W. 1125th St., Manhattan .(800)-877-1373
• Peekskill, 10566 - 41 North Division St. (866) 746-0552
• Queens, 11432 - 168-46 91st Ave., Jamaica (800) 877-1373
Rochester, 14614 .130 Main Street West - (866) 211-0644
Syracuse, 13203 - 935 James St. - (866) 802-3730

• DOWNSTATE MAIL ADDRESS

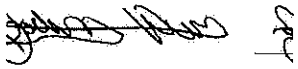
Claims-related mail for the Hauppauge, Hempstead, Peekskill and all NYC offices should be mailed to:
PO Box 5205 Binghamton, NY 13902-5205

AVISO DE CUMPLIMIENTO
LEY DE COMPENSACION OBRERA

A EMPLEADOS

INFORMACION IMPORTANTE PARA EMPLEADOS QUE SEAN LESIONADOS 0 SUFRAN UNA ENFERMEDAD OCUPACIONAL MIENTRAS TRABAJAN.

1. Su patrono esta cumpliendo la Ley de Compensacion Obrera cuando despliega este comunicado concerniente a sus derechos como trabajador lesionado.
2. Si usted no notifica a su patrono dentro del termino de 30 dias de haber sufrido su lesion su reclamacion podria ser desestimada, por eso notifique inmediatamente.
3. Usted tiene derecho a recibir cualquier tratarniento medico necesario relacionado con su lesion y debe gestionarlo inmediatamente.
4. Para el tratamiento de cualquier lesion o enfermedad relacionada con el trabajo usted puede escoger cualquier medico, podiatra, quiropractico o psicologo (si es referido por un medico autorizado) que esta autorizado y acepte pacientes de la Junta de Compensación Obrera. Sin embargo, si su patrono esta autorizado a participar en una organizacion certificada de proveedores preferidos (PPO), usted debera obtener tratamiento inicial para cualquier lesion o enfermedad relacionada con el trabajo de la correspondiente entidad. Patronos que participen en cualquiera de estos programas establecidos por ley estan obligados a proveer a sus empleados notificacion escrita explicando sus derechos y obligaciones bajo el programa que este acogido.
5. Usted debera requerir de su Medico que radique copias de los informes medicos de su caso en la Junta de Compensacion Obrera y en la compania de seguros de su patrono, que se indica al final de esta forma.
6. Usted tiene derecho a compensacion si su lesion relacionada con el trabajo le impide trabajar por mas de siete dias, le obliga a trabajar a sueldo mas bajo o resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitacion si necesita ayuda para regresar al trabajo.
7. No pague a ningun proveedor medico directamente por tratamiento de su lesion o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas all asegurador de su patrono. Si el caso es cuestionado, el proveedor debera esperar hasta que la junta decida el caso, antes de iniciar gestion de cobro alguna contra usted. Si usted no tramita su caso o la Junta con el trabajo, usted podria ser responsable del pago de las facturas.
8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado o por representante licenciado si usted asi lo desea. Si es representado, no pague al abogado o al representante licenciado. Cuando la Junta decida su caso, los honorarios seran determinados por la Junta y descontados de sus beneficios.
9. Si tiene dificultad en conseguir un formulario de reclamacion o necesita ayuda para llenarlo o tiene dudas sobre cualquier situacion relacionada con una lesion o enfermedad comuniquese con la oficina mas cercana de la Junta.



ARY S. WEISS CHAIR/PRESIDENTZACH

Workers' Compensation benefits, when due, will be paid by (Los beneficios de Compensacion Obrera, cuando debidos, seran pagados por):

SAMPLE

Name of employer (Nombre del patrono)

Effective From (En vigor Desde) _____ To _____ (Hasta Cancellation)

Policy No. (Poliza No) _____

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS

C-105(4-09)
S.I.F. U-30e
"U30SIF/SN"

PRESCRIBED BY CHAIR
WORKERS' COMPENSATION BOARD
STATE OF NEW YORK

www.wcb.state.ny.us

Failure by an employer to post this notice in and about the employer's place or places of business may result in a $250 penalty for each violation.

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

NOTICE OF COMPLIANCE
DISABILITY BENEFITS LAW
TO EMPLOYEES

1. If you are unable to work because of an illness or injury not work-related, you may be entitled to receive weekly benefits from your employer, or his or her insurance company, or from the Special Fund for Disability Benefits.
2. To claim benefits You must file a claim form, within 30 days from the first date of your disability, but in no event more than 26 weeks from such date.
3. Use one of the following claim forms:
   -if, when your disability begins you are employed or are unemployed for four weeks or less, use WHITE claim form (Form DB-450), which you may obtain from your employer, his or her insurance carrier, your health provider or any office of the Workers' Compensation Board, and send it to your employer or the insurance carrier named below.
   -If, when your disability begins, you have been unemployed more than four weeks, use the GREEN claim form (Form DB-300), which you may obtain from any Unemployment Insurance Office, your health provider, or any office of the Workers' Compensation Board. Send completed claim form to the Workers' Compensation Board, Disability Benefits Bureau Albany, New York 12241.
   IMPORTANT Before filing your claim, your health provider must complete the "Health Care Provider's Statement" on the claim form, showing your period of disability.
4. You are entitled to be treated by any physician, chiropractor, dentist, nurse-midwife, podiatrist or psychologist of your choice. However, unlike workers' compensation, your medical bills will not be paid unless your employer and/or union provide for the payment of such bills under a Disability Benefits Plan or Agreement.
5. If you are ill or injured during the time you are receiving Unemployment Insurance Benefits, file a claim for Disability Benefits as soon as you sustain the injury or illness, by following the instructions outlined above.
6. If you are out of work in excess of seven days, your employer is required to send you a Disability Benefits Statement of Rights (Form DB-271).
7. Other information about Disability Benefits may be obtained by writing or calling the nearest Workers' Compensation Board Office.

WORKERS' COMPENSATION BOARD OFFICES

Albany, 12241 -100 Broadway-Menands- (518) 474-6681
Binghamton, 13901 - State Office Bldg - 44 Hawley St. - (607) 721-8330
Buffalo, 14203-State Office Bldg -125 Main St - (716) 847-3177
Hempstead, 11550 -175 Fulton Avenue - (516) 560-7515
Rochester, 14614 - 130 Main Street West - (716) 258-8600
Syracuse, 13202 - State Office Bldg.-333 E. Washington St. - (315) 428-4465

ESTADO DE NUEVA YORK
JUNTA DE COMPENSACIÓN OBRERA

AVISO DE CUMPLIMIENTO
LEY DE BENEFICIOS POR INCAPACIDAD
A LOS EMPLEADOS

1. Si usted no puede trabajar debido a enfermedad o lesión no relacionada con el trabajo, podría tener derecho a recibir, beneficios semanales de su patrón o de la compañía de seguros de el/ella o del Fondo Especial para Beneficios por Incapacidad.
2. Para reclamar beneficios usted debe Presentar una forma de reclamación, dentro de 30 días a Partir de la Primera fecha de su incapacidad, pero en ningún caso más de 26 semanas de dicha fecha.
3. Use una de las siguientes formas de reclamación:
   -Si, cuando comience su incapacidad usted está empleado o ha estado desempleado por cuatro semanas o menos, use la forma de reclamación BLANCA (form DB-450), la cual puede obtener de su patrón o de la compañía de seguros de él/ella, o de su proveedor de cuidados de salud, o bien de cualquier oficina de la Junta de Compensación Obrera, y enviela a su patroh o a la compañía de seguros nombrada abajo.
   -Si, cuando comience su incapacidad, usted ha estado desempleado más de cuatro semanas, use la forma de reclamación VERDE (form DB-300), la cual puede obtener en cualquier Oficina de Seguro de Desempleo, de su proveedor de salud, o bien de cualquier oficina de la Junta de Compensacion Obrera Envie la forma de reclamación, debidamente terminada, a Workers' Compensation Board, Disability Benefits Bureau, Albany, New York 12241.
   IMPORTANTE Antes de presentar usted su reclamación, es necesario que su proveedor de salud complete la declaración del médico ("Health Care Provider's Statement") en la forma de reclamación, indicando el periodo de su incapacidad.
4. Usted tiene derecho a ser tratado por cualquier medico, quiropráctico, dentista enfermera-partera, podiatra o psicologo que usted elija. Pero, contrario a la compensación obrera, sus cuentas médicas no serán pagadas a menos que su patrón y/o Unión haga el pago de tales cuentas médicas bajo un Plan o Convenio de Beneficios por Incapacidad.
5. Si estuviera usted enfermo o lesionado durante el tiempo que esté recibiendo beneficios del Seguro de Desempleo, presente una reclamación para Beneficios por Incapacidad, siguiendo las instrucciones arriba descritas, tan pronto como sufra la lesión o la enfermedad.
6. Si usted está desempleado por más de siete días, su patrón está obligado a enviarle la declaración de Derechos de Beneficios por incapacidad (Form DB-271).
7. Otras informaciones relativas a Beneficios por incapacidad pueden obtenerse escribiendo o llamando a la oficina mas cercana de la Junta de Compensación Obrera.

Robert R Snashall

Robert R. Snashall
Chairman (Presidente)

The undersigned employer is in compliance with the provisions of the Disability Benefits Law (El patrón abajo firmante esta en conformidad con las disposiciones de la ley de Beneficios por Incapacidad).
Disability Benefits, when due, will be paid by (Los Beneficios por Incapacidad, cuando debidos, serán pagados por):

SAMPLE

Effective: From (_____ To UNTIL CANCELLED
(En Vigor Desde) (HASTA)
Policy No _____
(Poliza No.)

The benefits provided are (Los beneficios provistos son)

	Statutory (Estatutarios)		Under a Plan or Agreement (Bajo un Plan o Convenio)

Class(es) of employees covered (Clasé(s) de empleados amparados)
ALL EMPLOYEES ELIGIBLE UNDER NY DBL
Name of employer (Nombre del Patrón)

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

LA JUNTA DE COMPENSACIÓN OBRERA EMPLEA Y SIRVE A PERSONAS INCAPACITADAS SIN DISCRIMINAR.

By _____

DB-120 (2-97) Prescribed by Chair Workers' Compensation Board State of New York

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

Erie County Water Authority
ACORD Endorsement Samples

POLICY NUMBER: **COMMERCIAL GENERAL LIABILITY**

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

ADDITIONAL INSURED – OWNERS, LESSEES OR CONTRACTORS – (FORM B)

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART.

SCHEDULE

Name of Person or Organization:

(If no entry appears above, information required to complete this endorsement will be shown in the Declarations as applicable to this endorsement.)

WHO IS AN INSURED (Section II) is amended to include as an insured the person or organization shown in the Schedule, but only with respect to liability arising out of "your work" for that insured by or for you.

 ☐

POLICY NUMBER: COMMERCIAL GENERAL LIABILITY

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

ADDITIONAL INSURED – DESIGNATED PERSON OR ORGANIZATION

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART.

SCHEDULE

Name of Person or Organization:

(If no entry appears above, information required to complete this endorsement will be shown in the Declarations as applicable to this endorsement.)

WHO IS AN INSURED (Section II) is amended to include as an insured the person or organization shown in the Schedule as an insured but only with respect to liability arising out of your operations or premises owned by or rented to you.

   □