

## PROFESSIONAL SERVICES CONTRACT

AGREEMENT made this \_\_\_ day of August, 2018, by and between the **ERIE COUNTY WATER AUTHORITY**, with an office at 295 Main Street, Rm. 350, Buffalo, New York 14203 (hereinafter referred to as the “Authority”), and **E3 COMMUNICATIONS**, with an office at 551 Linwood Avenue, Buffalo, New York 14202 (hereinafter referred to as the “Consultant”).

The Authority desires to contract with the Consultant to render professional services upon the terms and for the consideration hereinafter stated.

The Consultant represents that it is properly qualified to render such services, and the parties desire to set forth herein the terms and conditions under which the said professional services will be furnished.

Now therefore, in consideration of mutual promises herein set forth, the parties agree as follows:

### **1. QUALIFICATION OF CONSULTANT:**

The Consultant shall perform its services under this agreement in a skillful and competent manner in accordance with the prevailing standards of the consulting profession. The Consultant will be responsible to the Authority for errors or omissions in the performance of its services and failure to perform thereof.

### **2. SCOPE OF SERVICES:**

The selected firm would be responsible for:

1. Developing and implementing proactive public relations programs on behalf of the Authority. Potential program areas would include, but not be limited to: media relations, customer communications/education; public affairs/advocacy; issues/crisis management; water quality initiatives; public awareness and community events programming; and web site/social media content management.
2. Providing strategic consultation and planning on Authority public relations programs and matters.
3. Providing strategic consultation and planning on Authority public relations matters.

4. Providing strategic consultation and planning to assist the Authority in managing crises and issues as they arise.
5. Writing and/or editing of public relations materials, such as press releases, media alerts and statements, opinion pieces and letters to the editor, issue and advocacy advertisements, annual report and annual water quality report, customer communications, and additional communications materials as requested.
6. Consult and advise on ECWA website content and design.
7. Monitoring, tracking, researching and distributing media reports related to the Authority, drinking water issues/regulations, etc.
8. Providing the Authority with routine graphic design services for placement of issues advertisements in print publications as well as assist in the design and layout of Authority's annual report, annual water quality report and additional publications and materials as needed.
9. Attend meetings with Commissioners to discuss ongoing public relations opportunities and challenges, as requested by the Secretary to the Authority.
10. Other public relations activities as requested by ECWA.
11. Develop communication with ECWA employees.

**3. DURATION AND PAYMENT FOR SERVICES:**

The Authority will retain the Consultant at a rate of \$6,000 per month for a period of three (3) years. This Agreement may be renewed at the option of both parties hereto for two (2) additional one (1) year terms at the option of the Authority on 30 days written notice to the firm on the same terms and conditions provided for herein at a cost mutually agreed upon by both parties and in accordance with industry standards. The first month's retainer will be due and payable upon an officer or agent of the Authority entering into this agreement. A monthly statement shall be furnished to the Authority for the retainer fee as well as any expenses incurred in the course of representation. Note there will be no cap on the number of hours rendered on a monthly basis. The fee does not include out of pocket costs for expenses that might be incurred by the agency. These costs could include media tracking services, production of collateral, delivery services and mileage to name just a few. Out of pocket expenses are billed at cost with no agency mark-up.

**4. SUBCONTRACT AND ASSIGNMENT:**

The Consultant may not subcontract or delegate any of the work, services, and/or other obligations of the Consultant without the express written consent of the Authority. The Authority and the Consultant bind themselves and their successors, administrators and assigns to the terms of this Agreement. The Consultant shall not assign, sublet or transfer its interest in the Agreement without the written consent of the Authority.

**5. AMENDMENTS:**

No modification or variation from the terms of this Agreement shall be effective unless it is in writing and authorized by a resolution of the Board of Commissioners of the Authority and signed by all parties.

**6. RIGHT TO TERMINATE:**

The Authority reserves the right to terminate the Consultant's services at any time, without cause, based on thirty (30) days' written notice. Consultant shall not be entitled to lost profit and shall perform only such services, after notification of termination, as the Authority directs.

**7. INDEMNIFICATION:**

The Consultant shall indemnify the Authority against any and all claims arising from the services performed by the Consultant herein and shall defend and hold harmless the Authority from and against all claims, suits, actions, costs, counsel fees, expenses, damages, judgments or decrees based upon or arising out of damage to property or injury to persons or other tortuous conduct caused or contributed to it by the Consultant or anyone under its direction or control or on its behalf in the course of its performance under this Agreement. The Consultant further agrees to indemnify, defend and hold harmless the Authority from any and all claims in reference to the services performed by the Consultant hereunder which may infringe on a patent, copyright, trade secret or other proprietary right of any third party.

**8. CONFIDENTIAL INFORMATION:**

In order to assist the Consultant in the performance of this Agreement, the Authority may provide the Consultant with confidential information including, but not limited to information relative to the services to be performed. All information received by the Consultant in any fashion and under any conditions resulting from the rendering of the services in consideration of this agreement, are considered confidential. The Consultant shall hold in confidence and not disclose to any person or any entity, any information regarding information learned during the performing of services including but not limited to information relative to the services to be performed.

The Consultant shall use at least the same degree of care to protect and prevent unauthorized disclosure of any confidential information as it would use to protect and prevent unauthorized disclosure of its own proprietary information. The Consultant shall use confidential information only in the performance of this Agreement. No other use of the confidential information whether for the consultant's benefit or for the benefit of others shall be permitted.

In no event is the Consultant authorized to disclose confidential information without the prior written approval of the Authority. The terms of this paragraph shall be binding during and subsequent to the termination of this agreement.

**9. INSURANCE:** As set forth in Exhibit "A".

**10. COPYRIGHTS, TRADEMARKS, AND LICENSING:**

All materials produced under this Agreement, whether produced by the Consultant alone or with others, and whether or not produced during regular working hours, shall be considered work made for hire and the property of the Authority. The Consultant shall, during and subsequent to the terms of this Agreement, assign to the Authority, without further consideration, all right, title and interest in all material produced under this Agreement. All material produced under this Agreement shall be and remain the property of the Authority whether or not registered.

**11. NEW YORK LAW AND JURISDICTION:**

Notwithstanding any other provision of this Agreement, any dispute concerning any question of fact or law arising under this Agreement which is not disposed of by agreement between the Consultant and the Authority shall be governed, interpreted and decided by a Court of competent jurisdiction of the State of New York in accordance with the laws of the State of New York.

**12. CONFLICTS OF INTEREST:**

The Consultant represents that it has advised the Authority in writing prior to the date of signing this Agreement of any relationships with third parties, including competitors of the Authority, which would present a conflict of interest with the rendering of the services, or which would prevent the Consultant from carrying out the terms of this Agreement or which would present a significant opportunity for the disclosure of confidential information. The Consultant will advise the Authority of any such relationships that arise during the term of this Agreement. The Authority shall then have the option to terminate the Agreement without further liability of the Consultant, except to pay for services actually rendered.

**13. ADDITIONAL CONDITIONS:**

The Consultant and the Authority acknowledge that there may be additional conditions, terms and provisions which shall apply specifically to the services to be performed. The parties agree to negotiate in good faith to agree upon such additional terms.

**14. ENTIRE AGREEMENT:**

This Agreement constitutes the entire understanding of the parties and no representations or agreements, oral or written, made prior to its execution shall vary or modify the terms herein. This Agreement supersedes all prior contemporaneous communications, representations, or agreements, whether oral or written with respect to the subject matter hereof and has been induced by no representations, statements or agreements other than those herein expressed. No agreement hereafter made between the parties shall be binding on either party unless reduced to writing and signed by an authorized officer of the party sought to be bound thereby.

**15. INDEPENDENT STATUS:**

Nothing contained in the Agreement shall be construed to render either the Authority or the Consultant a partner, employee or agent of the other, nor shall either party have authority to bind the other in any manner, other than as set forth in this Agreement, it being intended that the Consultant shall remain an independent contractor responsible for its own actions. The Consultant is retained by the Authority only for the purpose and to the extent set forth in this Agreement.

The Consultant is free to choose the aggregate number of hours worked and substantially all of the scheduling of such hours as it shall see fit at its discretion within the limitations set forth hereinbefore in Paragraph 3.

Neither the Consultant nor its employees shall be considered under the provisions of this Agreement or otherwise as having an employee, servant or agency status or as being entitled to participate in any plans, arrangements or distributions of the Authority.

In providing the services under this Agreement, the Consultant represents and warrants that it has complied with all applicable federal, state and local laws particularly with respect to licenses, withholdings, reporting and payment of taxes. The Consultant agrees to furnish copies of documentation to the Authority evidencing its compliance with such laws. The Consultant further represents and warrants that any income accruing to the Consultant and its employees from the Agreement shall be reported as such to the appropriate taxation authorities.

**16. COMPLIANCE:**

The Consultant agrees that the Agreement herein shall be in compliance with and governed by the provisions of Section 2875, 2876 and 2878 of the Public Authorities Law of the State of New York. The Consultant further affirms under the penalties of perjury that there was no collusion in the proposal submitted herein to ECWA which forms the basis of the within Agreement.

**17. GRATUITIES:**

The Consultant prohibits its employees from using their positions for personal financial gain, or from accepting any personal advantage from anyone under circumstance which might reasonably be interpreted as an attempt to influence the recipients in the conduct of their official duties. The Consultant or its employees shall not, under circumstances which might be reasonably interpreted as an attempt to influence the recipients in the conduct of their duties, extend any gratuity or special favor to employees of the Authority.

**18. NOTICE:**

Any notices required by this Agreement or otherwise shall be delivered by United States Postal mail or personal delivery upon the addresses hereinbefore stated. Any change in such addresses shall be required to be in writing to the other party and acknowledged as such.

**19. SEVERABILITY:**

If any provision of this agreement shall be held invalid or unenforceable, in whole or in part, such provision shall be modified to the minimum extent necessary to make it valid and enforceable, and the validity and enforceability of all other provisions of this agreement shall not be affected thereafter.

**ERIE COUNTY WATER AUTHORITY**

By \_\_\_\_\_  
Jerome D. Schad, Chair

**E3 COMMUNICATIONS**

By \_\_\_\_\_

**STATE OF NEW YORK )**  
**COUNTY OF ERIE ) ss:**

On the \_\_\_\_\_ day of August, in the year 2018, before me personally came Jerome D. Schad, to me known, who, being by me duly sworn, did depose and say that he resides in Amherst, New York, that he is the Chairman of the Corporation described in the above instrument; and that he signed his name thereto by order of the Board of Directors of said Corporation.

\_\_\_\_\_  
Notary Public

**STATE OF NEW YORK )**  
**COUNTY OF ERIE ) ss:**

On the \_\_\_\_\_ day of August, in the year 2018, before me personally came \_\_\_\_\_, to me known, who, being by me duly sworn, did depose and say that he resides in \_\_\_\_\_, New York, that he is the President of the Corporation described in the above instrument; and that he signed his name thereto by order of the Board of Directors of said Corporation.

\_\_\_\_\_  
Notary Public

**EXHIBIT “A”**

**INSURANCE REQUIREMENTS and CERTIFICATES**

INS2013-PS  
Revision date: 03/01/2013

**Erie County Water Authority Insurance Requirements for Professional Services**

**Project Number:** 201800099

**Description:** 2018 Request for Proposals for Public Relations Services

The following minimum insurance requirements shall apply to professional service providers under agreement with the Erie County Water Authority (ECWA). The professional service provider carries relevant insurance for the services covered. If at anytime, in the opinion of ECWA, there is an unusual or exceptional risk, ECWA may establish additional insurance requirements for the duration of the agreement. All insurance required herein shall be obtained at the sole cost and expense of the professional service provider, including deductibles and self-insured retentions. 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 10 01 or CA 99 48 12 93), as well as proof of MCS 90 04 00.

**Excess Umbrella Liability Insurance:**

\$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**

**Professional Liability Insurance:** Per each occurrence and in the aggregate. Continuous coverage shall be maintained, or on an extended discovery period ("tail coverage"), for a period of not less than two years from the time the agreement has been completed 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.

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.

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

Certificates of Insurance should be e-mailed to [AALESSI@ECWA.ORG](mailto: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.



Erie County Water Authority Insurance Requirements for Professional 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).

<b>PRODUCER</b> [Yellow Arrow]	CONTACT NAME: [Yellow Arrow] PHONE (A/C, No, Ext): [Yellow Arrow]      FAX (A/C, No): E-MAIL ADDRESS: PRODUCER CUSTOMER ID #:														
<b>INSURED</b> [Yellow Arrow]	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;">INSURER(S) AFFORDING COVERAGE</th> <th style="width: 20%;">NAIC #</th> </tr> </thead> <tbody> <tr><td>INSURER A : [Yellow Arrow]</td><td></td></tr> <tr><td>INSURER B :</td><td></td></tr> <tr><td>INSURER C :</td><td></td></tr> <tr><td>INSURER D :</td><td></td></tr> <tr><td>INSURER E :</td><td></td></tr> <tr><td>INSURER F :</td><td></td></tr> </tbody> </table>	INSURER(S) AFFORDING COVERAGE	NAIC #	INSURER A : [Yellow Arrow]		INSURER B :		INSURER C :		INSURER D :		INSURER E :		INSURER F :	
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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
	<b>GENERAL LIABILITY</b> <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR GENL AGGREGATE LIMIT APPLIES PER: POLICY <input checked="" type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC		<input checked="" type="checkbox"/>				EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000 MED EXP (Any one person) \$ 5,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000
	<b>AUTOMOBILE LIABILITY</b> <input checked="" type="checkbox"/> ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS HIRED AUTOS NON-OWNED AUTOS		<input checked="" type="checkbox"/>				COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$ \$
	<input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR <input checked="" type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DEDUCTIBLE <input checked="" type="checkbox"/> RETENTION \$ 10,000		<input checked="" type="checkbox"/>				EACH OCCURRENCE \$ AGGREGATE \$ \$ \$
	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) <input type="checkbox"/> Y/N If yes, describe under DESCRIPTION OF OPERATIONS below Professional Liability Claims Made:      Retroactive Date: Occurrence:		N/A				WC STATUTORY LIMITS    OTH-ER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$ Each Claim: Aggregate:
	<b>DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES</b> (Attach ACORD 101, Additional Remarks Schedule, if more space is required) Additional Insured on a Primary and non-contributory basis (General and Auto Liability): Erie County Water Authority Additional Insured form CG 20 26 or equivalent.						

<b>CERTIFICATE HOLDER</b> [Yellow Arrow] Erie County Water Authority 295 Main St, Suite 350 Buffalo, NY 14203  Attn: Anthony Alessi	<b>CANCELLATION</b> 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
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## **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](http://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](mailto: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:

Prove It to Move It  
**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.

<p align="center"><b>In the Application of                  (Legal Entity Name and Address):</b></p> <p>JOHN SMITH                  123 MAIN STREET                  ALBANY, NY 12207                  111-111-1111                  Federal ID Number: XXXXX6789</p>	<p align="center"><b>Business Applying For:                  BUILDING PERMIT</b></p> <p>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</p>
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**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.

<b>SIGN HERE</b>	Signature:	Date:
Exemption Certificate Number <b>2008-00197</b>		Received <b>October 2, 2008</b> NYS Workers' Compensation Board

CE-200 (Draft 06/02/08)

STATE OF NEW YORK  
WORKERS' COMPENSATION BOARD

CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

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

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 or its licensed agent, or until the policy expiration date listed in box "3c", whichever is earlier.*

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

**SAMPLE**

Prove It to Move It

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 OPERATION
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



**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

DIRECTOR, INSURANCE FUND UNDERWRITING  
Validation Number: 107031806

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

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"  <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/> 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 <input type="checkbox"/> included (Only check box if all partners/officers included) <input checked="" type="checkbox"/> 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: \_\_\_\_\_

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)	1b. Business Telephone Number of Insured  1c. NYS Unemployment Insurance Employer Registration Number of Insured  1d. Federal Employer Identification Number of Insured or Social Security Number
2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)  <b>State University of New York Room 302 1400 Washington Avenue Albany, NY 12222</b>	3a. Name of Insurance Carrier  3b. Policy Number of entity listed in box "1a":  3c. Policy effective period: _____ to _____
4. Policy covers: a. <input type="checkbox"/> All of the employer's employees eligible under the New York Disability Benefits Law b. <input type="checkbox"/> 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 _____ <small>(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)</small>	
Telephone Number _____ Title _____	
<b>IMPORTANT:</b> 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.*

Prove It to Move It

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 OPERATION
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)

\_\_\_\_\_  
(Homeowner's Name Printed)

Home Telephone Number \_\_\_\_\_

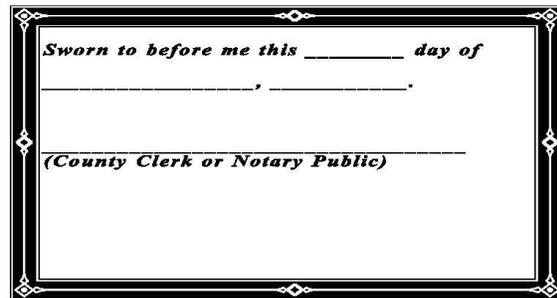
Property Address that requires the building permit:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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 COMPENSACIÓN OBRERA

NOTICE OF COMPLIANCE  
DISABILITY BENEFITS LAW  
TO EMPLOYEES

AVISO DE CUMPLIMIENTO  
LEY DE BENEFICIOS POR INCAPACIDAD  
A LOS EMPLEADOS

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 any Unemployment Insurance Office, 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.

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 él/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 envíela a su patrón 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 Compensación Obrera Envíe 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, quiroprático, dentista, enfermera-partera, podiatra o psicologo que usted elija. Pero, con excepción 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.

WORKERS' COMPENSATION BOARD OFFICES

Albany, 12241 -100 Broadway-Menands- (518) 474-6681  
 Binghamton, 13901 - State Office Bldg - 44 Hawley St. (607) 721-8333  
 Buffalo, 14203-State Office Bldg -125 Main St - (716) 847-3171  
 Hempstead, 11550 -175 Fulton Avenue - (516) 550-7145  
 Rochester, 14614 - 130 Main Street West - (716) 249-8544  
 Syracuse, 13202 - State Office Bldg.-333 E. Washington St. - (315) 428-4465

*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)

<input type="checkbox"/>	Statutory (Estatutarios)	<input type="checkbox"/>	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 *Robert R. Snashall*

**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.