

PROFESSIONAL SERVICES CONTRACT

AGREEMENT made this 28th day of April, 2017, by and between

ERIE COUNTY WATER AUTHORITY
295 Main Street, Room 350
Buffalo, New York 14203

hereinafter referred to as the "Authority", and

ERDMAN ANTHONY & ASSOCIATES, INC.
8608 Main Street
Buffalo, New York 14221

hereinafter referred to as "Consultant".

WHEREAS, the Authority desires to contract with the Consultant to render professional services upon the terms and for the consideration hereinafter stated;

WHEREAS, the Consultant represents that it is properly qualified to render such services, and

WHEREAS, 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. **QUALIFICATIONS 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:**

A. PROJECT DESCRIPTION:

This project consists of the design and construction of approximately:

- 1,850 linear feet of new waterline along Riverview Avenue and Patton Road (from Rogers Avenue to Colonial Drive) in the City of Tonawanda,
- 3,800 linear feet of new waterline along Main Street (from Seymour Street to Kohler Street) in the City of Tonawanda, and
- 3,200 linear feet of new waterline along Capen Boulevard (from Kenmore Avenue to Oxford Avenue) in the Town of Amherst, New York.

The existing waterlines will be abandoned in place. The sizes of the new waterlines will be determined as a part of the design project.

B. ENGINEERING SERVICES:

Consultant shall provide all engineering services necessary to design and install the improvements described in Section A, including, but not limited to, the following:

1. **Survey**

Upon authorization from the Authority, the Consultant shall complete the following services.

- a. Obtain field topographic survey data for the preparation of construction plans required for final design of the project. Survey data is to be according to NAD83 and NAVD88 standards.

2. **Design**

Upon authorization from the Authority, the Consultant shall complete the following services.

- a. Prepare detailed design drawings, specifications and contract documents. Tasks include, but are not limited to:
- 1) Conferences with the Authority, agencies, etc.
 - 2) Review of available drawings and records furnished by the Authority.
 - 3) Preparation of base drawings in AutoCAD version 2014 from the survey data obtained in the survey phase and the available records furnished by the Authority.
 - 4) Preparation of engineering calculations to support the design of the improvements, including related civil, hydraulic, mechanical, electrical, structural, and architectural features of the project.
 - 5) Submission of the plans to various utility companies and agencies as required.
 - 6) Preparation of final plans, profiles, and job specific detail drawings that include editing of the Authority's standard detail drawings where appropriate.
 - 7) Preparation of contract specifications that include editing of the Authority's standard "front end" specifications and standard technical specifications where appropriate and preparation of additional technical specifications as required.
 - 8) Obtaining New York State Wage Rates and inserting them into the specifications.
 - 9) Preparation of a quantity take-off and a construction cost estimate.
 - 10) Preparation of an engineering report and submission with contract specifications, drawings, application

forms and fees to Erie County Health Department for approval.

- 11) Attendance at a final design meeting with the Authority.
- b. Prepare engineering data, where necessary, with regard to regulatory permit applications as required to obtain local, state, federal and public utility approval for the initiation and construction of the work.
- c. Furnish to the Authority five (5) sets of drawings, specifications and other contract documents, for final review by the Authority and other approving agencies.
- d. Prepare documentation for compliance with New York State SEQR (Type II actions) and SWPPP.
- e. Prepare a schedule for the project utilizing the Authority's standard format. The project schedule shall be updated as needed.

3. **General Services**

Upon authorization from the Authority, the Consultant shall complete the following services.

- a. Furnish twenty (20) sets of contract drawings, final specifications, and other documents required for bidding and construction purposes for each contract.
- b. Conduct a pre-bid meeting when appropriate.
- c. Prepare and distribute addenda.
- d. Provide assistance to the Authority in securing bids, tabulating bid results, analyzing bid results, and making recommendations on the award of each construction contract.
- e. Conduct a pre-construction meeting and distribute minutes.
- f. Supply an approved contractor's schedule for construction of the project.
- g. Provide detailed initial stakeout (once only), including bench marks, reference and axis lines along the routes of the construction or where necessary.
- h. Give consultation and advice to the Authority during construction.
- i. Prepare elementary sketches and supplementary sketches, if required, to resolve actual field conditions encountered.
- j. Interpret contract documents and resolve problems as to amount, quality, acceptability, and fitness.
- k. Review the contractor's submittals of material and/or equipment for compliance with the Consultant's design concept and take appropriate action such as but not limited to: "approved", "approved as corrected", "revise and resubmit"; or "not approved".

- l. Furnish general construction inspection as to quality and quantity of the contractor=s work as the construction progresses in order to recommend partial payment.
- m. Schedule and attend progress meetings.
- n. Report to the Authority bi-weekly on the progress of the work via email, with the following information:
 - 1) Summary of the work performed in the previous two-week period.
 - 2) Attach an updated project schedule (in Microsoft Project format) identifying all project milestones and current project status.
 - 3) Forecast of all upcoming work and project costs expected for the project. Identify any contract items which may exceed bid quantities.
 - 4) Attach copies of final inspection reports (in .pdf format) for reports in the previous two-week period.
- o. Notify the Authority when a change in the work is proposed which will cause an adjustment in the contract cost. Evaluate whether the proposed change is justified and reasonable, and if necessary prepare change orders, field directives, and make recommendations for approval. Discuss changes in the plans or procedures authorized by the Consultant with the Authority prior to implementation. Obtain approval for all change orders from the Board of Commissioners prior to implementation.
- p. Check line and grade for preparation of record drawings.
- q. Make a final inspection, furnish a report on project completion, and make recommendations for final payments to contractors and for the release of retained amounts, if any.

4. **Resident Inspection**

Upon authorization from the Authority, the Consultant shall complete the following services.

- a. Provide technical inspection of construction by a full-time resident engineer and/or inspectors as required, who will:
 - 1) Inspect all work to determine the progress, quality, quantity and conformance of the work in accordance with contract documents.
 - 2) Notify customers prior to start of construction.
 - 3) Prepare daily inspector reports.
 - 4) Review, verify and approve requests for monthly and final payments to contractors, based on quantities of work put in place.

5. **Record Drawings**

Upon authorization from the Authority, the Consultant shall complete the following services.

- a. Provide record drawings, including the basemapping, (on AutoCAD Version 2014) of all completed work according to the latest ECWA As-Built Standards. Update the existing ECWA valve and hydrant details to reflect the completed work. Furnish one set of mylar transparencies and all AutoCAD files on CD of these drawings to the Authority.
- b. Provide horizontal and vertical coordinates using survey grade Real Time Kinematic (RTK) GPS with horizontal centimeter level accuracy and best possible vertical precision given the environmental conditions during collection for all mainline valves, hydrants, hydrant valves, permanent blow-offs, and meter pits. Coordinates shall be presented as points within an ESRI geodatabase feature class, or provided in Microsoft Excel, Microsoft Access, or .dbf format. At a minimum, the coordinate file shall contain a Northing, Easting, Elevation, horizontal precision, vertical precision, and Description for each feature.
- c. Record Drawings and coordinates to be based on the NY State Plane Coordinate System – West Zone. Data is to be according to NAD83 and NAVD88 datums. Coordinates shall be provided in Microsoft Excel, Microsoft Access, or .dbf format. At a minimum, the coordinate file shall contain a Northing, Easting, Elevation, and Description for each feature.
- d. Submit mylar transparencies, AutoCAD files, and GPS coordinates no later than one month after final payment of the Construction Contract is recommended for approval and in accordance with Authority Standards.

C. SPECIAL SERVICES

The Authority may require the Consultant to provide or arrange for and assist in obtaining one or more of the following special services in carrying out the project. Because it is not possible to determine in advance the need for or the cost of such services, these are included as separate elements of cost which shall be separately negotiated. These services include:

1. Soils Investigations - including test borings, pavement cores, and the related analysis.
2. Detailed mill, shop and/or laboratory inspection of materials and equipment.
3. Land surveys, maps, plates, descriptions and title investigations which may be required to acquire lands, easements, and rights-of-way for the proposed facilities.

4. Additional copies of reports, contract drawings and documents.
5. Extra travel and subsistence for the Consultant and his staff beyond that normally required under ordinary circumstances, when authorized by the Authority.
6. Assistance to the Authority serving as an expert witness in litigation arising from project development or construction.
7. New York State SEQR (Type I and Unlisted Actions).
8. Air, water, and/or soil sampling, testing, and/or analysis.
9. Operation and maintenance manuals.
10. Start-up services.
11. Hazardous material testing and assessment.
12. Wetlands investigations, delineation, and mitigation.

3. **PAYMENT FOR SERVICES:**

A. The Consultant agrees to accept a lump sum payment for all services to be provided herein except for Resident Inspection which shall be paid on a cost plus fixed fee basis per the schedule included in paragraph 3.D. The methods of payment are as follows.

1. **Survey**

For services described under Section 2B1, Survey, the Authority shall pay Consultant a lump sum which will include all expense, labor and cost associated with this task. Payment will be made monthly based on the percentage of completion up to 100% of the total lump sum amount.

2. **Design**

For services described under Section 2B2, Design, the Authority shall pay Consultant a lump sum which will include all expense, labor, and cost associated with this task. Payment will be made monthly based on the percentage of completion up to 70% of the total lump sum amount. After submission by the Consultant to the Authority of a draft set of contract documents, payment will be made monthly based on the percentage of completion up to 90% of the total lump sum amount. The balance will be paid when the final contract documents are submitted to the Authority.

3. **General Services**

For services described under Section 2B3, General Services, the Authority shall pay Consultant a lump sum which will include all expense, labor and cost associated with this task. Payment will be made monthly based on the percentage of completion up to 100% of the total lump sum amount.

4. **Resident Inspection**

For services described under Section 2B4, Resident Inspection, the Authority shall pay Consultant the direct cost of labor, times a multiplier based on the hours worked at straight time (without overtime premium), direct non-salary expenses, and a fixed fee. Payment for Resident Inspection labor and expenses will be made monthly based on actual costs. Payment for the fixed fee will be

made monthly based on the proportion of construction completed. Fixed fee shall be billed separately from the Resident Inspection costs.

5. **Record Drawings**

For services described under Section 2B5, Record Drawings, the Authority shall pay Consultant a lump sum which will include all expense, labor and cost associated with this task. Payment will be made monthly based on the percentage of completion up to 70% of the total lump sum amount. After submission by the Consultant to the Authority of draft record drawings, payment will be made monthly based on the percentage of completion up to 90% of the total lump sum amount. The balance will be paid when the final record drawings are submitted to the Authority.

B. SPECIAL SERVICES

For services described under Section 2C, Special Services, the Authority shall pay Consultant an amount to be negotiated at the time such service is required.

C. AUDIT

The Authority reserves the right to audit the Consultant's records to verify bills submitted and representations made. For this purpose, the Consultant agrees to make company records available for inspection upon written notice by the Authority. The Authority shall have two years from the date of the Consultant's final bill to complete its audit. If the audit establishes an overcharge, Consultant agrees to refund the excess.

D. ENGINEERING COST SCHEDULE

1. Engineering Costs:

Survey	\$25,000.00
Design	\$61,000.00
General Services	\$17,590.00
Estimated Resident Inspection	\$54,092.00
Resident Inspection Fixed Fee	\$6,010.00'
Record Drawings	\$11,700.00
Estimated Special Services	<u>\$7,000.00</u>
TOTAL ENGINEERING COST	\$182,392.00

2. Other Costs:

Direct Labor Cost Multiplier	2.25
Mileage	IRS rate
Subcontractor Expenses	Cost plus 5% maximum
All Other Direct Non-Salary Costs	At Cost

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 seven (7) 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 tortious 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. Consultant may provide such information to its subconsultants for the purpose of performing the services; or disclose such information, with notice to the Authority, if such information is required to be disclosed by law or court order. The terms of this paragraph shall be binding during and subsequent to the termination of this agreement.

9. **INSURANCE:** The Consultant shall secure and maintain such insurance as will protect itself from claims under the Workers' Compensation Act; claims for damages because of bodily injury, including personal injury, sickness or disease, or death of any of its employees or of any person other than its employees; and from claims for damages because of injury to or destruction of property including loss of use resulting therefrom in the amounts indicated on Exhibit "A". The Consultant shall provide and maintain insurance that will provide coverage for claims arising out of the negligent performance of its services. The Consultant shall provide Certificates of Insurance certifying the coverage required by this provision.
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.

In performing work under this agreement, the Consultant may be granted access to the Authority's GIS data, documents, and other information. The Consultant understands and agrees that the use of such data, documentation and information shall be treated as confidential information and the Consultant shall abide by the terms and conditions of any confidentiality and copyright leasing agreements (attached as Exhibit "B").

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 2.

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.
20. **TERMINATION:** The Authority reserves the right to terminate this contract in the event it is found that the Certification filed by the Consultant in accordance with New York State Finance Law '139-k was intentionally false or intentionally incomplete. Upon such finding, the Authority may exercise its termination right by providing written notification to the Consultant in accordance with the written notification terms of this contract.

ERIE COUNTY WATER AUTHORITY

By Robert Anderson

Robert Anderson, Chairman

ERDMAN ANTHONY & ASSOCIATES, INC.

By [Signature]
Daniel J. Ziemianski, P.E., Vice President

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

On the 28th day of April, in the year 2017, before me personally came Robert Anderson, 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.

[Signature]
Notary Public

PATRICIA FABOZZI #4957586
Notary Public, State of New York
Qualified in Erie County
My Commission Expires October 16, 2017

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

On the 11th day of April, in the year 2017, before me personally came Daniel J. Ziemianski, to me known, who, being by me duly sworn, did depose and say that he resides in AMHERST, New York, that he is the Vice 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.

[Signature]
Notary Public

Notary Public
State of New York
MARY A. LAWHON
My Commission Expires on 5/28/18

EXHIBIT A
INSURANCE REQUIREMENTS
ERIE COUNTY WATER AUTHORITY



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
04/11/2017

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 have ADDITIONAL INSURED provisions or 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 Poole Professional - NY 1160F Pittsford-Victor Rd. Pittsford, NY 14534 Mary-Beth Rumble	585-385-0428	CONTACT NAME:		FAX (A/C, No.):	585-662-5755
		PHONE (A/C, No., Ext):	585-385-0428	E-MAIL ADDRESS:	smiller@poole-ny.com
INSURED Erdman Anthony and Associates Inc. 145 Culver Road, Suite 200 Rochester, NY 14620	INSURER(S) AFFORDING COVERAGE				NAIC #
	INSURER A:	Travelers Indemnity Co.			25658
	INSURER B:	Phoenix Insurance Company			25623
	INSURER C:	XL Specialty Insurance Company			37885
	INSURER D:				
	INSURER E:				

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

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

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR <input checked="" type="checkbox"/> Business Owners GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PROJECT <input type="checkbox"/> LOC OTHER:	X	X	6805H877623 02520 25658 A++ XV	04/15/2017	04/15/2018	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 1,000,000 MED EXP (Any one person) \$ 10,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000 \$ COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000
B	AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO <input checked="" type="checkbox"/> OWNED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY	X	X	BA9D242282 02518 25658 A++ XV	04/15/2017	04/15/2018	\$ \$ \$ \$ \$ \$ \$ \$
A	<input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> DED <input checked="" type="checkbox"/> RETENTION \$ 10000	X	X	CUP6G576644 02520 25623 A++ XV	04/15/2017	04/15/2018	\$ \$ \$ \$ \$ \$ \$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) <input checked="" type="checkbox"/> Y / N <input checked="" type="checkbox"/> N / A If yes, describe under DESCRIPTION OF OPERATIONS below	X		UB4374T524 02518 25623 A++ XV	04/15/2017	04/15/2018	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ 1,000,000 E.L. DISEASE - EA EMPLOYEE \$ 1,000,000 E.L. DISEASE - POLICY LIMIT \$ 1,000,000
C	Prof. Liability Pollution Liability	X		DPR9912781 00779 37885 AXV	04/15/2017	04/15/2018	PER CLAIM \$ 3,000,000 AGGREGATE \$ 5,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Erie County Water Authority and all others required are included as additional insureds on a primary non-contributory basis to the extent allowed on the blanket additional insured endorsements included on the above listed policies. Includes 30-day notice of cancellation & waiver of subrogation. Re: 201700004 Multi Waterline Replacements (GLAI)

APPROVED APR 19 2017
Project # 201700004

CERTIFICATE HOLDER Erie County Water Authority Attn: Anthony Alessi 295 Main Street, Suite 350 Buffalo, NY 14203-2494 ECWA-01	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

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

BLANKET ADDITIONAL INSURED (ARCHITECTS, ENGINEERS AND SURVEYORS)

This endorsement modifies insurance provided under the following:
COMMERCIAL GENERAL LIABILITY COVERAGE PART

1. The following is added to SECTION II – WHO IS AN INSURED:

Any person or organization that you agree in a "written contract requiring insurance" to include as an additional insured on this Coverage Part, but:

- a. Only with respect to liability for "bodily injury", "property damage" or "personal injury"; and
- b. If, and only to the extent that, the injury or damage is caused by acts or omissions of you or your subcontractor in the performance of "your work" to which the "written contract requiring insurance" applies, or in connection with premises owned by or rented to you.

The person or organization does not qualify as an additional insured:

- c. With respect to the independent acts or omissions of such person or organization; or
- d. For "bodily injury", "property damage" or "personal injury" for which such person or organization has assumed liability in a contract or agreement.

The insurance provided to such additional insured is limited as follows:

- e. This insurance does not apply on any basis to any person or organization for which coverage as an additional insured specifically is added by another endorsement to this Coverage Part.
- f. This insurance does not apply to the rendering of or failure to render any "professional services".
- g. In the event that the Limits of Insurance of the Coverage Part shown in the Declarations exceed the limits of liability required by the "written contract requiring insurance", the insurance provided to the additional insured shall be limited to the limits of liability required by that "written contract requiring insurance". This endorsement does not increase the limits of insurance described in Section III – Limits Of Insurance.

- h. This insurance does not apply to "bodily injury" or "property damage" caused by "your work" and included in the "products-completed operations hazard" unless the "written contract requiring insurance" specifically requires you to provide such coverage for that additional insured, and then the insurance provided to the additional insured applies only to such "bodily injury" or "property damage" that occurs before the end of the period of time for which the "written contract requiring insurance" requires you to provide such coverage or the end of the policy period, whichever is earlier.

2. The following is added to Paragraph 4.a. of SECTION IV – COMMERCIAL GENERAL LIABILITY CONDITIONS:

The insurance provided to the additional insured is excess over any valid and collectible other insurance, whether primary, excess, contingent or on any other basis, that is available to the additional insured for a loss we cover. However, if you specifically agree in the "written contract requiring insurance" that this insurance provided to the additional insured under this Coverage Part must apply on a primary basis or a primary and non-contributory basis, this insurance is primary to other insurance available to the additional insured which covers that person or organizations as a named insured for such loss, and we will not share with the other insurance, provided that:

- (1) The "bodily injury" or "property damage" for which coverage is sought occurs; and
- (2) The "personal injury" for which coverage is sought arises out of an offense committed;

after you have signed that "written contract requiring insurance". But this insurance provided to the additional insured still is excess over valid and collectible other insurance, whether primary, excess, contingent or on any other basis, that is available to the additional insured when that person or organization is an additional insured under any other insurance.

COMMERCIAL GENERAL LIABILITY

3. The following is added to Paragraph 8., **Transfer Of Rights Of Recovery Against Others To Us**, of **SECTION IV – COMMERCIAL GENERAL LIABILITY CONDITIONS**:

We waive any right of recovery we may have against any person or organization because of payments we make for "bodily injury", "property damage" or "personal injury" arising out of "your work" performed by you, or on your behalf, done under a "written contract requiring insurance" with that person or organization. We waive this right only where you have agreed to do so as part of the "written contract requiring insurance" with such person or organization signed by you before, and in effect when, the "bodily injury" or "property damage" occurs, or the "personal injury" offense is committed.

4. The following definition is added to the **DEFINITIONS** Section:

"Written contract requiring insurance" means that part of any written contract under which you are required to include a person or organization as an additional insured on this Coverage Part, provided that the "bodily injury" and "property damage" occurs and the "personal injury" is caused by an offense committed:

- a. After you have signed that written contract;
- b. While that part of the written contract is in effect; and
- c. Before the end of the policy period.

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

<p>1a. Legal Name & Address of Insured (Use street address only)</p> <p>Erdman Anthony and Associates Inc. 145 Culver Road, Suite 200 Rochester, NY 14620</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>1b. Business Telephone Number of Insured 585-427-8888</p> <p>1c. NYS Unemployment Insurance Employer Registration Number of Insured</p> <p>1d. Federal Employer Identification Number of Insured or Social Security Number 160511690</p>
<p>2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)</p> <p>Erie County Water Authority Attn: Anthony Alessi 295 Main Street, Suite 350 Buffalo, NY 14203-2494</p>	<p>3a. Name of Insurance Carrier 02578 25623 A++ XV Phoenix Insurance Company</p> <p>3b. Policy Number of entity listed in box "1a" UB4374T524</p> <p>3c. Policy effective period 04/15/2017 to 04/15/2018</p> <p>3d. The Proprietor, Partners or Executive Officers are <input checked="" type="checkbox"/> included. (Only check box if all partners/officers included) <input type="checkbox"/> all excluded or certain partners/officers excluded.</p>

APPROVED APR 19 2017 *KS*

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: Sandye Miller
(Print name of authorized representative or licensed agent of insurance carrier)

Approved by: *Sandye Miller* April 11, 2017
(Signature) (Date)

Title: Producer

Telephone Number of authorized representative or licensed agent of insurance carrier: 781-245-5400

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

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

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	
<p>1a. Legal Name and Address of Insured (Use street address only) Erdman Anthony Holding Co 145 Culver Road Rochester, NY 14620</p> <p>Legal Name and Address of Division/Location requesting certification:</p>	<p>1b. Business Telephone Number of Insured (716) 427-8888</p> <p>1c. NYS Unemployment Insurance Employer Registration Number of Insured</p> <p>1d. Federal Employer Identification Number of Insured or Social Security Number 161404980</p>
<p>2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)</p> <p>Erie County Water Authority 295 Main Street, Room 350 Buffalo, NY 14203</p> <p style="text-align: center;">APPROVED [Stamp] K3D</p>	<p>3a. Name of Insurance Carrier CIGNA LIFE INSURANCE COMPANY OF NEW YORK</p> <p>3b. Policy Number of entity listed in box "1a": NYD074836</p> <p>3c. Policy effective period: 01/01/2017 to 01/01/2018</p> <p style="text-align: right; font-size: 1.2em;">06538 64548 A XV</p>
<p>4. Policy covers:</p> <p><input checked="" type="checkbox"/> a. All of the employer's employees eligible under the New York Disability Benefits Law</p> <p><input type="checkbox"/> b. Only the following class or classes of the employer's employees:</p>	
<p>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.</p> <p style="text-align: center; font-size: 1.5em;"><i>Amy K. Guinan</i></p> <p>Date Signed January 5, 2017 By _____ (Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)</p> <p>Telephone Number <u>1.866-761-4236</u> Title <u>Underwriting Director</u></p>	
<p>IMPORTANT: If box "4a" is checked, and this form is signed by the insurance carrier's authorized representative or NYS Licensed Insurance Agent of that carrier, this certificate is COMPLETE. Mail it directly to the certificate holder. If box "4b" is checked, this certificate is NOT COMPLETE for purposes of Section 220, Subd. 8 of the Disability Benefits Law. It must be mailed for completion to the Workers' Compensation Board, DB Plans Acceptance Unit, 328 State Street, Schenectady, New York 12305.</p>	
PART 2. To be completed by NYS Workers' Compensation Board (Only if box "4b" of Part 1 has been checked)	
<p>State Of New York Workers' Compensation Board</p> <p>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.</p> <p>Date Signed _____ By _____ (Signature of NYS Workers' Compensation Board Employee)</p> <p>Telephone Number _____ Title _____</p>	

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.

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 benefits under the New York State Disability 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". ***This Certificate is valid for the earlier of one year after this form is approved by the insurance carrier or its licensed agent, or the policy expiration date listed in box "3c".***

Please Note: Upon the cancellation of the disability 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 Benefits Coverage or other authorized proof that the business is complying with the mandatory coverage requirements of the New York State Disability Benefits Law.

DISABILITY 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 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 the payment of disability 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 for all employees has been secured as provided by this article.

Erie County Water Authority Insurance Requirements for Professional Services

Project Number: 201700087

Description: Engineering services for the design and construction of several waterline replacement projects within the Authority Direct Service area per a Request for Proposals (RFP).

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, Completed Operations Liability and Explosion, Collapse and Underground Coverage) – 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**

X **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:

X \$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

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 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.



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	
	INSURER A:	NAIC #
	INSURER B:	
	INSURER C:	
	INSURER D:	
	INSURER E:	

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 <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PROJECT <input type="checkbox"/> LOC	X	X				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
	AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS	X	X				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 type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DEDUCTIBLE <input checked="" type="checkbox"/> RETENTION \$ 10,000	X	X				EACH OCCURRENCE \$ AGGREGATE \$ \$ \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below Y/N <input type="checkbox"/> N/A						SUBMIT proof of Workers Compensation and disability as per examples attached WC STATUTORY LIMITS OTHER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
	Professional Liability Claims Made: Retroactive Date: Occurrence:						Per Specific Agreement Each Claim: Aggregate:

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 (General and Auto Liability): Erie County Water Authority
Additional Insured form CG 20 26 or equivalent.

CERTIFICATE HOLDER

CANCELLATION

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

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

Attn: Anthony Alessi

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:



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

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

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

<p>1a. Legal Name & Address of Insured (Use street address only)</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>1b. Business Telephone Number of Insured</p> <p>1c. NYS Unemployment Insurance Employer Registration Number of Insured</p> <p>1d. Federal Employer Identification Number of Insured or Social Security Number</p>
<p>2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)</p> 	<p>3a. Name of Insurance Carrier</p> <p>3b. Policy Number of entity listed in box "1a"</p> <p>3c. Policy effective period _____ to _____</p> <p>3d. The President, Partners or Executive Officers are included. (Only check box if all partners/officers included) <input type="checkbox"/> all excluded or certain partners/officers excluded.</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

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 226, subd. 4 of the Disability Benefits Law)

EMPLOYER	FEDERAL EMPLOYER IDENTIFICATION NUMBER
	LOCATION OF OPERATION
ADDRESS (HOME OR MAIN OFFICE)	OPERATIONS TO BE COVERED 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 (5/04)

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

AAAAAA

POLICYHOLDER		CERTIFICATE HOLDER	
POLICY NUMBER	CERTIFICATE NUMBER	PERIOD COVERED BY THIS CERTIFICATE 01/01/2009 TO 05/01/2010	DATE 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

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

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 <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) State University of New York Room 302 1400 Washington Avenue Albany, NY 12222	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 _____ (Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)	
Telephone Number _____ Title _____	
IMPORTANT: If box "4a" is checked, and this form is signed by the insurance carrier's authorized representative or NYS Licensed Insurance Agent of that carrier, this certificate is COMPLETE. Mail it directly to the certificate holder. If box "4b" is checked, this certificate is NOT COMPLETE for purposes of Section 220, Subd. 8 of the Disability Benefits Law. It must be mailed for completion to the Workers' Compensation Board, DB Plans Acceptance Unit, 20 Park Street, Albany, New York 12207.	
PART 2. To be completed by NYS Workers' Compensation Board (Only if box "4b" of Part 1 has been checked)	
State Of New York Workers' Compensation Board	
According to information maintained by the NYS Workers' Compensation Board, the above-named employer has complied with the NYS Disability Benefits Law with respect to all of his/her employees.	
Date Signed _____ By _____ (Signature of NYS Workers' Compensation Board Employee)	
Telephone Number _____ Title _____	

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

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. 2 of the Disability Benefits Law)

EMPLOYER	FEDERAL EMPLOYER IDENTIFICATION NUMBER
ADDRESS (HOME OR MAIN OFFICE)	LOCATION OF OPERATION
	OPERATIONS TO BEG. 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.

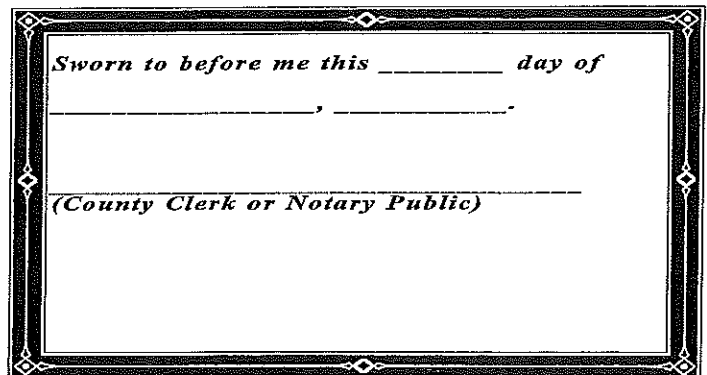
(Signature of Homeowner)

(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 COMPENSACION OBRERA
NOTICE OF COMPLIANCE
WORKERS' COMPENSATION LAW

AVISO DE CUMPLIMIENTO
LEY DE COMPENSACION OBRERA

TO EMPLOYEES

A EMPLEADOS

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

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

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.

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 tratamiento 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 Compensacion Obrera. Sin embargo, si su patrono esta autorizado a participar en una organizacion certificada de proveedores preferidos (PPO), usted debera obtener tratamiento inicial con 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 poner a sus empleados notificacion escrita explicando sus derechos y obligaciones bajo el programa que este acogido.
5. Usted debera recomendarle 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 al 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.

WORKERS' COMPENSATION BOARD OFFICES

- Albany, 12241 - 100 Broadway-Menands - (866) 750-5157
- Brooklyn, 11201 - 111 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


 ARY S. WEISS CHAIR/PRESIDENT ZACH

Workers' Compensation benefits, when due, will be paid by

(Los beneficios de Compensacion Obrera, cuando debidos, seran pagados por):

Name of employer (Nombre del patrono)

SAMPLE

Effective From _____ To _____
 (En vigor Desde) (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

ESTADO DE NUEVA YORK
JUNTA DE COMPENSACIÓN OBRERA

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 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.

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 período de su incapacidad.
4. Usted tiene derecho a ser tratado por cualquier medico, quiropráctico, dentista, enfermera-partera, podiatra o psicólogo 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 OFFICE

Albany, 12241 - 160 Broadway-Menands- (518) 474-6681
 Binghamton, 13901 - State Office Bldg - 44 Hawley St. - (716) 721-8333
 Buffalo, 14203-State Office Bldg -125 Main St - (716) 847-3171
 Hempstead, 11550 -175 Fulton Avenue - (516) 560-7115
 Rochester, 14614 - 130 Main Street West - (716) 278-6522
 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):

The benefits provided are (Los beneficios provistos son)

SAMPLE

Effective: From (_____) To UNTIL CANCELLED
 (En Vigor Desde) (HASTA)

Policy No _____
 (Poliza No.)

<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.

SAMPLE ISO FORM

EXHIBIT B

ERIE COUNTY WATER AUTHORITY CONFIDENTIALITY AND COPYRIGHT LICENSING AGREEMENT

LICENSE:

Upon execution of this Agreement, the Licensee acquires from the Licensor a license to use the aforementioned property of the Licensor for the purpose of completing the work under this Agreement.

The Licensor reserves the right to incorporate any Licensee-created data into the Licensor's database.

OWNERSHIP:

This License Agreement does not constitute a transfer of title or interest in the data. Any portion of the data that is modified or merged into another computer file or program by the Licensee, or is integrated with other programs or data to form derivative products, shall continue to be subject to the provisions of this License Agreement. The Licensor retains ownership of the data and all such portions.

CONFIDENTIALITY CLAUSE:

The Licensee agrees that all digital data and hard copy from the ECWA GIS Basemap Features provided to the Licensee are copyrighted by the Licensor, are protected by the copyright laws of the United States, and are furnished to the Licensee with all rights reserved. Therefore, the Licensee is hereby permitted to use the digital data and hard copies thereof only for the purposes allowed under this Agreement. The Licensee agrees not to otherwise copy, reproduce or use the digital data, hard copy, or the information contained therein for any other purpose whatsoever.

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A.M. Best Rating Services

The Travelers Indemnity Company (2)

A.M. Best #: 002520 NAIC #: 25658 FEIN #: 080566050

Domiliary Address

One Tower Square
Hartford, CT 06183
United States

Web: www.travelers.com

Phone: 860-271-0111

Fax: 860-271-7002

View additional news, reports and products for this company.

Assigned to insurance companies that have, in our opinion, a superior ability to meet their ongoing insurance obligations.



Best's Credit Ratings

Financial Strength Rating View Definition

Rating: A++ (Superior)
Affiliation Code: g (Group)
Financial Size Category: XV (\$2 Billion or greater)
Outlook: Stable
Action: Affirmed
Effective Date: July 22, 2016
Initial Rating Date: June 30, 1922

Long-Term Issuer Credit Rating View Definition

Long-Term: aa+
Outlook: Stable
Action: Affirmed
Effective Date: July 22, 2016
Initial Rating Date: April 18, 2005

u Denotes Under Review Best's Rating

Best's Credit Rating Analyst

Rating issued by: A.M. Best Rating Services, Inc.

Senior Financial Analyst: Gregory Dickerson

Director: Jennifer Marshall, CPCU, ARM

Disclose Information



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[A.M. Best Affirms Ratings of The Travelers Companies, Inc. and Its Subsidiaries](#)
July 22, 2016

Rating History

A.M. Best has provided ratings & analysis on this company since 1922.

Financial Strength Rating

Effective Date	Rating
7/22/2016	A++
5/28/2015	A++
6/23/2014	A++
5/30/2013	A+
6/10/2012	A+

Long-Term Issuer Credit Rating

Effective Date	Rating
7/22/2016	aa+
5/28/2015	aa+
6/23/2014	aa+
5/30/2013	aa
6/10/2012	aa

AMB Credit Reports



AMB Credit Report - includes Best's Financial Strength Rating and rationale along with comprehensive analytical commentary, detailed business overview and key financial data. Report Revision Date: 2/3/2017 (represents the latest significant change).



Historical Reports are available in [AMB Credit Report Archive](#).

View additional [news](#), [reports](#) and [products](#) for this company.

Press Releases

Date	Title
Jul 22, 2016	A.M. Best Affirms Ratings of The Travelers Companies, Inc. and Its Subsidiaries
May 28, 2015	A.M. Best Affirms Ratings of The Travelers Companies, Inc. and Its Subsidiaries
May 23, 2014	A.M. Best Upgrades Ratings of The Travelers Companies, Inc. and Most of Its Subsidiaries
May 30, 2013	A.M. Best Revises Outlook to Positive for The Travelers Companies, Inc. and Most of Its Subsidiaries
May 10, 2012	A.M. Best Affirms Ratings of The Travelers Companies, Inc. and Its Subsidiaries
May 26, 2011	A.M. Best Affirms Ratings of The Travelers Companies, Inc. and Its Subsidiaries
Jun 08, 2010	A.M. Best Upgrades Issuer Credit Ratings of Travelers Group
Mar 13, 2009	A.M. Best Withdraws Ratings of Atlantic Insurance Company
Jun 03, 2008	A.M. Best Affirms Ratings of Travelers Insurance Companies and Several of Its Subsidiaries
Oct 02, 2007	A.M. Best Upgrades and Withdraws Several Ratings for Travelers Reflecting Affiliated Transactions

1 2 3 Page size: 10 22 items in 3 pages

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The Phoenix Insurance Company (2)

A.M. Best #: 002518 NAIC #: 25623 FEIN #: 060303275

Domiciliary Address

One Tower Square
Hartford, CT 06183
United States

Web: www.travelers.com

Phone: 860-277-0111

Fax: 860-277-7002



Assigned to insurance companies that have, in our opinion, a superior ability to meet their ongoing insurance obligations.

View additional [news](#), [reports](#) and [products](#) for this company.

Based on A.M. Best's analysis, 068470 - The Travelers Companies, Inc. is the AMB Ultimate Parent and identifies the topmost entity of the corporate structure. View a list of [operating insurance entities](#) in this structure.

Best's Credit Ratings

Financial Strength Rating [View Definition](#)

Rating:	A++ (Superior)
Affiliation Code:	g (Group)
Financial Size Category:	XV (\$2 Billion or greater)
Outlook:	Stable
Action:	Affirmed
Effective Date:	July 22, 2016
Initial Rating Date:	December 31, 1907

Long-Term Issuer Credit Rating [View Definition](#)

Long-Term:	aa+
Outlook:	Stable
Action:	Affirmed
Effective Date:	July 22, 2016
Initial Rating Date:	April 18, 2005

u Denotes [Under Review Best's Rating](#)

Best's Credit Rating Analyst

Rating Issued by: A.M. Best Rating Services, Inc.
Senior Financial Analyst: Gregory Dickerson
Director: Jennifer Marshall, CPCU, ARM

Disclosure Information



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[A.M. Best Affirms Ratings of The Travelers Companies, Inc. and Its Subsidiaries](#)
July 22, 2016

Rating History

A.M. Best has provided ratings & analysis on this company since 1907.

Financial Strength Rating

Effective Date	Rating
7/22/2016	A++
5/28/2015	A++
5/23/2014	A++
5/30/2013	A+
5/10/2012	A+

Long-Term Issuer Credit Rating

Effective Date	Rating
7/22/2016	aa+
5/28/2015	aa+
5/23/2014	aa+
5/30/2013	aa
5/10/2012	aa

AMB Credit Reports



AMB Credit Report - includes Best's Financial Strength Rating and rationale along with comprehensive analytical commentary, detailed business overview and key financial data. Report Revision Date: 2/3/2017 (represents the latest significant change).



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Press Releases

Date	Title
Jul 22, 2016	A.M. Best Affirms Ratings of The Travelers Companies, Inc. and Its Subsidiaries
May 28, 2015	A.M. Best Affirms Ratings of The Travelers Companies, Inc. and Its Subsidiaries
May 23, 2014	A.M. Best Upgrades Ratings of The Travelers Companies, Inc. and Most of Its Subsidiaries
May 30, 2013	A.M. Best Revises Outlook to Positive for The Travelers Companies, Inc. and Most of Its Subsidiaries
May 10, 2012	A.M. Best Affirms Ratings of The Travelers Companies, Inc. and Its Subsidiaries
May 26, 2011	A.M. Best Affirms Ratings of The Travelers Companies, Inc. and Its Subsidiaries
Jun 08, 2010	A.M. Best Upgrades Issuer Credit Ratings of Travelers Group
Jun 03, 2008	A.M. Best Affirms Ratings of Travelers Insurance Companies and Several of Its Subsidiaries
Nov 13, 2007	A.M. Best Affirms Ratings of Allianz Global Corporate & Specialty, North America and Fireman's Fund Insurance Company
Jun 18, 2007	A.M. Best Affirms Ratings of Travelers Insurance Companies and Several of Its Subsidiaries

1 2 Page size: 10 18 items in 2 pages

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XL Specialty Insurance Company (2)

A.M. Best #: 000779 NAIC #: 37885 FEIN #: 850277191

Administrative Office

Seaview House 70 Seaview Avenue
Stamford, CT 06902-6040

United States

[View Additional Address Information](#)



Assigned to insurance companies that have, in our opinion, an excellent ability to meet their ongoing insurance obligations.

Web: www.xlcatlin.com

Phone: 203-964-5200

Fax: 203-964-3444

View additional [news, reports and products](#) for this company.

Based on A.M. Best's analysis, [046310 - XL Group Ltd](#) is the AMB Ultimate Parent and identifies the topmost entity of the corporate structure. View a list of [operating insurance entities](#) in this structure.

Best's Credit Ratings

Financial Strength Rating [View Definition](#)

Rating:	A (Excellent)
Affiliation Code:	g (Group)
Financial Size Category:	XV (\$2 Billion or greater)
Outlook:	Stable
Action:	Affirmed
Effective Date:	August 03, 2016
Initial Rating Date:	June 30, 1989

Long-Term Issuer Credit Rating [View Definition](#)

Long-Term:	a+
Outlook:	Stable
Action:	Affirmed
Effective Date:	August 03, 2016
Initial Rating Date:	April 11, 2005

u Denotes [Under Review Best's Rating](#)

Best's Credit Rating Analyst

Rating Issued by: A.M. Best Rating Services, Inc.
Senior Financial Analyst: Susan Molineux
Director: Greg Reisner

Note: Credit Ratings on this company are [European Union Endorsed](#).

Disclosure Information



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[A.M. Best Revises ICR Outlook to Stable for XL Group Ltd's Subsidiaries; Upgrades ICRs of Catlin Ins. Co. Ltd. and Subsidiaries](#)
August 03, 2016

Rating History

A.M. Best has provided ratings & analysis on this company since 1989.

Financial Strength Rating

Effective Date	Rating
8/3/2016	A
5/1/2015	A
1/9/2015	A u
12/10/2014	A
10/29/2013	A
10/4/2012	A
9/21/2011	A

Long-Term Issuer Credit Rating

Effective Date	Rating
8/3/2016	a+
5/1/2015	a+
1/9/2015	a+ u
12/10/2014	a+
10/29/2013	a
10/4/2012	a

Related Financial and Analytical Data

The following links provide access to related data records that A.M. Best utilizes to provide financial and analytical data on a consolidated or branch basis.

AMB #	Company Name	Company Description
067531	XL Specialty Insurance Company CAB	Represents the Property/ Casualty financials for the Canada Branch of this legal entity.

AMB Credit Reports



AMB Credit Report - Includes Best's Financial Strength Rating and rationale along with comprehensive analytical commentary, detailed business overview and key financial data. Report Revision Date: 10/19/2016 (represents the latest significant change).



Historical Reports are available in [AMB Credit Report Archive](#).

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Press Releases

Date	Title
Aug 03, 2016	A.M. Best Revises ICR Outlook to Stable for XL Group Ltd's Subsidiaries; Upgrades ICRs of Catlin Ins. Co. Ltd. and Subsidiaries
May 01, 2015	A.M. Best Removes From Under Review and Affirms Ratings of XL Group plc and its Subsidiaries
Jan 09, 2015	A.M. Best Places Ratings of XL Group plc and Its Subsidiaries Under Review with Negative Implications
Dec 10, 2014	A.M. Best Upgrades Issuer Credit Rating for XL Group plc and Its Property/Casualty Subsidiaries
Oct 29, 2013	A.M. Best Revises Issuer Credit Rating Outlook to Positive for XL Group plc and Its Property/Casualty Subsidiaries
Oct 04, 2012	A.M. Best Affirms Ratings of XL Group plc, Its Property/Casualty Subsidiaries and XLIT Ltd.
Sep 21, 2011	A.M. Best Affirms Ratings of XL Group plc, Its Property/Casualty Subsidiaries and XL Group Ltd.
Feb 22, 2011	A.M. Best Affirms Ratings of XL Group Ltd. and Its Property/Casualty Subsidiaries
Mar 02, 2010	A.M. Best Withdraws Ratings of XL Lloyds Insurance Company
Sep 09, 2009	A.M. Best Affirms Ratings of XL Capital Ltd and Its Property/Casualty Subsidiaries

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A.M. Best Rating Services

The Travelers Indemnity Company (2)

A.M. Best #: 002520 NAIC #: 25658 FEIN #: 060566050

Domiciliary Address

One Tower Square
Hartford, CT 06189
United StatesWeb: www.travelers.com

Phone: 860-277-0111

Fax: 860-277-7002

Financial Strength Rating



Assigned to insurance companies that have, in our opinion, a superior ability to meet their ongoing insurance obligations.

View additional [news, reports and products](#) for this company.Based on A.M. Best's analysis, 058470 - The Travelers Companies, Inc. is the AMB Ultimate Parent and identifies the topmost entity of the corporate structure. View a list of [operating insurance entities](#) in this structure.

Best's Credit Ratings

Financial Strength Rating [View Definition](#)

Rating:	A++ (Superior)
Affiliation Code:	g (Group)
Financial Size Category:	XV (\$2 Billion or greater)
Outlook:	Stable
Action:	Affirmed
Effective Date:	July 22, 2016
Initial Rating Date:	June 30, 1922

Long-Term Issuer Credit Rating [View Definition](#)

Long-Term:	aa+
Outlook:	Stable
Action:	Affirmed
Effective Date:	July 22, 2016
Initial Rating Date:	April 18, 2005

u Denotes [Under Review Best's Rating](#)

Best's Credit Rating Analyst

Rating Issued by: A.M. Best Rating Services, Inc.
Senior Financial Analyst: Gregory Dickerson
Director: Jennifer Marshall, CPCU, ARM

Disclosure Information

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July 22, 2016

Rating History

A.M. Best has provided ratings & analysis on this company since 1922.

Financial Strength Rating

Effective Date	Rating
7/22/2016	A++
5/28/2015	A++
5/23/2014	A++
5/30/2013	A+
5/10/2012	A+

Long-Term Issuer Credit Rating

Effective Date	Rating
7/22/2016	aa+
5/28/2015	aa+
5/23/2014	aa+
5/30/2013	aa
5/10/2012	aa

AMB Credit Reports

A.M. Best Rating Services

The Phoenix Insurance Company (2)

A.M. Best #: 002518 NAIC #: 25623 FEIN #: 060303275

Domiciliary Address
One Tower Square
Hartford, CT 06183
United States



Assigned to insurance companies that have, in our opinion, a superior ability to meet their ongoing insurance obligations.

Web: www.travelers.com
Phone: 860-277-0111
Fax: 860-277-7002

View additional [news, reports and products](#) for this company.

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Best's Credit Ratings

Financial Strength Rating View Definition

Rating: A++ (Superior)
Affiliation Code: g (Group)
Financial Size Category: XV (\$2 Billion or greater)
Outlook: Stable
Action: Affirmed
Effective Date: July 22, 2016
Initial Rating Date: December 31, 1907

Long-Term Issuer Credit Rating View Definition

Long-Term: aa+
Outlook: Stable
Action: Affirmed
Effective Date: July 22, 2016
Initial Rating Date: April 18, 2005

u Denotes [Under Review Best's Rating](#)

Best's Credit Rating Analyst

Rating Issued by: A.M. Best Rating Services, Inc.
Senior Financial Analyst: Gregory Dickerson
Director: Jennifer Marshall, CPCU, ARM

Disclosure Information



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July 22, 2016

Rating History

A.M. Best has provided ratings & analysis on this company since 1907.

Financial Strength Rating

Effective Date	Rating
7/22/2016	A++
5/28/2015	A++
5/23/2014	A++
5/30/2013	A+
5/10/2012	A+

Long-Term Issuer Credit Rating

Effective Date	Rating
7/22/2016	aa+
5/28/2015	aa+
5/23/2014	aa+
5/30/2013	aa
5/10/2012	aa

AMB Credit Reports

A.M. Best Rating Services

XL Specialty Insurance Company (2)

A.M. Best #: 000779 NAIC #: 37885 FEIN #: 850277191

Administrative Office

Seaview House 70 Seaview Avenue
Stamford, CT 06902-6040

United States

Web: www.xlcatlin.com

Phone: 203-964-5200

Fax: 203-964-3444

[View Additional Address Information](#)

Financial Strength Rating



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Best's Credit Ratings

Financial Strength Rating [View Definition](#)

Rating:	A (Excellent)
Affiliation Code:	g (Group)
Financial Size Category:	XV (\$2 Billion or greater)
Outlook:	Stable
Action:	Affirmed
Effective Date:	August 03, 2016
Initial Rating Date:	June 30, 1989

Long-Term Issuer Credit Rating [View Definition](#)

Long-Term:	a+
Outlook:	Stable
Action:	Affirmed
Effective Date:	August 03, 2016
Initial Rating Date:	April 11, 2005

u Denotes [Under Review Best's Rating](#)

Best's Credit Rating Analyst

Rating Issued by: A.M. Best Rating Services, Inc.

Senior Financial Analyst: Susan Molineux

Director: Greg Reisner

Note: Credit Ratings on this company are [European Union Endorsed](#).

Disclosure Information

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August 03, 2016

Rating History

A.M. Best has provided ratings & analysis on this company since 1989.

Financial Strength Rating

Effective Date	Rating
8/3/2016	A
5/1/2015	A
1/9/2015	A u
12/10/2014	A
10/29/2013	A
10/4/2012	A
9/21/2011	A

Long-Term Issuer Credit Rating

Effective Date	Rating
8/3/2016	a+
5/1/2015	a+
1/9/2015	a+ u
12/10/2014	a+
10/29/2013	a
10/4/2012	a

A.M. Best Rating Services

Cigna Life Insurance Company of New York (2)

A.M. Best #: 006538 NAIC #: 64548 FEIN #: 132556568

Administrative Office
Two Liberty Place 1601 Chestnut Street, TL14A
Philadelphia, PA 19192-2362
United States

[View Additional Address Information](#)

Financial Strength Rating



Assigned to insurance companies that have, in our opinion, an excellent ability to meet their ongoing insurance obligations.

Web: www.cigna.com
Phone: 215-761-1000

View additional [news, reports and products](#) for this company.

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Best's Credit Ratings

Financial Strength Rating [View Definition](#)

Rating: A u (Excellent)
Affiliation Code: g (Group)
Financial Size Category: XV (\$2 Billion or greater)
Implication: Developing
Action: Under Review
Effective Date: June 24, 2015
Initial Rating Date: June 30, 1976

Long-Term Issuer Credit Rating [View Definition](#)

Long-Term: a u
Implication: Developing
Action: Under Review
Effective Date: June 24, 2015
Initial Rating Date: December 21, 2005

u Denotes [Under Review Best's Rating](#)

Best's Credit Rating Analyst

Rating Issued by: A.M. Best Rating Services, Inc.
Financial Analyst: Saurin Parikh
Senior Director: Sally A. Rosen

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[A.M. Best Places Ratings of Cigna Corporation and Its Subsidiaries Under Review with Developing Implications](#)
June 24, 2015

Rating History

A.M. Best has provided ratings & analysis on this company since 1976.

Financial Strength Rating

Effective Date	Rating
6/24/2015	A u
2/13/2015	A
2/13/2014	A
2/14/2013	A
12/2/2011	A
1/28/2011	A

Long-Term Issuer Credit Rating

Effective Date	Rating
6/24/2015	a u
2/13/2015	a
2/13/2014	a
2/14/2013	a
12/2/2011	a
1/28/2011	a