ERIE COUNTY WATER AUTHORITY
AUTHORIZATION FORM
For Approval/Execution of Documents
(check which apply)

**Contract:** _____ **Project No.:** 201900047

**Project Description:** Lawley Services Inc. Professional Services Contract

**Item Description:**

- [ ] Agreement
- [X] Professional Service Contract
- [ ] Amendment
- [ ] Change Order
- [ ] BCD
- [ ] NYSDOT Agreement
- [ ] Contract Documents
- [ ] Addendum
- [ ] Recommendation for Award of Contract
- [ ] Recommendation to Reject Bids
- [ ] Request for Proposals
- [ ] Other _____

**Action Requested:**

- [X] Board Authorization to Execute
- [X] Legal Approval
- [ ] Board Authorization to Award
- [X] Execution by the Chairman
- [ ] Board Authorization to Advertise for Bids
- [ ] Execution by the Secretary to the Authority
- [ ] Board Authorization to Solicit Request for Proposals
- [ ] Other _____

**Approvals Needed:**

**APPROVED AS TO CONTENT:**

- [X] Department Head _____ Date: 5/7/19
- [X] Risk Manager _____ Date: 05/08/2019
- [X] Director of Administration _____ Date: 5/7/19
- [X] Executive Engineer _____ Date: _____

**APPROVED AS TO FORM:**

- [X] Legal Margaret A. Murphy Date: 5/8/19

**APPROVED FOR BOARD RESOLUTION:**

- [X] Secretary to the Authority _____ Date: 5/9/19

**Remarks:** _____

**Resolution Date:** _____ **Item No:** _____

# PROFESSIONAL SERVICES CONTRACT

AGREEMENT made this ___ day of May 2019, by and between

**ERIE COUNTY WATER AUTHORITY**
295 Main Street, Rm. 350
Buffalo, New York 14203

hereinafter referred to as the "Authority", and

**LAWLEY SERVICE, INC.,**
361 Delaware Ave.
Buffalo, NY 14202

hereinafter referred to as the "Consultant"

**WHEREAS,** the Authority desires to contract with the Consultant to render risk management and insurance broker services upon the terms and for the consideration set forth in this Agreement; and

**WHEREAS,** the Consultant represents it is properly qualified to render such services, and the parties desire to set forth herein the terms and conditions under which the said risk management and insurance broker services will be furnished,

**NOW, THEREFORE,** in consideration of mutual promises herein set forth, the parties agree as follows:

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

2. **SCOPE OF SERVICES:** The Consultant shall provide risk management and insurance broker services (the "Work"), as more fully described in Schedule "A." The Work shall be carried out by the Consultant in accordance with current industry standards and trade practices.

## 3. TERM AND PAYMENT FOR SERVICES:

### A. TERM:

The Consultant services, as described herein, shall commence on July 1, 2019 and terminate on June 30, 2020 ("Term") unless terminated earlier pursuant to the provisions of this Agreement.

### B. PAYMENT FOR SERVICES:

The Consultant shall be paid for the Work to be performed pursuant to Paragraph 2 of this Agreement in the manner and at the rates set forth in Schedule "A." Unless otherwise expressly stated in this Agreement, no payment shall be made by the Authority to the Consultant for out-of-pocket expenses or disbursements made in connection with the services rendered or the work to be performed hereunder. Any and all requests for payment to be made, including any request for partial payment if such is permitted hereunder, shall be submitted by the Consultant to the Authority and paid only after approval by the Authority.

### C. AUDIT:

Prior to the making of any payments hereunder, 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 (2) 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.

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 prior 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. Any purported delegation of duties, assignment of rights or subcontracting of Work under this Agreement without the prior express written consent of the Authority is void. All subcontracts that have received such prior written consent shall provide that sub consultants are subject to all terms and conditions set forth in this Agreement. It is recognized and understood by the Consultant that for the purposes of this Agreement, all work performed by an Authority approved subcontractor shall be deemed work performed by the Consultant and the Consultant shall insure that such subcontracted work is subject to the material terms and conditions of this Agreement.

5. **THIRD PARTY RIGHTS:** Nothing herein is intended or shall be construed to confer upon or give to any third party or its successors and assigns any rights, remedies or basis for reliance upon, under or by reason of this Agreement, except in the event that specific third party rights are expressly granted herein.

6. **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.

7. **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. Upon receipt of notice that the Authority is terminating this Agreement, the Consultant shall stop work immediately and incur no further costs in furtherance of this Agreement without the express approval of the Authority, and the Consultant shall direct any approved sub-consultants to do the same. The Consultant and any sub-consultants shall not be entitled to lost profit.

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, is 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, except such information as required under applicable laws and regulations of New York State. The Consultant shall use at least the same degree of care to protect and prevent unauthorized disclosure of any confidential information as it would use to protect and prevent unauthorized disclosure of its own proprietary information. The Consultant shall use confidential information only in the performance of this Agreement. No other use of the confidential information whether for the Consultant's benefit or for the benefit of others shall be permitted. In no event is the Consultant authorized to disclose confidential information without the prior written approval of the Authority. The terms of this paragraph shall be binding during and subsequent to the termination of this Agreement.

9. **INSURANCE:** The Consultant agrees to procure and maintain insurance naming the Authority as additional insured, where applicable, as provided and described in exhibit "A", entitled "Standard Insurance Provisions," with the exception of professional liability insurance coverage in which the Consultant shall be required to provide proof of coverage in an amount no less than five million ($5,000,000) dollars per occurrence and aggregate.

10. **INDEMNIFICATION:** In addition to, and not in limitation of the insurance provisions contained in Schedule "B," the Consultant shall indemnify the Authority, its officers, employees and agents from and against any and all claims arising directly or indirectly out of the performance or failure to perform hereunder by the Consultant or third parties under the direction or control of the Consultant and hold harmless the Authority from and against all claims, suits, actions, costs, counsel fees, expenses, damages, judgments or decrees based upon or arising out of damage to property or injury to persons or other tortuous conduct caused or contributed to it by the Consultant or anyone under its direction or control or on its behalf in the course of its performance under this Agreement.

11. **COPYRIGHTS, TRADEMARKS, AND LICENSING:** All records or recorded data of any kind compiled by the Consultant in completing the Work described in this Agreement, including but not limited to written reports, studies, drawings, blueprints, computer printouts, graphs, charts, plans, specifications and all other similar recorded data, shall become and remain the property of the Authority. The Consultant may retain copies of such records for its own use and shall not disclose any such information without the express written consent of the Authority. The Authority shall have the right to reproduce and publish such records, if it so desires, at no additional cost to the Authority.

    Notwithstanding the foregoing, all deliverables created under this Agreement by the Consultant are to be considered "works made for hire." If any of the deliverables do not qualify as "works made for hire," the Consultant hereby assigns to the Authority all right, title and interest (including ownership of copyright) in such deliverables and such assignment allows the Authority to obtain in its name copyrights, registrations and similar protections which may be available. The Consultant agrees to assist the Authority, if required, in perfecting these rights. The Consultant shall provide the Authority with at least one copy of each deliverable.

    The Consultant agrees to defend, indemnify and hold harmless the Authority for all damages, liabilities, losses and expenses arising out of any claim that a deliverable infringes upon an intellectual property right of a third party. If such a claim is made, or appears likely to be made, the Consultant agrees to enable the Authority's continued use of the deliverable, or to modify or replace it. If the Authority determines that none of these alternatives is reasonably available, the deliverable may be returned.

12. **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.

13. **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.

14. **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.

15. **ENTIRE AGREEMENT:** This Agreement and its attachments constitute 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.

16. **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.

17. **APPLICABLE LAWS:** The Consultant shall comply, at its own expense, with the provisions of all applicable local, state and federal laws, rules and regulations. The Consultant shall further comply, at its own expense, with all applicable rules, regulations and licensing requirements pertaining to its professional status and that of its employees, partners, associates, sub consultants and others employed to render the Work hereunder.

18. **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 the Authority which forms the basis of the within Agreement.

19. **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.

20. **NOTICE:** All notices of any nature referred to in this Agreement shall be in writing and either sent by registered or certified mail postage pre-paid, or delivered by hand or overnight courier, as set forth below or to such other addresses as the respective parties hereto may designate in writing. Notice shall be effective on the date of receipt. Notices shall be sent to the following:

To the ERIE COUNTY WATER AUTHORITY:

Chair, Board of Commissioners
Erie County Water Authority
295 Main Street, Suite 350
Buffalo, NY 14203

To the Consultant:

Michael R. Lawley
Lawley Service, Inc.
361 Delaware Ave.
Buffalo, NY 14202

21. **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 Agreement.

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

**ERIE COUNTY WATER AUTHORITY**

By_____
Jerome D. Schad, Chairman

**LAWLEY SERVICE, INC**

By_____
Michael R. Lawley, Managing Partner

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

On the _____day of _____, in the year 2019, before me personally came Jerome D. Schad, to me known, who, being by me duly sworn, did depose and say that he resides in Amherst, New York, that he is the Chairman of the Corporation described in the above instrument; and that he signed his name thereto by order of the Board of Directors of said Corporation.

_____
Notary Public

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

On the _____day of _____, in the year 2019, before me personally came Michael R. Lawley, to me known, who, being by me duly sworn, did depose and say that he resides in _____, New York, that he is the Managing Partner of the Corporation described in the above instrument; and that he signed his name thereto by order of the Board of Directors of said Corporation.

_____
Notary Public

## SCHEDULE "A"

## SCOPE OF SERVICES AND FEES

I. **Insurance Brokerage Services** Consultant shall have the responsibility of acting as the Authority's insurance and risk management representative to the insurance marketplace. The Authority reserves the right to determine which type of coverage and insurance policy will be placed by the Consultant. As part of the annual insurance marketing process, the Consultant shall take into account and address for each of the lines of insurance the Authority holds, including:

- There will be no reduction in policy limits, coverage terms and conditions, or increase in deductibles, unless the market conditions will not allow a similar renewal or without prior written approval of the Authority.
- Estimate premium savings or premium increases by policy and by specific coverage enhancements.
- Estimate the additional premium (if any) to reduce any of the retention or deductible levels under the existing policies.
- Principal markets contacted and the advantages and disadvantages of each option.
- Determine whether the current policies be consolidated, changed, or endorsed in order to obtain premium savings or increase the breadth of coverage.
- All insurance policies are to be placed with insurance companies that have an A.M. Best rating of at least A- with a financial size category rating of VIII. All carriers must be licensed to do business in New York State. Exceptions to this can be obtained via written approval by the Authority prior to placement of coverage.
- Advise on use of wholesalers or intermediaries.
- Consultant shall conduct annual risk financing alternatives analysis and provide programmatic advice to the Authority that will serve to achieve the Authority's cost containment and program quality objectives.
- Consultant shall report to the Authority's Legal Department on how Consultant will issue and update publications describing the Authority's insurance policies. An insurance summary of each policy shall be written which will include all pertinent information regarding limits, deductibles, perils, exclusions, etc.

On an annual basis, in advance of the renewal date of existing or new insurance policies and in conjunction with the Authority, the following activities shall be performed by the Consultant:

- Review of insurance market conditions in terms of capacity, pricing and limitations or extensions of coverage.
- Conduct a financial review of present or proposed insurance companies to confirm the current companies meet the Authority's financial stability requirements.
- Conduct an exposure analysis and prepare reports of all exposures to accidental event risk loss which can be covered by insurance.
- Review all identified risks to determine if risks have increased or decreased.
- Compile information for underwriters in order for them to be able to fairly evaluate their exposures and accept the transfer of the Authority's risks.
- Review and document all placed policies, cover notes and binders to make sure they contain the correct information on pricing, terms, conditions and other relevant information.
- Policies are to be received by the Authority within 45 days of the date they are obtained from underwriters by the Consultant.

**II.** **Workers Compensation Claim Management and Loss Control Services** Consultant shall work with the Authority, its insurance carriers and all appropriate personnel to provide the following services which are including but not limited to:

**A.** **Workers Compensation Claim Management**
Workers Compensation claim management will include:

1) **Workers Compensation Claim Review** – Conduct quarterly claim reviews with Workers Compensation carrier to mitigated Workers Compensation losses

2) **Annual Experience Mod Analysis** – Utilize ModMaster Software to verify the accuracy of the experience modification factor

3) **First Aid Claim Program:** Process and fee schedule First Aid Claims (Medical Only per NYS WC Section 110

**B.** **General Workers' Compensation Support**
Coordinate with the Authority's Workers Compensation Insurance carrier as requested. Create special handling instructions with the carrier. Review open

claims and provide the Authority with a sorted list of claims to be settled and reimbursed claims. Advise on disposition strategies and reserving.

**C. Loss Control Services**

Lawley loss control will compliment your in-house safety department. Services include but not limited to:

- Site Safety reviews
- Lockout program updates
- Safety meeting attendance
- Training
- Program Development/Implementation
- Written Safety Program Updates
- Safety Benchmarking
- Accident Investigation
- Loss History Analysis
- Grant Writing
- Review of insurance company inspection reports.
- Maintain Loss prevention information including detailed information on loss prevention recommendations, the Authority's responses and follow-up activities.

**D. Auto Liability Risk Assessment**

Review current fleet program(s), including evaluation of exposures and current controls. Enhancement recommendations will be provided as necessary.

**E. Carrier Recommendation Reviews**

A review and assessment of carrier recommendations will be provided. Possible negotiation with carriers for control alternatives. Categorize recommendations along with their status in a reviewable format to include responses and follow-up activities.

**F. Claim Management**

Review of open property and liability claim and claim status.

**G. Review of Leases and Contracts**

Services will be performed on an "as-requested" basis. Assess coverage alignment in relationship to contractual requirements.

**H. Loss Analysis**

Combine and categorize past losses. Assess losses for trends, specific high-activity locations, high-dollar claims, extended-period open claims, and claim history summaries.

## III. Workers Compensation Service Fees and Consultant Compensation

Workers Compensation service fees and Consultant compensation will be paid in the following manner:

$10,000 - Workers Compensation Claim Management Services
$40,000 - Loss Control Services
$20,000 - Policy Administration Services of Workers Compensation Program

$70,000 – Total Service Fees

## IV. Insurance Brokerage Services

Consultant shall be compensated by commissions paid by carriers.*

*A Policy Administration fee is applied for the Workers Compensation policy in lieu of commission as consultant does not receive commission from the New York State Insurance Fund (NYSIF)

# SCHEDULE "B"

# INSURANCE REQUIREMENTS and CERTIFICATES

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

**Project Number:** **201900047**

**Project Vendor:** **Lawley Services, Inc.**

**Description:** **Erie County Water Authority Insurance Brokerage Services for 2019-2020**

The following minimum insurance requirements shall apply to professional service providers under agreement with the Erie County Water Authority (ECWA). The professional service provider carries relevant insurance for the services covered. If at anytime, in the opinion of ECWA, there is an unusual or exceptional risk, ECWA may establish additional insurance requirements for the duration of the agreement. All insurance required herein shall be obtained at the sole cost and expense of the professional service provider, including deductibles and self-insured retentions. These requirements include but are not limited to the minimum insurance requirements.

An X indicates insurance coverage is required.

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

__X__ **Per Policy**

____ **Per Project or Job**

____ **Per Location**

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

__X__ **Commercial Business Automobile Insurance** in an amount of not less than $1,000,000 each accident and shall cover liability arising out of any automobile owned, leased, hired, borrowed and non-owned automobiles. Additionally, if vehicles are used for transporting hazardous materials, the contractor shall obtain and maintain the "broadened" coverage (endorsement CA 99 48 10 01 or CA 99 48 12 93), as well as proof of MCS 90 04 00.

___ **Excess Umbrella Liability Insurance:**

___ $1,000,000 in the aggregate

___ $2,000,000 in the aggregate

___ $3,000,000 in the aggregate

___ $4,000,000 in the aggregate

___ $5,000,000 in the aggregate

___ **Per Policy**

___ **Per Project or Job**

___ **Per Location**

__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:

___ $1,000,000 in the aggregate

___ $2,000,000 in the aggregate

___ $3,000,000 in the aggregate

___ $4,000,000 in the aggregate

__X__ $5,000,000 in the aggregate

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

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

___ **Fidelity Bond:**

Any vendor with access to ECWA financial systems must provide a Fidelity Bond in the amount of at least Five Hundred Thousand and 00/100 Dollars ($500,000.00) through a responsible Surety Company naming ECWA as third (3rd) party to the Bond, with respect to all of vendor's employees, as may be necessary to protect against losses, including, without limitation, those arising from theft, embezzlement, fraud, or misplacement of funds, money, or documents. Coverage must extend to any losses incurred by ECWA due to theft, embezzlement or fraud by vendor, vendor's employees or subcontractors. Vendor shall notify ECWA in writing within five (5) days of filing a claim under such coverage and to assign to the Authority, as the case may be, the proceeds of such coverage allocable to losses suffered with respect to the property of ECWA.

__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.

Erie County Water Authority Insurance Requirements for Professional Services

# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

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

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

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

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

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

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

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

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

Attn: Anthony Alessi

**CANCELLATION**

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

AUTHORIZED REPRESENTATIVE

# Understanding New York Workers Compensation Board

## Workers Compensation and N.Y.S Disability Benefits Liability

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

The forms discussed are:

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

2) Workers Compensation

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

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

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

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

3) New York State Disability Benefits Law (DBL)

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

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

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

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

NEW YORK STATE | **Workers' Compensation Board**

# CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

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

This certifies that the insurance carrier indicated above in box "3" insures the business referenced above in box "1a" for workers' compensation under the New York State Workers' Compensation Law. **(To use this form, New York (NY) must be listed under Item 3A on the INFORMATION PAGE of the workers compensation insurance policy).** The Insurance Carrier or its licensed agent will send this Certificate of Insurance to the entity listed above as the certificate holder in box "2".



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

This certificate is issued as a matter of information only and confers no rights upon the certificate holder. This certificate does not amend, extend or alter the coverage afforded by the policy listed, nor does it confer any rights or responsibilities beyond those contained in the referenced policy.

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

**Please Note: Upon 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: William Lawley Jr.
(Print name of authorized representative or licensed agent of insurance carrier)

Approved by: _____
(Signature) (Date)

Title: Managing Partner

Telephone Number of authorized representative or licensed agent of insurance carrier: (716) 849-8618

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

## Workers' Compensation Law

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

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

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

# Form CE-200

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

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

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

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

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

**Workers' Compensation Exemption Statement:**

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

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

**Disability Benefits Exemption Statement:**

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

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

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

| SIGN HERE | Signature: | Date: |
|---|---|---|

**Exemption Certificate Number**
**2008-00197**

**Received**
**October 2, 2008**
**NYS Workers' Compensation Board**



CE-200 (Draft 06/02/08)

**Form SI-12**

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

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

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

| EMPLOYER | FEDERAL EMPLOYER IDENTIFICATION NUMBER |
|---|---|
| | LOCATION OF OPERATIONS |
| ADDRESS (HOME OR MAIN OFFICE) | |
| | OPERATIONS TO BEGIN ON OR ABOUT: |



There are on file with the Workers' Compensation Board, documents indicating that the above-named employer has complied with the Disability Benefits Law with respect to all of his or her employees in the following manner:

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

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

Date:

By:_____
Gina Wagoner
WC Examiner

DB-155 (3/04)

THIS AGENCY EMPLOYS & SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

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

# CERTIFICATE OF WORKERS' COMPENSATION INSURANCE

^^^^^^

| POLICYHOLDER | CERTIFICATE HOLDER |
|---|---|
| | |

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

THIS IS TO CERTIFY THAT THE POLICYHOLDER NAMED ABOVE IS INSURED WITH THE NEW YORK STATE INSURANCE FUND UNDER POLICY NO. 2058 840-6 UNTIL 05/01/2010, COVERING THE ENTIRE OBLIGATION OF THIS POLICYHOLDER FOR WORKERS' COMPENSATION UNDER THE NEW YORK WORKERS' COMPENSATION LAW WITH RESPECT TO ALL OPERATIONS IN THE STATE OF NEW YORK, EXCEPT AS INDICATED BELOW.

IF SAID POLICY IS CANCELLED, OR CHANGED PRIOR TO 05/01/2010 IN SUCH MANNER AS TO AFFECT THIS CERTIFICATE, 10 DAYS WRITTEN NOTICE OF SUCH CANCELLATION WILL BE GIVEN TO THE CERTIFICATE HOLDER ABOVE. NOTICE BY REGULAR MAIL SO ADDRESSED SHALL BE SUFFICIENT COMPLIANCE WITH THIS PROVISION. THE NEW YORK STATE INSURANCE FUND DOES NOT ASSUME ANY LIABILITY IN THE EVENT OF FAILURE TO GIVE SUCH NOTICE.

THIS CERTIFICATE DOES NOT APPLY TO BUILDING DEMOLITION.

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS NOR INSURANCE COVERAGE UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICY.



NEW YORK STATE INSURANCE FUND

John Manetti

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"<br><br>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<br>☐ included (Only check box if all partners/officers included)<br>all excluded or certain partners/officers excluded | 1f. Federal Employer Identification Number of Business referenced in box "1a" |
| 2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as Certificate Holder) | 3. Name and Address of Group Self-Insurer |



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

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

*If this certificate is no longer valid according to the above guidelines and the business referenced in box "1a" continues to be named on a permit, license or contract issued by the certificate holder, the business must provide the certificate holder either with a new certificate or other authorized proof the business is complying with the mandatory coverage requirements of the New York State Workers' Compensation Law.*
**Under penalty of perjury, I certify that I am an authorized representative of the Group Self-Insurer referenced above and that the business referenced in box "1a" has the coverage as depicted on this form.**

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

Certified by: _____
(Signature) (Date)

Title: _____

Telephone Number: _____

NEW YORK STATE | Workers' Compensation Board

# CERTIFICATE OF INSURANCE COVERAGE
## DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

**PART 1. To be completed by Disability and Paid Family Leave Benefits Carrier or Licensed Insurance Agent of that Carrier**

| | |
|---|---|
| 1a. Legal Name & Address of Insured (use street address only)<br><br>Work Location of Insured *(Only required if coverage is specifically limited to certain locations in New York State, i.e., Wrap-Up Policy)* | 1b. Business Telephone Number of Insured<br><br>1c. Federal Employer Identification Number of Insured or Social Security Number |
| 2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) | 3a. Name of Insurance Carrier<br>**ShelterPoint Life Insurance Company**<br>3b. Policy Number of Entity Listed in Box "1a"<br><br>3c. Policy effective period<br>_____ to _____ |

4. Policy provides the following benefits:
   - ☐ A. Both disability and paid family leave benefits.
   - ☐ B. Disability benefits only.
   - ☐ C. Paid family leave benefits only.
5. Policy covers:
   - ☐ A. All of the employer's employees eligible under the NYS Disability and Paid Family Leave Benefits Law.
   - ☐ B. Only the following class or classes of employer's employees:

_____

_____

Under penalty of perjury, I certify that I am an authorized representative or licensed agent of the insurance carrier referenced above and that the named insured has NYS Disability and/or Paid Family Leave Benefits Insurance coverage as described above.

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

Telephone Number _____ Name and Title _____

IMPORTANT: If Boxes 4A and 5A are checked, and this form is signed by the insurance carrier's authorized representative or NYS Licensed Insurance Agent of that carrier, this certificate is COMPLETE. Mail it directly to the certificate holder.

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

**PART 2. To be completed by the NYS Workers' Compensation Board** (Only if Box 4C or 5B of Part 1 has been checked)

### State of New York
### Workers' Compensation Board

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

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

Telephone Number _____ Name and Title _____

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





DB-120.1 (10-17)

# Additional Instructions for Form DB-120.1

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

The insurance carrier must notify the above certificate holder and the Workers' Compensation Board within 10 days IF a policy is cancelled due to nonpayment of premiums or within 30 days IF there are reasons other than nonpayment of premiums that cancel the policy or eliminate the insured from coverage indicated on this Certificate. (These notices my be sent by regular mail.) Otherwise, this Certificate is valid for one year after this form is approved by the insurance carrier or its licensed agent, or until the policy expiration date listed in Box 3c, whichever is earlier

This certificate is issued as a matter of information only and confers no rights upon the certificate holder. This certificate does not amend, extend or alter the coverage afforded by the policy listed, nor does it confer any rights or responsibilities beyond those contained in the referenced policy.

This certificate may be used as evidence of a Disability and/or Paid Family Leave Benefits contract of insurance only while the underlying policy is in effect.

**Please Note: Upon the cancellation of the disability and/or paid family leave benefits policy indicated on this form, if the business continues to be named on a permit, license or contract issued by a certificate holder, the business must provide that certificate holder with a new Certificate of NYS Disability and/or Paid Family Leave Benefits Coverage or other authorized proof that the business is complying with the mandatory coverage requirements of the New York State Disability and Paid Family Leave Benefits Law.**

## DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

### §220. Subd. 8

(a) The head of a state or municipal department, board, commission or office authorized or required by law to issue any permit for or in connection with any work involving the employment of employees in employment as defined in this article, and not withstanding any general or special statute requiring or authorizing the issue of such permits, shall not issue such permit unless proof duly subscribed by an insurance carrier is produced in a form satisfactory to the chair, that the payment of disability benefits and after January first, two thousand and twenty-one, the payment of family leave benefits for all employees has been secured as provided by this article. Nothing herein, however, shall be construed as creating any liability on the part of such state or municipal department, board, commission or office to pay any disability benefits to any such employee if so employed.

(b) The head of a state or municipal department, board, commission or office authorized or required by law to enter into any contract for or in connection with any work involving the employment of employees in employment as defined in this article and notwithstanding any general or special statute requiring or authorizing any such contract, shall not enter into any such contract unless proof duly subscribed by an insurance carrier is produced in a form satisfactory to the chair, that the payment of disability benefits and after January first, two thousand eighteen, the payment of family leave benefits for all employees has been secured as provided by this article.

# FORM DB-155

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

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

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

| EMPLOYER | FEDERAL EMPLOYER IDENTIFICATION NUMBER |
|---|---|
| | LOCATION OF OPERATIONS |
| ADDRESS (HOME OR MAIN OFFICE) | |
| | OPERATIONS TO BEGIN ON OR ABOUT: |



There are on file with the Workers' Compensation Board, documents indicating that the above-named employer has complied with the Disability Benefits Law with respect to all of his or her employees in the following manner:

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

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

Date:

By: _____
Gina Wagoner
WC Examiner

DB-155 (3/04)

THIS AGENCY EMPLOYS & SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

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

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

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

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

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

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

I also agree to either:

- acquire appropriate workers' compensation coverage and provide appropriate proof of that coverage on forms approved by the Chair of the NYS Workers' Compensation Board to the government entity issuing the building permit if I need to hire or pay individuals a total of 40 hours or more per week (aggregate hours for all paid individuals on the jobsite) for work indicated on the building permit, or if appropriate, file a CE-200 exemption form; OR

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

_____ _____

(Signature of Homeowner) (Date Signed)

_____ Home Telephone Number _____

(Homeowner's Name Printed)

Property Address that requires the building permit:

_____

_____

_____

_____

***Sworn to before me this _____ day of***

_____, _____.

_____

***(County Clerk or Notary Public)***

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

**LAWS OF NEW YORK, 1998**
**CHAPTER 439**

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

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

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

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

## Implementing Section 125 of the General Municipal Law

### 1. General Contractors -- Business Owners and Certain Homeowners

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

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

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

### 2. Owner-occupied Residences

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

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

# STATE OF NEW YORK - WORKERS' COMPENSATION BOARD

ESTADO DE NUEVA YORK - JUNTA DE COMPENSACION OBRERA

## NOTICE OF COMPLIANCE
## WORKERS' COMPENSATION LAW

### TO EMPLOYEES

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

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

WORKERS' COMPENSATION BOARD OFFICES

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

• DOWNSTATE MAIL ADDRESS

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

## AVISO DE CUMPLIMIENTO
## LEY DE COMPENSACION OBRERA

### A EMPLEADOS

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

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

ARY S. WEISS CHAIR/PRESIDENT/ZACH



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

*SAMPLE*

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

Policy No. (Poliza No) _____

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

**Name of employer (Nombre del patrono)**

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

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

PRESCRIBED BY CHAIR
WORKERS' COMPENSATION BOARD
STATE OF NEW YORK

www.wcb.state.ny.us

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

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

NOTICE OF COMPLIANCE
DISABILITY BENEFITS LAW
TO EMPLOYEES

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

WORKERS' COMPENSATION BOARD OFFICES

Albany, 12241 -100 Broadway-Menands- (518) 474-6681
Binghamton, 13901 - State Office Bldg - 44 Hawley St. - (607) 721-8358
Buffalo, 14203-State Office Bldg -125 Main St - (716) 847-317
Hempstead, 11550 -175 Fulton Avenue - (516) 560-7
Rochester, 14614 - 130 Main Street West - (716) 2
Syracuse, 13202 - State Office Bldg.-333 E. Washington St. - (315) 428-4465

ESTADO DE NUEVA YORK
JUNTA DE COMPENSACIÓN OBRERA

AVISO DE CUMPLIMIENTO
LEY DE BENEFICIOS POR INCAPACIDAD
A LOS EMPLEADOS

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

Robert R. Snashall
**Robert R. Snashall**
**Chairman (Presidente)**



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

SAMPLE

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

The benefits provided are (Los beneficios provistos son)

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

Class(es) of employees covered (Clasé(s) de empleados amparados)
ALL EMPLOYEES ELIGIBLE UNDER NY DBL

Name of employer (Nombre del Patrón)

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

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

By _____

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

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

# Erie County Water Authority
# ACORD Endorsement Samples

**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.

   □

**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.