SAMPLE _ FOR REFERENCE ONLY
FORM DB 120.1

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)	1b. Business Telephone Number of Insured
AGENCY NAME AGENCY ADDRESS (Needs to match Contract Address) Work Location of Insured *(Only required if coverage is specifically limited to certain locations in New York State, i.e., Wrap-Up Policy)*	Ph# 1c. Federal Employer Identification Number of Insured or Social Security Number FEIN
2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) COUNTY OF ERIE 95 FRANKLIN STREET BUFFALO NY 14202	3a. Name of Insurance Carrier **ShelterPoint Life Insurance Company** 3b. Policy Number of Entity Listed in Box "1a" 3c. Policy effective period Date to Date

4. Policy provides the following benefits:
   - [x] A. Both disability and paid family leave benefits.
   - [ ] B. Disability benefits only.
   - [ ] C. Paid family leave benefits only.

5. Policy covers:
   - [x] 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)