B&ECPL Certificate of Insurance Review

Specimen Certificates

(A) Construction and Maintenance

(B) Purchase or Lease of Merchandise or Equipment

(C) Professional Services

(D) Property Leased to Others or Use of Facilities or Grounds

(E) Concessionaires Services

(F) Livery Services

(G) All Purpose Public Entity Contracts

- Disability and Workers Compensation Information
- WC/DBL Posting Notices – Not Acceptable
- Frequently Asked Questions

INSTRUCTIONS FOR B&ECPL STANDARD INSURANCE CERTIFICATE

I. Insurance shall be procured and certificates delivered before commencement of work or delivery of merchandise or equipment.

II. CERTIFICATES OF INSURANCE

A. Shall be made to the "Buffalo & Erie County Public Library, Business Office, 1 Lafayette Square, Buffalo, NY 14203"

B. Coverage must comply with all specifications of the contract.

C. Must be executed by an insurance company, agency or broker, which is licensed by the Insurance Department of the State of New York. If executed by a broker, notarized copy of authorization to bind or certify coverage must be attached.

III. Forward the completed certificate to: Buffalo & Erie County Public Library (B&ECPL) for construction, purchase, lease or service.

IV. Minimum coverage with limits are as follows:

Vendor Classification	A Construction and Maintenance	B Purchase or Lease of Merchandise or Equipment	C Professional Services	D Property Leased To Others Or Use Of Facilities Or Grounds	E Concession-aires Services	F Livery Services	G All Purposes Public Entity Contracts
Commercial Gen. Liab.	$1,000,000 per occ.	$1,000,000 CSL	$1,000,000 CSL	$1,000,000	$1,000,000 CSL	$1,000,000	$1,000,000 CSL
General Aggregate	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000
Products Completed Operations Liability	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000
Blanket Broad Form Contractual Liability	INCLUDE						
Contractual Liability		INCLUDE	INCLUDE	INCLUDE	INCLUDE	INCLUDE	INCLUDE
Broad Form P.D.	INCLUDE						
X.C.U. (explosion, collapse, Underground)	INCLUDE						
Liquor Law				INCLUDE	INCLUDE		
Auto Liab.	$1,000,000 CSL		$1,000,000 CSL	$1,000,000 CSL	$1,000,000 CSL	$1,000,000 CSL	$1,000,000 CSL
Owned	INCLUDE		INCLUDE	INCLUDE	INCLUDE	INCLUDE	INCLUDE
Hired	INCLUDE		INCLUDE	INCLUDE	INCLUDE	INCLUDE	INCLUDE
Non-Owned	INCLUDE		INCLUDE	INCLUDE	INCLUDE	INCLUDE	INCLUDE
Excess/Umbrella Liab.	$5,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$5,000,000	$1,000,000
Worker's Compensation	STATUTORY	STATUTORY	STATUTORY	STATUTORY	STATUTORY	STATUTORY	STATUTORY
& Employer's Liability							
Disability Benefits	STATUTORY	STATUTORY	STATUTORY	STATUTORY	STATUTORY	STATUTORY	STATUTORY
Professional Liability			$5,000,000				
Buffalo & Erie County Public Library, To Be Named Add'l Insd.	Gen. Liab., Auto Liab., & Excess	Broad Form Vendors May Be Required	Gen. Liab., Auto Liab., & Excess	Gen. Liab., Auto Liab., & Excess	Gen. Liab., Auto Liab., & Excess	Gen. Liab., Auto Liab., & Excess	Gen. Liab., Auto Liab., & Excess

V. Construction contracts require excess Umbrella Liability limits of $5,000,000.

VI Coverage must be provided on a primary-non contributory bases.

VII. Designated Construction Project - General Aggregate Limit, Per Project Endorsement CG 25 03 is required.

VIII. In the event the concessionaire is required to have a N.Y.S. license to dispense alcoholic beverages an endorsement for liquor liability is required.

IX. Waiver of Subrogation: Required on all lines unless noted

X Transportation of people in buses, vans or station wagons requires $5,000,000 excess liability.

XI. Workers Compensation: State Workers' Compensation / Disability Benefits Law
Use Applicable Certificates Below:

Workers Compensation Forms

CE-200	Exemption
C105.2	Commercial Insurer
SI-12	Self Insurer
GSI-105.2	Group Self Insured
U-26.3	New York State Insurance Fund

DBL (Disability Benefits Law) Forms

CE-200	Exemption
DB-120.1	Insurers
DB-155	Self Insured

XII. The "ACORD" form certificate may be used in place of the B&ECPL Standard Insurance Certificate, provided that all of the above referenced requirements are incorporated into the "ACORD" form certificate.

Library Standard Insurance Certificate

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: EMAIL ADDRESS PRODUCER CUSTOMER ID #:	
	INSURER(S) AFFORDING COVERAGE	**NAIC #**
INSURED	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 ☐ COMMERCIAL GENERAL LIABILITY ☐ CLAIMS-MADE ☐ OCCUR ☐ ☐ GEN'L AGGREGATE LIMIT APPLIES PER: ☐ POLICY ☐ PRO-JECT ☐ LOC						EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS COMP/OP AGG 	$ $ $ $ $ $ $
	AUTOMOBILE LIABILITY ☐ ANY AUTO ☐ ALL OWNED AUTOS ☐ SCHEDULED AUTOS ☐ HIRED AUTOS ☐ NON-OWNED AUTOS ☐						COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) 	$ $ $ $ $ $
	☐ UMBRELLA LIAB ☐ OCCUR ☐ EXCESS LIAB ☐ CLAIMS-MADE ☐ DEDUCTIBLE ☐ RETENTION $						EACH OCCURRENCE AGGREGATE 	$ $ $ $
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICE/MEMBER EXCLUDED? **(Mandatory in NH)** Y/N ☐ If yes describe under DESCRIPTION OF OPERATIONS below	N/A					☐ WC STATU TORY LIMITS- ☐ OTH ER- E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L.DISEASE - POLICY LIMIT	$ $ $ $

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

CERTIFICATE HOLDER

Buffalo & Erie County Public Library
c/o Business Office
1 Lafayette Square
Buffalo, NY 14203
716-858-7170 Fax: 7168586544

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

Construction and Maintenance (A)

Library Standard Insurance Certificate

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

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

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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] Includes XCU	X	X				PERSONAL & ADV INJURY	$ 1,000,000
	[X] Blanket Broad Form Contractual						GENERAL AGGREGATE	$ 2,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						PRODUCTS COMP/OP AGG	$ 2,000,000
	[ ] POLICY [X] PRO-JECT [ ] LOC							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
	[X] ANY AUTO						BODILY INJURY (Per person)	$
	[ ] ALL OWNED AUTOS						BODILY INJURY (Per accident)	$
	[ ] SCHEDULED AUTOS						PROPERTY DAMAGE (Per accident)	$
	[ ] HIRED AUTOS	X	X					$
	[ ] NON-OWNED AUTOS							$
	[X] UMBRELLA LIAB [X] OCCUR						EACH OCCURRENCE	$ 5,000,000
	[ ] EXCESS LIAB [ ] CLAIMS-MADE	X	X				AGGREGATE	$ 5,000,000
	[ ] DEDUCTIBLE							$
	[X] RETENTION $ 10,000							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICE/MEMBER EXCLUDED? [ ] **(Mandatory in NH)** If yes describe under DESCRIPTION OF OPERATIONS below	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	$

SAMPLE

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

Buffalo & Erie County Public Library is included as an additional insured per form CG 20 10 11 85 or its equivalent. Insurance is provided on a primary and non-contributory basis.

CERTIFICATE HOLDER

Buffalo & Erie County Public Library
c/o Business Office
1 Lafayette Square
Buffalo, NY 14203
716-858-7170 Fax: 7168586544

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

For Library use only: Name of Library/Dept. Requesting Certificate _____

Purchase Order or Contact Number _____

Vendor Insurance Classification _____

Purchase or Lease of Merchandise or Equipment (B)

Library Standard Insurance Certificate

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

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

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INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	GENERAL LIABILITY							
	[X] COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$ 1,000,000
	[ ] CLAIMS-MADE [X] OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 100,000
		X	X				MED EXP (Any one person)	$ 5,000
							PERSONAL & ADV INJURY	$ 1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 2,000,000
	[ ] POLICY [X] PRO-JECT [ ] LOC						PRODUCTS COMP/OP AGG	$ 2,000,000
								$
	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						PROPERTY DAMAGE (Per accident)	$
	[ ] HIRED AUTOS	X	X					$
	[ ] NON-OWNED AUTOS							$
	[X] UMBRELLA LIAB [X] OCCUR						EACH OCCURRENCE	$ 1,000,000
	[ ] EXCESS LIAB [ ] CLAIMS-MADE						AGGREGATE	$ 1,000,000
	[ ] DEDUCTIBLE	X	X					$
	[X] RETENTION $ 10,000							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICE/MEMBER EXCLUDED? [ ] **(Mandatory in NH)** If yes describe under DESCRIPTION OF OPERATIONS below	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	$

SAMPLE

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

Buffalo & Erie County Public Library is included as an additional insured. Insurance provided on a primary and non-contributory basis.

CERTIFICATE HOLDER

Buffalo & Erie County Public Library
c/o Business Office
1 Lafayette Square
Buffalo, NY 14203
716-858-7170 Fax: 7168586544

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

For Library use only: Name of Library/Dept. Requesting Certificate

Purchase Order or Contact Number

Vendor Insurance Classification

Professional Services (C)

Library Standard Insurance Certificate

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

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

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

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CERTIFICATE HOLDER

Buffalo & Erie County Public Library
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Buffalo, NY 14203
716-858-7170 Fax: 7168586544

CANCELLATION

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AUTHORIZED REPRESENTATIVE

For Library use only: Name of Library/Dept. Requesting Certificate

Purchase Order or Contact Number

Vendor Insurance Classification

SAMPLE

Property Leased to Others or Use of Facilities or Grounds (D)

Library Standard Insurance Certificate

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

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

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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 ☒ OCCUR						MED EXP (Any one person)	$ 5,000
	X Liquor Law	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 ☒ 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						PROPERTY DAMAGE (Per accident)	$
	☐ HIRED AUTOS	X	X					$
	☐ NON-OWNED AUTOS							$
	X UMBRELLA LIAB ☒ OCCUR						EACH OCCURRENCE	$ 1,000,000
	☐ EXCESS LIAB ☐ CLAIMS-MADE	X	X				AGGREGATE	$ 1,000,000
	☐ DEDUCTIBLE							$
	X RETENTION $ 10,000							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICE/MEMBER EXCLUDED? ☐ **(Mandatory in NH)** If yes describe under DESCRIPTION OF OPERATIONS below	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	$

SAMPLE

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CERTIFICATE HOLDER

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1 Lafayette Square
Buffalo, NY 14203
716-858-7170 Fax: 7168586544

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AUTHORIZED REPRESENTATIVE

For Library use only: Name of Library/Dept. Requesting Certificate _____

Purchase Order or Contact Number _____

Vendor Insurance Classification _____

Concessionaires Services (E)

Library Standard Insurance Certificate

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

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

Buffalo & Erie County Public Library is included as an additional insured. Insurance is on a primary and non-contributory basis

CERTIFICATE HOLDER

Buffalo & Erie County Public Library
c/o Business Office
1 Lafayette Square
Buffalo, NY 14203
716-858-7170 Fax: 7168586544

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

For Library use only: Name of Library/Dept. Requesting Certificate _____

Purchase Order or Contact Number _____

Vendor Insurance Classification _____

SAMPLE

Livery Services (F)

Library Standard Insurance Certificate

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: EMAIL 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							
	[X] COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$ 1,000,000
	[ ] CLAIMS-MADE [X] OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 100,000
		X	X				MED EXP (Any one person)	$ 5,000
							PERSONAL & ADV INJURY	$ 1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 2,000,000
	[ ] POLICY [X] PRO-JECT [ ] LOC						PRODUCTS COMP/OP AGG	$ 2,000,000
								$
	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						PROPERTY DAMAGE (Per accident)	$
	[ ] HIRED AUTOS	X	X					$
	[ ] NON-OWNED AUTOS							$
	[X] UMBRELLA LIAB [X] OCCUR						EACH OCCURRENCE	$ 5,000,000
	[ ] EXCESS LIAB [ ] CLAIMS-MADE						AGGREGATE	$ 5,000,000
	[ ] DEDUCTIBLE	X	X					$
	[X] RETENTION $ 10,000							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICE/MEMBER EXCLUDED? [ ] **(Mandatory in NH)** If yes describe under DESCRIPTION OF OPERATIONS below	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	$

SAMPLE

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

Buffalo & Erie County Public Library is included as an additional insured. Insurance is provided on a primary and non-contributory basis.

CERTIFICATE HOLDER

Buffalo & Erie County Public Library
c/o Business Office
1 Lafayette Square
Buffalo, NY 14203
716-858-7170 Fax: 7168586544

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

For Library use only: Name of Library/Dept. Requesting Certificate _____

Purchase Order or Contact Number _____

Vendor Insurance Classification _____

All Purposes Public Entity Contracts (G)

Library Standard Insurance Certificate

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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: EMAIL 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:**

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

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

Buffalo & Erie County Public Library is included as an additional insured. Insurance is provided on a primary and non-contributory basis.

SAMPLE

CERTIFICATE HOLDER

Buffalo & Erie County Public Library
c/o Business Office
1 Lafayette Square
Buffalo, NY 14203
716-858-7170 Fax: 7168586544

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

For Library use only: Name of Library/Dept. Requesting Certificate _____

Purchase Order or Contact Number _____

Vendor Insurance Classification _____

Understanding New York Workers Compensation Board

Workers Compensation and N.Y.S Disability Benefits Liability

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

The forms discussed are:

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

2) Workers Compensation

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

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

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

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

3) New York State Disability Benefits Law (DBL)

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

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

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

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

Form CE-200

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

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

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

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

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

Workers' Compensation Exemption Statement:

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

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

Disability Benefits Exemption Statement:

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

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

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

SIGN HERE	Signature:	Date:

Exemption Certificate Number
2008-00197

Received
October 2, 2008
NYS Workers' Compensation Board

CE-200 (Draft 06/02/08)

Sample

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

1a. Legal Name & Address of Insured (Use street address only) **Work Location of Insured** ***(Only required if coverage is specifically limited to certain locations in New York State, i.e., a Wrap-Up Policy)***	**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)	**3a. Name of Insurance Carrier** **3b. Policy Number of entity listed in box "1a"** **3c. Policy effective period** **_____ to _____** **3d. The Proprietor, Partners or Executive Officers are** **included.** **(Only check box if all partners/officers included)** **all excluded or certain partners/officers excluded.**

SAMPLE

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 <u>Item 3A</u> on the INFORMATION PAGE of the workers' compensation insurance policy).** The Insurance Carrier or its licensed agent will send this Certificate of Insurance to the entity listed above as the certificate holder in box "2".

The Insurance Carrier will also notify the above certificate holder within 10 days IF a policy is canceled due to nonpayment of premiums or within 30 days IF there are reasons other than nonpayment of premiums that cancel the policy or eliminate the insured from the coverage indicated on this Certificate. (These notices may be sent by regular mail.) ***Otherwise, this Certificate is valid for one year after this form is approved by the insurance carrier, its licensed agent, or until the policy expiration date listed in box "3c", <u>whichever is earlier</u>.***

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 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:

SAMPLE

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.

SAMPLE

NEW YORK STATE INSURANCE FUND

John Masetti

DIRECTOR, INSURANCE FUND UNDERWRITING

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

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

CERTIFICATE OF PARTICIPATION IN WORKERS' COMPENSATION GROUP SELF-INSURANCE

1a. Legal Name and Address of Business Participating in Group Self-Insurance (Use Street Address Only)	1d. Business Telephone Number of Business referenced in box "1a" 1e. NYS Unemployment Insurance Employer Registration Number of Business referenced in box "1a"
1b. Effective Date of Membership in the Group	
1c. The Proprietor, Partners or Executive Officers are ☐ included (Only check box if all partners/officers included) ☐ all excluded or certain partners/officers excluded	1f. Federal Employer Identification Number of Business referenced in box "1a"
2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as Certificate Holder)	3. Name and Address of Group Self-Insurer

SAMPLE

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. ☐ All of the employer's employees eligible under the New York Disability Benefits Law

b. ☐ 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)

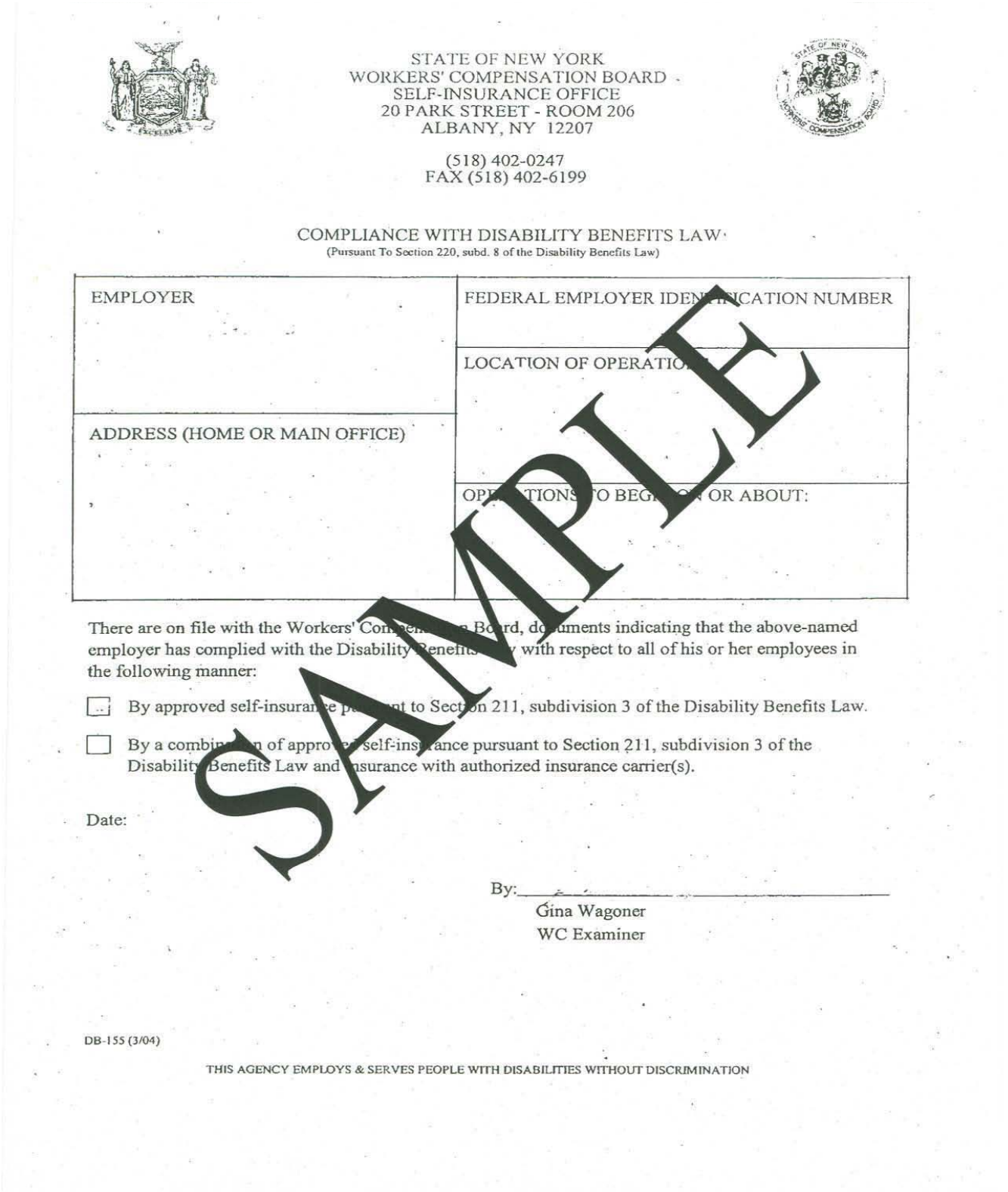
Telephone Number_____ Title_____

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.***

DB-120.1 (5-06)

SAMPLE

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

SAMPLE

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-1shall 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

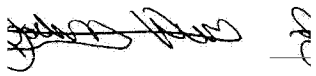
Claims-related mail for the Hauppauge, Hempstead, Peekskill and all NYC offices should be mailed to:
PO Box 5205 Binghamton, NY 13902-5205

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 a que este acogido.
5. Usted debera requerir de su Medico que radique copias de los informes medicos de su caso en la Junta de Compensacion Obrera y en la compania de seguros de su patrono, que se indica al final de esta forma.
6. Usted tiene derecho a compensacion si su lesion relacionada con el trabajo le impide trabajar por mas de siete dias, le obliga a trabajar a sueldo mas bajo o resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitacion si necesita ayuda para regresar al trabajo.
7. No pague a ningun proveedor medico directamente por tratamiento de su lesion o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas all asegurador de su patrono. Si el caso es cuestionado, el proveedor debera esperar hasta que la junta decida el caso, antes de iniciar gestion de cobro alguna contra usted. Si usted no tramita su caso o la Junta con el trabajo, usted podria ser responsable del pago de las facturas.
8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado o por representante licenciado si usted asi lo desea. Si es representado, no pague al abogado o al representante licenciado. Cuando la Junta decida su caso, los honorarios seran determinados por la Junta y descontados de sus beneficios.
9. Si tiene dificultad en conseguir un formulario de reclamacion o necesita ayuda para llenarlo o tiene dudas sobre cualquier situacion relacionada con una lesion o enfermedad comuniquese con la oficina mas cercana de la Junta.



ARY S. WEISS CHAIR/PRESIDENT ZACH

NOT ACCEPTABLE

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

SAMPLE

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

Policy No. (Poliza No) _____

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) 721-8330
Buffalo, 14203-State Office Bldg -125 Main St - (716) 847-3177
Hempstead, 11550 -175 Fulton Avenue - (516) 560-7745
Rochester, 14614 - 130 Main Street West - (716) 258-8500
Syracuse, 13202 - State Office Bldg.-333 E. Washington St. - (315) 428-4465

ESTADO DE NUEVA YORK
JUNTA DE COMPENSACIÓN OBRERA

AVISO DE CUMPLIMIENTO
LEY DE BENEFICIOS POR INCAPACIDAD
A LOS EMPLEADOS

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

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

NOT ACCEPTABLE

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 (En Vigor Desde) _____ To (HASTA) UNTIL CANCELLED
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.

FAQ's

CERTIFICATES

Q1. I am required to obtain proof of insurance coverage for Commercial General Liability, auto liability, excess/umbrella, workers compensation, NYS disability, professional liability and builders' risk. What forms are acceptable for proof of each of the above types of insurance? Are there any exceptions to the forms?

A1. For most lines of coverage, Buffalo & Erie County Public Library requires its proprietary certificate of Insurance. The certificate is available from the Buffalo & Erie County Public Library business office.

[The only acceptable proof of Workers Comp coverage can be found on page 11 (Understanding New York Workers Compensation Board)]

Q2. Explain the differences among the three types of coverage, that is, how does general liability, auto liability, and excess/umbrella liability differ?

A2. General Liability, commonly referred to as Commercial General Liability insurance responds to pay those sums an insured becomes legally obligated to pay as damages to a third-party for bodily injury, property damage, personal & advertising injury. General Liability insurance generally excludes such liability arising out of the operation, maintenance or use of an automobile, watercraft, or aircraft. These policies also pay for the insured's defense costs.

Auto Liability Coverage responds to pay those sums the insured becomes legally obligated to pay as damages to a third-party for bodily injury or property damage arising out of the operation, maintenance, or use of an auto. This insurance also pays for the insured's defense costs.

The Excess/Umbrella policy also responds to pay adverse judgments or settlements the insured becomes legally obligated to pay as damages on an excess basis once the applicable underlying limit of insurance becomes exhausted.

Q3. I have been told the certificate holder must be Buffalo & Erie County Public Library. Why is it not acceptable for the certificate holder to be the department requesting coverage?

A3. It is not acceptable for the certificate holder to be an internal department requesting coverage in that it is the Buffalo & Erie County Public Library actually entering into the agreement with the service provider. Technically the particular department is not an entity that has the legal ability to enter into a contract.

Q4. Are there any coverage situations where Buffalo & Erie County Public Library must be named as an insured, and not the certificate holder?

A4. In all instances, Buffalo & Erie County Public Library must be provided with "Additional Insured" status on the Commercial General Liability, Business Auto, and Excess/Umbrella policies. In **all** circumstances Buffalo & Erie County Public Library must be shown as certificate holder.

AUTOMOBILIE LIABILITY

Q5. Why must an organization have auto coverage if the organization does not own a motor vehicle?

A5. Even though a person or business may not own any autos, risk of getting sued resulting from the operation, maintenance, or use of an auto still exists. Vehicles owned by others driven on behalf of an employer can impute negligence upon the employer. These are referred to as "non-owned" autos. Other circumstance may arise where an insured hires, rents or borrows an auto whereby liability could arise out of its use.

Q6. What do the boxes labeled "any auto"; "all owned autos"; "scheduled autos"; "hired autos"; and "non-owned autos" mean?

A6. "Any Auto" represents that the policy's covered autos include any owned, non owned or hired autos. "Owned Autos" limit the policy's covered autos to only those vehicles "titled" to the insured. "Scheduled Autos" limit the policy's covered autos to only those vehicles listed on the policy. "Hired Autos" represents those vehicles the insured rents without a driver. "Non Owned" represents those autos that are driven on the named insureds behalf but are owned by someone else. Example: Employee drives his/her own vehicle for the benefit of the employer.

EXCESS/UMBRELLA

Q7. What is umbrella and/or excess coverage? How do they differ, if at all?

A7. Umbrella policies are third party liability policies that respond to provide excess insurance limits over underlying liability policies in the event the underlying limit gets exhausted by the payment of claims. The umbrella customarily offers a broader scope of coverage than excess liability policies. Excess liability policies only offer additional limits of insurance over exhausted underlying liability policies but do not offer broader coverage.

Q8. What does it mean when the certificate says excess/umbrella "follows form"?

A8. Umbrella/Excess coverage referencing the term "follows form" indicates that the umbrella/excess policy's definitions, exclusions, conditions, etc. will be the same as what is provided by the underlying policy.

Q9. Is it acceptable to waive excess/umbrella coverage, if the limits of general and auto are increased?

A9. In theory it is acceptable when required limits are acquirable from the insurance carrier. Generally speaking, insurance companies will not offer primary limits greater than $1,000,000 per occurrence. A few may offer up to $2,000,000 per occurrence. In order to provide additional limits to these customarily written primary limits, an umbrella/excess policy must be used to provide B&ECPL's required limits of insurance.

ADDITIONAL INSURED STATUS

Q10. What is additional insured status?

A10. An "additional Insured" is an individual person or entity that has direct rights to another party's insurance policy protection and limits. Such status is provided to support the terms of a "risk transfer" agreement AKA a "hold harmless" agreement.

Q11. Why is it necessary that Buffalo & Erie County Public Library be named as additional insured on general liability, auto and excess/umbrella?

A11. It is necessary the Buffalo & Erie County Public Library be named as "Additional Insured" on the Commercial General Liability, Automobile Liability, and Umbrella/Excess liability policies because Buffalo & Erie County Public Library has to potential to be named as a defendant in a lawsuit arising out of an endeavor with an individual or entity that Buffalo & Erie County Public Library has entered into a contract with. Should a court find Buffalo & Erie County Public Library vicariously liable (indirectly), the Library wishes for the other party's insurance policy to pay to defend and indemnify the Library.

Q12. How is additional insured status indicated on the ACORD/Buffalo & Erie County Public Library certificate? Is there only one way to indicate additional insured status?

A12. The most recent ACORD /Buffalo & Erie County Public Library Certificate provides an "Additional Insured" column requiring a check mark (√) to indicate such "Additional Insured" status is in place. Circumstances may arise where Buffalo & Erie County Public Library is identified as "additional insured" in the "remarks" section of the certificate.

Q13. What does it mean when the certificate indicates that excess/umbrella "follows form"? Is "follows form" acceptable proof of additional insured status for excess/umbrella.

A13. See Question & Answer #8

MISCELLANEOUS

Q14. In the description/special provisions box, I have seen the phrase "with regard to ongoing work". What does "ongoing work" mean? Should I decline the certificate if the phrase is present?

A14. The term "ongoing work" or "ongoing operations" contemplates work that is occurring and has not yet been completed per the terms of a contract or agreement. Work that has been completed per the terms of a contract is expressed as "completed operations". Buffalo & Erie County Public Library requires all parties that contract work of the Library must carry liability coverage for both "ongoing operations" and "completed operations". Acceptable proof of insurance must include both of these coverages.

Q15. Should I be checking the policy expiration date? Why?

A15. Yes, policy expiration dates should be checked. The reason for such practice is to assure that the insurance required is in force at the time the services are being provided to the Library. It is also important that any Umbrella/Excess liability policies have the same policy effective dates (concurrency) as the Commercial General Liability policy.

Q16. What should I be looking for with respect to the policy limits?

A16. The minimum limits of insurance required for the various types of service providers are indicated on the "Instructions for Buffalo & Erie County Public Library Standard Insurance Certificate" as well as on the "Certificate of Insurance" templates for the type of service provider.