Fax to: 914-377-6521

ACORD CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

PRODUCER

NAME & ADDRESS OF INSURANCE AGENCY
ISSUING CERTIFICATE OF INSURANCE

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 POLICIES BELOW.

INSURED

NAME & ADDRESS OF INSURED

INSURERS AFFORDING COVERAGE		NAIC #
INSURER A:		
INSURER B:	MUST BE LICENSED IN NEW YORK STATE	
INSURER C:		
INSURER D:		
INSURER E:		

COVERAGES

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. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	ADD'L INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS	
A	☒	GENERAL LIABILITY ☒ COMMERICAL GENERAL LIABILITY ☐ CLAIMS MADE ☐ OCCUR ☐ ____ ☐ ____ GEN'L AGGREGATE LIMIT APPLIES PER: ☐ POLICY ☐ PROJECT ☐ LOC	POLICY #	MM/DD/YY	MM/DD/YY	EACH OCCURENCE	$1,000,000.
						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 (Each accident)	
						BODILY INJURY (Per person)	
						BODILY INJURY (Per accident)	
						PROPERTY DAMAGE (Per accident)	
		GARAGE LIABILITY ANY AUTO ☐ ____				AUTO ONLY - EA ACCIDENT	
						OTH-ACC AUTO ONLY AGG	$
	☐	EXCESS/UMBRELLA LIABILITY ☐ OCCUR ☐ CLAIMS MADE ☐ DEDUCTIBLE ☐ RETENTION $				EACH OCCURRENCE	$
						AGGREGATE	$
							$
							$
							$
	☐	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below	CANNOT BE FILED ON ACCORD FORM	CANNOT BE FILED ON ACCORD FORM	CANNOT BE FILED ON ACCORD FORM	☐ WC STATU-TORY LIMITS ☐ OTH-ER	
						E.L. EACH ACCIDENT	$
						E.L. DISEASE - EA EMPLOYEE	$
						E.L. DISEASE - POLICY LIMIT	$
	☐	OTHER					

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS

(Must Read): CERTIFICATE HOLDER IS ADDITIONAL INSURED.

CERTIFICATE HOLDER

CITY OF YONKERS
87 NEPPERHAN AVENUE
YONKERS, NEW YORK 10701

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE INSURER AFFORDING COVERAGE WILL ENDEAVOR TO MAIL 30 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE

Mayor Mike Spano CITY OF YONKERS

SAM BORRELLI
COMMISSIONER

DEPARTMENT OF HOUSING AND BUILDINGS
87 Nepperhan Avenue 5th Floor
Yonkers, NY 10701
Building Tel. 914.377.6500
Fax 914.377.6521

CONTRACTOR/HOMEOWNER/ESTATE'S HOLD HARMLESS INDEMNIFICATION AGREEMENT WITH THE CITY OF YONKERS

_____

Name of Contractor/Homeowner
(To be completed by homeowner **ONLY** if a contractor is not associated with the application)

_____

Contractor's email AND phone #

As consideration of the City of Yonkers issuing permits to perform work in the City, _____ (ENTITY NAME LISTED ABOVE) will protect, defend, indemnify, and hold the City of Yonkers and it's servants, agents and the City's elected officials harmless from all losses sustained, claims, liens, or demands made, cause of action, suits filed, judgments awarded or penalties, interest, court costs or attorneys' fees incurred, arising from or in connection with the work.

Job Site Address: _____

Application No.: _____ **Block:** _____ **Lot:** _____

Signature: _____

Print Name: _____

State of _____

County of _____

Subscribed and sworn to before me this _____ day of _____ 20_____

_____

Commissioner of Deeds /Notary Public Signature & Seal

Please return ORIGINAL DOCUMENT WITH ORIGINAL SIGNATURES to the address above.

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

1a. Legal Name & Address of Insured (Use street address only)	1b. Business Telephone Number of Insured 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) CITY OF YONKERS DEPARTMENT OF HOUSING AND BUILDINGS 87 NEPPERHAN AVENUE YONKERS, NEW YORK 10701	3a. Name of Insurance Carrier 3b. Policy Number of entity listed in box "2" 3c. Policy effective period 3d. The Proprietor, Partners or Executive Officers are included. (Only check box if all partners/officers included) excluded or certain partners/officers excluded.

SAMPLE

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

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

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

New York State Insurance Fund

Workers Compensation & Disability Benefits Specialists Since 1914

199 CHURCH STREET, NEW YORK, N.Y. 10007-1100
Phone: (212) 587-8076

CERTIFICATE OF WORKERS' COMPENSATION INSURANCE

POLICYHOLDER	CERTIFICATE HOLDER

POLICY NUMBER	CERTIFICATE NUMBER	PERIOD COVERED BY THIS CERTIFICATE	DATE

THIS IS TO CERTIFY THAT THE POLICYHOLDER NAMED ABOVE IS INSURED WITH THE NEW YORK STATE INSURANCE FUND UNDER POLICY NO. 1196 111-8 UNTIL 04/16/200[illegible] 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 NOTED BELOW.

IF SAID POLICY IS CANCELLED, OR CHANGED [illegible] TO [illegible] 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 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.

THIS POLICY IS CANCELLED EFFECTIVE

NEW YORK STATE INSURANCE F

Vincent M. Tracy

DIRECTOR, INSURANCE FUND UNDERWRI

This certificate can be validated on our web site at https://www.nysif.com/cert/certval.asp

VALIDATION NUMBER: 37184

26.2

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):

X

Business Applying For:
Building Permit

From: YONKER BUILDING DEPARTMENT

The location of where work will be performed is X

Estimated dates necessary to complete work associated with the building permit are **Not Supplied.**
The estimated dollar amount of project is X

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 subcontract-

Please see the back of page for instructions

Disability Benefits Exemption Statement:

The above named business is certifying that [illegible] **TO OBTAIN NEW YORK STATE STATUTORY DISABILITY BENEFI[illegible] COVERAGE** for the following reason:
The business MUST be either: 1) [illegible]ividual; OR 2) is a partnership (including LLC, LLP, PLLP, RLLP, or LP) under the laws of New York St[illegible]ation; OR 3) is a one or two person owned corporation, with those individuals owning all of the stock and hol[illegible] of the corporation (in a two person owned corporation each individual must be an officer and own at least one share of st[illegible] 4) is a business with no NYS location. In addition, the business does not require disability benefits coverage at this time [illegible] 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, [illegible], 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: X	Date: X

Exemption Certificate Number: 2012-007019

Received: X 2012
NYS Workers' Compensation Board

CE-200 12/2008

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

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
- ✦ 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:

_____

_____

_____

_____

BP-1 (3/99)

Sworn to before me this _____ day of

_____, _____.

_____

(County Clerk or Notary Public)

Effective December 20, 2011

New York State Workers Compensation

CE-200 EXEMPTION FORM

is available at www.wcb.ny.gov

FOR AN ON-LINE APPLICATION:

CE-200 (12/08) is an on-line application that allows an immediate print of the exemption form.

- Click on **On-Line Services** – on the right side of the screen.
- Then click on **Request for WC/DB Exemption** and follow the directions.

OR

FOR AN APPLICATION BY MAIL:

CE-200 (2/09) is an application which must be printed and mailed/faxed to Albany. The exemption certificate is then mailed to the applicant.

- Click on **Forms** – at the top center of the page.
- Click on **List of ALL Common Workers Compensation Board Forms.**
  The forms are in ALPHABETICAL ORDER.
  Scroll down to **CE-200 (2/09)** – which is half way down the page.