

INSURANCE SUBMISSION REQUIREMENT CHART

ALL CONTRACTORS/ELECTRICIANS/
HVAC CONTRACTORS MUST SUBMIT
A COPY OF THEIR RESPECTIVE
NASSAU COUNTY LICENSE ALONG
WITH INSURANCES.

RESIDENTIAL PROJECTS

UTILIZING CONTRACTORS, HVAC CON-
TRACTORS AND/OR ELECTRICIANS

NOTE: IF USING PLUMBERS, YOU MUST USE A
VILLAGE LICENSED PLUMBER AND THEREFORE
INSURANCE REQUIREMENTS DO NOT NEED TO
BE SUBMITTED FOR APPLICATIONS

CONTRACTORS/ELECTRICIANS/HVAC
CONTRACTORS WITH EMPLOYEES

CONTRACTORS/ELECTRICIANS/HVAC
WITHOUT EMPLOYEES

NEED TO SUBMIT:

WORKER'S COMPENSATION
INSURANCE

ONLY ALLOWED ON FORM:
C-105.1, C-105.2 OR U26.3

VILLAGE MUST BE LISTED AS
CERTIFICATE HOLDER:

VILLAGE OF NEW HYDE PARK
1420 JERICO TURNPIKE

NEED TO SUBMIT:

DISABILITY INSURANCE

ONLY ALLOWED ON FORM:
DB-120.1 OR DB-120.2

VILLAGE MUST BE LISTED AS
CERTIFICATE HOLDER:

VILLAGE OF NEW HYDE PARK
1420 JERICO TURNPIKE
NEW HYDE PARK, N.Y. 11040

NEED TO SUBMIT:

LIABILITY INSURANCE

ONLY ALLOWED ON FORM:
ACORD 25

VILLAGE MUST BE LISTED AS
CERTIFICATE HOLDER:

VILLAGE OF NEW HYDE PARK
1420 JERICO TURNPIKE
NEW HYDE PARK, N.Y. 11040

LANGUAGE MUST BE
INSERTED STATING,
"CERTIFICATE HOLDER IS
LISTED AS ADDITIONALLY
INSURED".

NEED TO SUBMIT:

WORKER'S COMPENSATION
INSURANCE

ONLY ALLOWED ON FORM:
CE-200

VILLAGE MUST BE LISTED AS
CERTIFICATE HOLDER:

VILLAGE OF NEW HYDE PARK
1420 JERICO TURNPIKE
NEW HYDE PARK, N.Y. 11040

MUST ALSO LIST ADDRESS,
COST AND DURATION OF
PROJECT, AS WELL AS
ORIGINAL SIGNATURE

NEED TO SUBMIT:

LIABILITY INSURANCE

ONLY ALLOWED ON FORM:
ACORD 25

VILLAGE MUST BE LISTED AS
CERTIFICATE HOLDER:

VILLAGE OF NEW HYDE PARK
1420 JERICO TURNPIKE
NEW HYDE PARK, N.Y. 11040

LANGUAGE MUST BE
INSERTED STATING,
"CERTIFICATE HOLDER IS
LISTED AS ADDITIONALLY
INSURED".

SAMPLE

CERTIFICATE OF WORKERS' COMPENSATION INSURANCE



SCAN TO VALIDATE
AND SUBSCRIBE

***** 201637948

[REDACTED]
[REDACTED]
NEW YORK NY 10028

POLICYHOLDER [REDACTED] [REDACTED] [REDACTED]		CERTIFICATE HOLDER VILLAGE OF NEW HYDE PARK 1420 JERICHO TURNPIKE NEW HYDE PARK NY 11040	
POLICY NUMBER [REDACTED]	CERTIFICATE NUMBER [REDACTED]	POLICY PERIOD 04/01/2022 TO 04/01/2023	DATE 5/24/2022

THIS IS TO CERTIFY THAT THE POLICYHOLDER NAMED ABOVE IS INSURED WITH THE NEW YORK STATE INSURANCE FUND UNDER POLICY NO. 2378 907-6, 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 YOU WISH TO RECEIVE NOTIFICATIONS REGARDING SAID POLICY, INCLUDING ANY NOTIFICATION OF CANCELLATIONS, OR TO VALIDATE THIS CERTIFICATE, VISIT OUR WEBSITE AT [HTTPS://WWW.NYSIF.COM/CERT/CERTVAL.ASP](https://www.nysif.com/cert/certval.asp). THE NEW YORK STATE INSURANCE FUND IS NOT LIABLE IN THE EVENT OF FAILURE TO GIVE SUCH NOTIFICATIONS.

THE POLICY INCLUDES A WAIVER OF SUBROGATION ENDORSEMENT UNDER WHICH NYSIF AGREES TO WAIVE ITS RIGHT OF SUBROGATION TO BRING AN ACTION AGAINST THE CERTIFICATE HOLDER TO RECOVER AMOUNTS WE PAID IN WORKERS' COMPENSATION AND/OR MEDICAL BENEFITS TO OR ON BEHALF OF AN EMPLOYEE OF OUR INSURED IN THE EVENT THAT, PRIOR TO THE DATE OF THE ACCIDENT, THE CERTIFICATE HOLDER HAS ENTERED INTO A WRITTEN CONTRACT WITH OUR INSURED THAT REQUIRES THAT SUCH RIGHT OF SUBROGATION BE WAIVED.

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

NEW YORK STATE INSURANCE FUND

DIRECTOR, INSURANCE FUND UNDERWRITING

VALIDATION NUMBER: 706914697



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

03/29/2024

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

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

PRODUCER	CONTACT NAME: PHONE (A/C, No, Ext): E-MAIL ADDRESS:	FAX (A/C, No):
INSURED	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A:	
	INSURER B:	
	INSURER C:	
	INSURER D:	
	INSURER E:	
	INSURER F:	

COVERAGES

CERTIFICATE NUMBER: 24-25 NY Master

REVISION NUMBER:

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

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	☒ COMMERCIAL GENERAL LIABILITY ☐ CLAIMS-MADE ☒ OCCUR Pollution \$1,000,000 ☒ Prof \$1,000,000 claims made GEN'L AGGREGATE LIMIT APPLIES PER: ☐ POLICY ☒ PRO-JECT ☐ LOC OTHER: Proj Agg Cap at \$5,000,000	Y		IEPUW0030352600	04/01/2024	04/01/2025	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 500,000 MED EXP (Any one person) \$ 25,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000 Self Insured Retention \$ 100,000 COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
B	AUTOMOBILE LIABILITY ☒ ANY AUTO OWNED AUTOS ONLY ☐ SCHEDULED AUTOS ☒ HIRED AUTOS ONLY ☒ NON-OWNED AUTOS ONLY			152401-1525492-Y	04/01/2024	04/01/2025	EACH OCCURRENCE \$ 4,000,000 AGGREGATE \$ 4,000,000 PER STATUTE ☐ OTH-ER ☐ E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$ CGL \$4M xs \$1M Auto \$2M xs \$1M
A	UMBRELLA LIAB ☒ OCCUR ☒ EXCESS LIAB ☐ CLAIMS-MADE DED RETENTION \$			XSCUW0030352700	04/01/2024	04/01/2025	
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y / N ☐	N / A				
A	Excess Limits Clarification			XSCUW0030352700	04/01/2024	04/01/2025	

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

Village of New Hyde Park as Additional Insured per written contract per forms attached to the extent provided therein.

↑ IMPORTANT

CERTIFICATE HOLDER

CANCELLATION

Village of New Hyde Park
1420 Jericho Turnpike

New Hyde Park

NY 11040

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

ECH

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SAMPLE



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)

[REDACTED]

[REDACTED]
NEW HYDE PARK, NY 11040

Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e., Wrap-Up Policy)

1b. Business Telephone Number of Insured

[REDACTED]

1c. Federal Employer Identification Number of Insured or Social Security Number

[REDACTED]

2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)

Village of New Hyde Park

1420 Jericho Turnpike
NEW HYDE PARK, NY 11040

3a. Name of Insurance Carrier

Standard Security Life Insurance Company of New York

3b. Policy Number of Entity Listed in Box "1a"

104050-0000

3c. Policy effective period

8/1/2017

to

1/23/2023

4. Policy provides the following benefits:

- ☒ A. Both disability and paid family leave benefits.
☐ B. Disability benefits only.
☐ C. Paid family leave benefits only.

5. Policy covers:

- ☒ A. All of the employer's employees eligible under the NYS Disability and Paid Family Leave Benefits Law.
☐ B. Only the following class or classes of employer's employees:

MUST BE CURRENT

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 1/24/2022

By

[Signature]
(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number (212) 355-4141

Name and Title

Bebi Ishmail, Supervisor-DBL/Policy Services

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

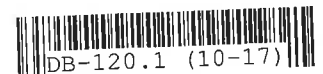
(Signature of Authorized NYS Workers' Compensation Board Employee)

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)



SAMPLE



**Workers'
Compensation
Board**

**Certificate of Attestation of Exemption
from New York State Workers' Compensation and/or
Disability and Paid Family Leave 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 and paid family leave 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): [REDACTED] [REDACTED] [REDACTED] [REDACTED]	Business Applying For: Electrical Permit From: Village of New Hype Park The location of where work will be performed is [REDACTED] Estimated dates necessary to complete work associated with the building permit are from October 20, 2023 to October 31, 2023 . The estimated dollar amount of project is \$0 - \$10,000
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Workers' Compensation Exemption Statement:

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

The applicant is acting as a general contractor with no employees, day laborers, leased employees, borrowed employees, part-time employees, unpaid volunteers and only has independent contractors that meet the standards of the New York Construction Industry Fair Play Act (Section 861 of the New York State Labor Law).

Disability and Paid Family Leave Benefits Exemption Statement:

The above named business is certifying that it is **NOT REQUIRED TO OBTAIN NEW YORK STATE STATUTORY**

DISABILITY AND PAID FAMILY LEAVE BENEFITS INSURANCE COVERAGE for the following reason:

The business MUST be either: 1) owned by one individual; OR 2) is a partnership (including LLC, LLP, PLLP, RLLP, or LP) under the laws of New York State and is not a corporation; OR 3) 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 4) is a business with no NYS location. In addition, the business does not require disability and paid family leave 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 and Paid Family Leave Benefits Law.)

I, Edwin Orellana, am the CEO 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 and paid family leave benefits coverage is required, the above-named legal entity will immediately acquire appropriate New York State specific workers' compensation insurance and/or disability and paid family leave 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

[Signature]

Date:

10/19/23

Exemption Certificate Number

~~2020-075084~~

Received

~~October 19, 2023~~

NYS Workers' Compensation Board