TOWN OF COLONIE

Building Department
Public Operations Center
347 Old Niskayuna Road
Latham, New York 12110

Peter G. Crummey
Town Supervisor

Phone (518) 783-2706 Fax (518) 783-2772
www.colonie.org/departments/building

Wayne Spenziero
Manager

To all Building and Zoning Permit applicants:

Section 125 of the General Municipal Law requires that any individual applying for a building permit show proof to the Building Department that they are following the mandatory coverage provisions of the Workers' Compensation Law before the building permit is issued.

The Town of Colonie requires proof of General Liability Insurance and Workers' Compensation Insurance before we can issue a building permit.

A Certificate of Insurance showing General Liability Insurance with the **Town of Colonie** as certificate holder.

New York State mandates that we have proof of Workers' Compensation Insurance coverage. All applicants who list themselves as the general contractor on the building permit must prove that they are following Section 57 of the Workers' Compensation Law by producing ONE of the following forms:

1. Submit form C-105.2 as proof of Worker's Comp insurance
2. Submit U-26.3 if you are covered by the State Insurance Fund
3. If you participate in Workers' Compensation self-insurance, submit form SI-12 or GSI-105.2
4. For entities with NO employees, a CE-200 is required to be submitted for each specific application.

The Town of Colonie must be listed as the certificate holder on the applicable Workers' Compensation Insurance coverage submitted.

ACORD FORMS ARE NOT ACCEPTABLE PROOF OF WORKERS' COMPENSATION COVERAGE

For general questions regarding Workers' Compensation Insurance, visit www.wcb.ny.gov

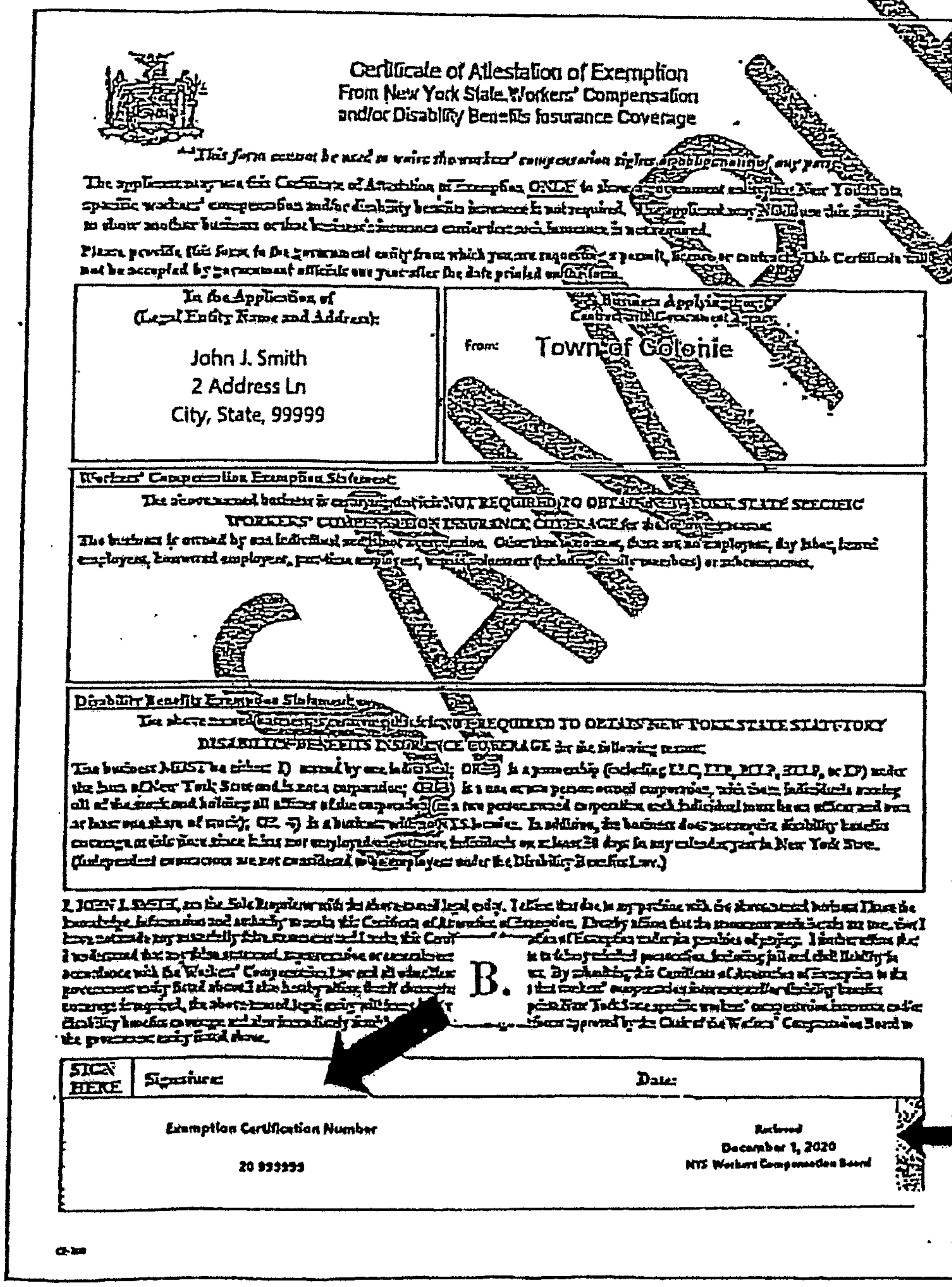
CE-200 Exemption for Workers Compensation AND/OR Disability Insurance

Licensee's exempt from such New York State insurance coverage, may find the appropriate (WC/DB Exemptions Form CE-200) on the New York State Workers" Compensation Board's we at www.wcb.state.ny.us.

Instructions:

- Go to www.wcb.ny.gov
- At the top left, there will be a search bar -- search "CE-200"
- Choose the second option "Request Certificate of Attestation of Exemption (CE-200) and follow the prompts.

Below is an Example of the CE-200 Exemption Form



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 Contract with Government Agency:
John J. Smith 2 Address Ln City, State, 99999	From: Town of Colonie

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:

[illegible]

B.

SIGN HERE	Signature:	Date:

Exemption Certification Number

20 999999

Received
December 1, 2020
NYS Workers Compensation Board

A.

The CE-200 mus approved by the York State Woi Compensation.

A. This exceptio must be done during the cur year.

B. Be sure the licensee sign bottom of the or it is invalid.

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

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

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

ICER	CONTACT NAME:	
	PHONE (A/C, No, Ext):	FAX (A/C, No):
	E-MAIL ADDRESS:	

	INSURER(S) AFFORDING COVERAGE	NAIC #
ED	INSURER A :	
Contractor Name Contractor Street Address or P.O. Box Contractor City, State & Zip Code	INSURER B :	
	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

ERAGES CERTIFICATE NUMBER: REVISION NUMBER:

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

TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
						MED EXP (Any one person)	$
						PERSONAL & ADV INJURY	$
EN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
OTHER:							$
ITOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
ANY AUTO						BODILY INJURY (Per person)	$
ALL OWNED AUTOS ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
HIRED AUTOS ☐ NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
							$
UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
DED ☐ RETENTION $							$
RKERS COMPENSATION D EMPLOYERS' LIABILITY Y / N						PER STATUTE ☐ OTH-ER	
PROPRIETOR/PARTNER/EXECUTIVE FICER/MEMBER EXCLUDED? (Mandatory in NH) N/A						E.L. EACH ACCIDENT	$
s, describe under SCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
						E.L. DISEASE - POLICY LIMIT	$

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

FICATE HOLDER	CANCELLATION
Town of Colonie 347 Old Niskayuna Rd Latham, NY 12110	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

NEW YORK STATE | Workers' Compensation Board

CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

1a. Legal Name & Address of Insured (use street address only) Contractor Name Contractor Street Address or P.O. Box Contractor City, State & Zip Code 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 Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) Town of Colonie 347 Old Niskayuna Rd Latham, NY 12110	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.

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

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

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

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

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

Under penalty of perjury, I certify that I am an authorized representative or licensed agent of the insurance carrier referenced above and that the named insured has the coverage as depicted on this form.

Approved by: _____
(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.

NYSIF New York State Insurance Fund

Workers' Compensation & Disability Benefits Specialists Since 1914

105 CORPORATE PARK DRIVE SUITE 200, WHITE PLAINS, NEW YORK 10604-3814

CERTIFICATE OF WORKERS' COMPENSATION INSURANCE (RENEWED)

AAA 133635141

Insurance Agency Inc
1 Address Ln
City, State 99999

QR Code

Scan to Validate

POLICYHOLDER	CERTIFICATE HOLDER
Contractor LLC 2 Address Ln City, State 99999	Town Of Colonie 347 Old Niskayuna Rd Latham, NY 12110

POLICY NUMBER	CERTIFICATE NUMBER	POLICY PERIOD	DATE
W -000A-00	772543	10/[illegible]016 TO 10/22/2017	10/18/2016

THIS IS TO CERTIFY THAT THE POLICYHOLDER NAMED ABOVE IS INSURED WITH THE NEW YORK STATE INSURANCE FUND UNDER POLICY NO. 1339-410-1, 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, AND, WITH RESPECT TO OPERATIONS OUTSIDE OF NEW YORK, TO THE POLICYHOLDER'S REGULAR NEW YORK STATE EMPLOYEES ONLY.

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. THE NEW YORK STATE INSURANCE FUND IS NOT LIABLE IN THE EVENT OF FAILURE TO GIVE SUCH NOTIFICATIONS.

THIS POLICY DOES NOT COVER CLAIMS OR SUITS THAT ARISE FROM BODILY INJURY SUFFERED BY THE OFFICERS OF THE INSURED CORPORATION.

Name , PRESIDENT
Establishment LLC
Address Ln
City, State, 99999

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

Signature

DIRECTOR, INSURANCE FUND UNDERWRITING

VALIDATION NUMBER:

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