GENERAL CONTRACTORS

For businesses listed as the general contractor, please submit the following appropriate insurance documentation with your application:

- Liability Insurance
  - Acord Form with:
    - Valid dates
    - Certificate Holder:
      Town of Newburgh
      21 Hudson Valley Professional Plaza Newburgh, NY 12550
- Workers Compensation
  - C105.2 Form with:
    - Valid dates
    - Certificate Holder:
      Town of Newburgh
      21 Hudson Valley Professional Plaza Newburgh, NY 12550

OR

- For Workers Compensation Exemption:
  - CE-200 Form:
    - Please visit www.wcb.ny.gov to fill out form
      - ➢ Please be sure to include:
        - Estimated time frame/dates necessary to complete work
        - Estimated dollar amount of project
        - Workers Compensation Exemption statement that applies to applicant
    - Once the form is completed online, before printing, please confirm certificate number and date. After printing, please sign the CE-200 form.

HOMEOWNERS

For homeowner listed as general contractor for the job/project, you will need to submit the following with your application:

- Copy of your Homeowners Insurance Policy
  - Declaration page
- CE-200 Form:
  - Please visit www.wcb.ny.gov to fill out form
    - ➢ Please be sure to include:
      - Estimated time frame/dates necessary to complete work
      - Location (address) of where work will be performed
      - Estimated dollar amount of project
      - Workers Compensation Exemption statement that applies to applicant
  - Once the form is completed online, before printing, please confirm certificate number and date. After printing, please sign CE-200 form.

Please Note

- ❖ The above-mentioned website is run by New York State & we cannot help you through the online process. If you have any questions, please call their helpline: 866-546-9322
- ❖ Each building permit application requires its own CE-200 form. You cannot use the same form for multiple permits.

EXAMPLE OF LIABILITY INSURANCE

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
5/18/2021

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 Alliant Insurance Services, Inc. 40 Stanford Drive 2nd Floor Farmington CT 06032	CONTACT NAME: PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Guardian Insurance Company Inc	17779
INSURER B : Cincinnati Insurance Company	10677
INSURER C : American Guarantee and Liabili	26247
INSURER D :	
INSURER E :	
INSURER F :	

INSURED DACOLLI-01

Your business name here

COVERAGES **CERTIFICATE NUMBER:** 377496358 **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	
B	X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE [X] OCCUR X Contractual Incl GEN'L AGGREGATE LIMIT APPLIES PER: POLICY [X] PRO-JECT [X] LOC OTHER:	Y			1/1/2021	1/1/2022	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG $	$2,000,000 $300,000 $10,000 $2,000,000 $4,000,000 $4,000,000 $
B	AUTOMOBILE LIABILITY X ANY AUTO OWNED AUTOS ONLY HIRED AUTOS ONLY SCHEDULED AUTOS NON-OWNED AUTOS ONLY	Y			1/1/2021	1/1/2022	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) $	$2,000,000 $ $ $ $
B	X UMBRELLA LIAB X OCCUR EXCESS LIAB CLAIMS-MADE DED RETENTION $	Y			1/1/2021	1/1/2022	EACH OCCURRENCE AGGREGATE $	$3,000,000 $3,000,000 $
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N [N] If yes, describe under DESCRIPTION OF OPERATIONS below	N/A			1/1/2021	1/1/2022	X PER STATUTE OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $1,000,000 $1,000,000 $1,000,000
A	NY Disability				1/1/2021	1/1/2022	Contineous	Statutory

CERTIFICATE HOLDER

Town of Newburgh
Code Compliance Department
21 Hudson Valley Professional Plaza
Newburgh NY 12550

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

ACORD Form

C105.2 FORM EXAMPLE

NEW YORK STATE | Workers' Compensation Board

CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

1a. Legal Name & Address of Insured (use street address only) Your business info. here 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 Newburgh 21 Hudson Valley Professional Plaza Newburgh, NY 12550	3a. Name of Insurance Carrier 3b. Policy Number of Entity Listed in Box "1a" 3c. Policy effective period 09/26/2020 to 09/26/2021 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".

The insurance carrier must notify the above certificate holder and the Workers' Compensation Board 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 or its licensed agent, or until the policy expiration date listed in box "3c", whichever is earlier.**

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: _____
(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 | Workers' Compensation Board

Certificate of Attestation of Exemption from New York State Workers' Compensation and/or Disability and Paid Family Leave Benefits Insurance Coverage

CE-200 EXAMPLE

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):	**Business Applying For:** Building Permit ☆
Newburgh, NY 12550 PHONE: 84[illegible] FEIN	**From: Town of Newburgh Building Department** The location of where work will be performed is **Newburgh, NY 12550.** Estimated dates necessary to complete work associated with the building permit are from **January 21, 2022 to June 30, 2022.** The estimated dollar amount of project is **$0 - $10,000**

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 applicant is a homeowner serving as the general contractor for a primary/secondary owner-occupied residence. The homeowner has ONLY uncompensated friends and family working on his/her residence or is hiring individuals a total of less than 40 aggregate hours per week and has a current homeowners insurance policy that covers the property.

↑ CHOOSE THE STATEMENT THAT BEST DESCRIBES YOUR PROJECT | SITUATION.

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 applicant is a homeowner serving as the general contractor for his/her primary/secondary personal residence. The homeowner 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, Lisa Dubaldi, am the Homeowner 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: X	Date: X

Exemption Certificate Number: 2022-003736

Received January 21, 2022 NYS Workers' Compensation Board

CE-200 01/2018

* THIS FORM IS NEEDED FOR EACH PERMIT *
* YOU CAN NOT USE THIS FOR MULTIPLE PERMITS - EACH ONE IS INDIVIDUAL