NEW YORK STATE | 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)
RESONANCE TECHNOLOGY GLOBAL, LTD

28 ROCKRIDGE RD
MOUNT VERNON, NY 10552

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
(914) 447-3581 x

1c. Federal Employer Identification Number of Insured or Social Security Number
27-2391338

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

258 Main Street

Nelsonville, NY 10516

3a. Name of Insurance Carrier
**Standard Security Life Insurance Company of New York**

3b. Policy Number of Entity Listed in Box "1a"
L87006-000

3c. Policy effective period
6/7/2018 to 3/12/2021

4. Policy provides the following benefits:
- [X] A. Both disability and paid family leave benefits.
- [ ] B. Disability benefits only.
- [ ] C. Paid family leave benefits only.

5. Policy covers:
- [X] 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:

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 3/13/2020 By _____
(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, Supervisior-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.***

# Additional Instructions for Form DB-120.1

By signing this form, the insurance carrier identified in Box 3 on this form is certifying that it is insuring the business referenced in box "1a" for disability and/or paid family leave benefits under the New York State Disability and Paid Family Leave Benefits Law. The Insurance Carrier or its licensed agent will send this Certificate of Insurance to the entity listed 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 cancelled 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 coverage indicated on this Certificate. (These notices my 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 Disability and/or Paid Family Leave Benefits contract of insurance only while the underlying policy is in effect.

**Please Note: Upon the cancellation of the disability and/or paid family leave benefits 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 NYS Disability and/or Paid Family Leave Benefits Coverage or other authorized proof that the business is complying with the mandatory coverage requirements of the New York State Disability and Paid Family Leave Benefits Law.**

## DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

### §220. Subd. 8

(a) 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 employment as defined in this article, and not withstanding 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 the payment of disability benefits and after January first, two thousand and twenty-one, the payment of family leave benefits for all employees has been secured as provided by this article. 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 disability benefits to any such employee if so employed.

(b) 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 employment as defined in this article and 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 the payment of disability benefits and after January first, two thousand eighteen, the payment of family leave benefits for all employees has been secured as provided by this article.

# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 03/13/2020

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**

StateFarm

SAMANTHA POLITI STATE FARM AGENCY
532 BEDFORD ROAD
BEDFORD HILLS, NY 10507

CONTACT NAME: SAMANTHA POLITI
PHONE (A/C, No, Ext): 914-241-2990 FAX (A/C, No): 914-241-2945
E-MAIL ADDRESS:

| INSURER(S) AFFORDING COVERAGE | NAIC # |
|---|---|
| INSURER A : State Farm Fire and Casualty Company | 25143 |
| INSURER B : | |
| INSURER C : | |
| INSURER D : | |
| INSURER E : | |
| INSURER F : | |

**INSURED**

RESONANCE TECHNOLOGY GLOBAL, LTD.
28 ROCKRIDGE RD
MT VERNON, NY MT VERNON

**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 INSD | SUBR WVD | POLICY NUMBER | POLICY EFF (MM/DD/YYYY) | POLICY EXP (MM/DD/YYYY) | LIMITS | |
|---|---|---|---|---|---|---|---|---|
| A | [X] COMMERCIAL GENERAL LIABILITY<br>[ ] CLAIMS-MADE [X] OCCUR<br>GEN'L AGGREGATE LIMIT APPLIES PER:<br>[X] POLICY [X] PRO-JECT [ ] LOC<br>[ ] OTHER: | Y | Y | 98-CG-Z519-8 | 12/19/2019 | 12/19/2020 | EACH OCCURRENCE | $ 1,000,000 |
| | | | | | | | DAMAGE TO RENTED PREMISES (Ea occurrence) | $ 100,000 |
| | | | | | | | MED EXP (Any one person) | $ 5,000 |
| | | | | | | | PERSONAL & ADV INJURY | $ 1,000,000 |
| | | | | | | | GENERAL AGGREGATE | $ 2,000,000 |
| | | | | | | | PRODUCTS - COMP/OP AGG | $ 2,000,000 |
| | | | | | | | | $ |
| | AUTOMOBILE LIABILITY<br>[ ] ANY AUTO<br>[ ] OWNED AUTOS ONLY [ ] SCHEDULED AUTOS<br>[ ] HIRED AUTOS ONLY [ ] NON-OWNED AUTOS ONLY | | | | | | COMBINED SINGLE LIMIT (Ea accident) | $ |
| | | | | | | | BODILY INJURY (Per person) | $ |
| | | | | | | | BODILY INJURY (Per accident) | $ |
| | | | | | | | PROPERTY DAMAGE (Per accident) | $ |
| | | | | | | | | $ |
| | [ ] UMBRELLA LIAB [ ] OCCUR<br>[ ] EXCESS LIAB [ ] CLAIMS-MADE<br>[ ] DED [ ] RETENTION $ | | | | | | EACH OCCURRENCE | $ |
| | | | | | | | AGGREGATE | $ |
| | | | | | | | | $ |
| | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY<br>ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N [ ]<br>(Mandatory in NH)<br>If yes, describe under DESCRIPTION OF OPERATIONS below | N / A | | | | | [ ] PER STATUTE [ ] OTH-ER | |
| | | | | | | | E.L. EACH ACCIDENT | $ |
| | | | | | | | E.L. DISEASE - EA EMPLOYEE | $ |
| | | | | | | | E.L. DISEASE - POLICY LIMIT | $ |
| | | | | | | | | |

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

As per all policy terms & exclusions certificate holder is named as additional insured all locations all covered operations.

**CERTIFICATE HOLDER**

Village of Nelsonville
258 Main Street
Nelsonville, NY 10516

**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

NEW YORK STATE | Workers' Compensation Board

# CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

| | |
|---|---|
| 1a. Legal Name & Address of Insured (use street address only)<br>RESONANCE TECHNOLOGY GLOBAL, LTD.<br>28 ROCKRIDGE RD<br>MT VERNON, NY MT VERNON<br><br>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<br>718-361-1611<br>1c. NYS Unemployment Insurance Employer Registration Number of Insured<br><br>1d. Federal Employer Identification Number of Insured or Social Security Number<br>27-2391338 |
| 2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)<br>VILLAGE OF NELSONVILLE<br>258 MAIN STREET<br>NELSONVILLE, NY 10516 | 3a. Name of Insurance Carrier<br>State Farm Fire and Casualty Company<br>3b. Policy Number of Entity Listed in Box "1a"<br>98-CN-C425-8<br>3c. Policy effective period<br>01/27/2020 to 01/27/2021<br>3d. The Proprietor, Partners or Executive Officers are<br>☐ included. (Only check box if all partners/officers included)<br>☒ 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: STACY UPHAM
(Print name of authorized representative or licensed agent of insurance carrier)

Approved by: _____ 3/16/20
(Signature) (Date)

Title: ACCOUNT MANAGER

Telephone Number of authorized representative or licensed agent of insurance carrier: 914.241.2990

**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.**