SAMPLE

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

PRODUCER
Issuing Agent Name
Issuing Agent Address
Issuing Agent Address
Issuing Agent Phone #

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 of Contractor, Permit or License Holder
Address
Address

INSURERS AFFORDING COVERAGE	NAIC #
INSURER A: Company Name	
INSURER B:	
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 [X] COMMERCIAL GENERAL LIABILITY [ ] CLAIMS MADE [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: [ ] POLICY [ ] PRO-JECT [ ] LOC	Policy #	01/01/0	01/01/0	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 50,000 $ 5,000 $ 1,000,000 $ 2,000,000 $ 2,000,000
A		AUTOMOBILE LIABILITY [X] ANY AUTO [X] ALL OWNED AUTOS [X] SCHEDULED AUTOS [X] HIRED AUTOS [X] NON-OWNED AUTOS	Policy #	01/01/0	01/01/0	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
		GARAGE LIABILITY [ ] ANY AUTO				AUTO ONLY - EA ACCIDENT OTHER THAN AUTO ONLY: EA ACC AGG	$ $ $
A		EXCESS/UMBRELLA LIABILITY [X] OCCUR [ ] CLAIMS MADE [ ] DEDUCTIBLE [ ] RETENTION $	Policy #	01/01/0	01/01/0	EACH OCCURRENCE AGGREGATE	$ 1,000,000 $ 1,000,000 $ $ $
A		WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below	Use C105.2, U-26.3 SI-12, GSI105.2, WC/DB100 or 101			WC STATU-TORY LIMITS / OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ $ $
A		OTHER NYS Disability	Use DB-120.1, DB-155 WC/DB100 or 101				

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

RE: (Reference Project/Job); City of Canandaigua is an Additional Insured for General Liability on a Primary and Non-Contributory basis.

CERTIFICATE HOLDER

City of Canandaigua
Attn: Nancy Abdallah
2 North Main Street
Canandaigua, NY 14424

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER 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

FORM DB-120.1

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

CERTIFICATE OF INSURANCE COVERAGE UNDER THE NYS DISABILITY BENEFITS LAW

PART 1. To be completed by Disability Benefits C[illegible]ier or Licensed Insurance Agent of that Carrier

1a. Legal Name and Address of Insured (Use street address on[illegible]

1b. Bu[illegible]hone Number of Insured

NYS [illegible]t Insurance Employer Registration [illegible]

1d. [illegible]yer Id[illegible]ation Number of Insured or [illegible]

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

[illegible]. Polic[illegible]isted In [illegible]"1a":

[illegible]olicy effe[illegible]

[illegible]o

4. Policy cov[illegible]

[illegible]of the emplo[illegible]oyees eligible[illegible]er the NYS Disability Benefits Law

[illegible]he follow[illegible]f the employer's employees

Under penalty of [illegible]ry, I certify that I am [illegible]author[illegible]tive [illegible]ized a[illegible] of the insurance carrier referenced above and that the named insu[illegible]has NYS Disability Benefits [illegible]e coverage as described a[illegible]

Date Signed_____ By_____

[illegible]ture of [illegible]e ca[illegible]t representative or NYS Licensed [illegible]nce Agent of that insurance carrier)

Telephone Number_____ [illegible]Title

IMPORTANT: If box "4a" is checked, and this [illegible]Insurance [illegible]er's authorized representative or NYS [illegible]sed Insurance Agent of that carrier, this certificate is COMPLET[illegible]ly on t[illegible]ur.

If box "4b" is checked, this certificate is NO[illegible]for p[illegible]Section 220, Subd. 8 of the Disability Benefits Law. It must be mailed for completion to the Workers' Compensation [illegible]ce Unit, 20 Park Street, Albany, New York 12207.

PART 2. To be completed by NYS Workers' [illegible]ard (Only if box "4b" of Part 1 has been checked)

[illegible]ork
Worke[illegible]ompe[illegible]tion Board

According to information maintained by the NY[illegible]kers' Co[illegible]tion Board, the above-named employer has complied with the NYS Disability Benefits Law with respect to all of his/[illegible]

Date Signed_____ By_____

[illegible]e of NYS Workers' Compensation Board Employee)

Telephone Number_____ Title_____

Please Note: Only insurance carriers licensed to write NYS disability 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 (5-06)

Form C-105.2

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)	3a. Name of Insurance Carrier 3b. Policy Number of entity listed in box "1" 3c. Policy effective period 4. The Proprietor, Partners or Executive Officers are ☐ included. (Only check box if all partners/officers included) ☐ excluded or certain partners/officers excluded.

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 be valid 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 changes other than nonpayment of premiums that cancel the policy or eliminate the insured from the coverage indicated on this Certificate. (Such 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.

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.