



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
03/09/2020

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).

<b>PRODUCER</b> Eastern Shore Associates An ISU Network Member P.O. Box 480, 101 Cayuga St. Fulton NY 13069	<b>CONTACT NAME:</b> Athena Halstead <b>PHONE (A/C No, Ext):</b> (315) 598-8000 <b>E-MAIL ADDRESS:</b> ahalstead@esainsurance.com <b>FAX (A/C, No):</b> (315) 598-1183																				
	<table border="1"> <tr> <th colspan="2">INSURER(S) AFFORDING COVERAGE</th> <th>NAIC #</th> </tr> <tr> <td>INSURER A:</td> <td>Dryden Mutual Insurance Co</td> <td>13919</td> </tr> <tr> <td>INSURER B:</td> <td></td> <td></td> </tr> <tr> <td>INSURER C:</td> <td></td> <td></td> </tr> <tr> <td>INSURER D:</td> <td></td> <td></td> </tr> <tr> <td>INSURER E:</td> <td></td> <td></td> </tr> <tr> <td>INSURER F:</td> <td></td> <td></td> </tr> </table>	INSURER(S) AFFORDING COVERAGE		NAIC #	INSURER A:	Dryden Mutual Insurance Co	13919	INSURER B:			INSURER C:			INSURER D:			INSURER E:			INSURER F:	
INSURER(S) AFFORDING COVERAGE		NAIC #																			
INSURER A:	Dryden Mutual Insurance Co	13919																			
INSURER B:																					
INSURER C:																					
INSURER D:																					
INSURER E:																					
INSURER F:																					
<b>INSURED</b>  Liverpool NY 13090																					


**COVERAGES**                      **CERTIFICATE NUMBER:** 20-21 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	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE \$ 2,000,000
	<input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000
							MED EXP (Any one person) \$ 5,000
							PERSONAL & ADV INJURY \$ 2,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE \$ 5,000,000
	<input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC						PRODUCTS - COMP/OP AGG \$ 5,000,000
	OTHER:						\$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident) \$
	<input type="checkbox"/> ANY AUTO						BODILY INJURY (Per person) \$
	<input type="checkbox"/> OWNED AUTOS ONLY						BODILY INJURY (Per accident) \$
	<input type="checkbox"/> HIRED AUTOS ONLY						PROPERTY DAMAGE (Per accident) \$
	<input type="checkbox"/> SCHEDULED AUTOS NON-OWNED AUTOS ONLY						\$
	UMBRELLA LIAB						EACH OCCURRENCE \$
	<input type="checkbox"/> EXCESS LIAB						AGGREGATE \$
	<input type="checkbox"/> OCCUR						\$
	<input type="checkbox"/> CLAIMS-MADE						\$
	DED						\$
	RETENTION \$						\$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY						PER STATUTE
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)						OTHER
	If yes, describe under DESCRIPTION OF OPERATIONS below	N/A					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)

RE: 2 Day job framing and siding a seasonal room for a house in Clay, NY.

<b>CERTIFICATE HOLDER</b>  Town of Clay 4401 Route 31  Clay NY 13041	<b>CANCELLATION</b>  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  
---	---

© 1988-2015 ACORD CORPORATION. All rights reserved.



✓

**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.

<p style="text-align: center;"><b>In the Application of (Legal Entity Name and Address):</b></p>	<p style="text-align: center;"><b>Business Applying For:</b> Building Permit</p> <p><b>From: Town of Clay</b></p> <p>The location of where work will be performed is <b>17 Mann Drive, Liverpool, NY 13088.</b></p> <p>Estimated dates necessary to complete work associated with the building permit are from <b>May 26, 2020 to June 2, 2020.</b></p> <p>The estimated dollar amount of project is <b>\$0 - \$10,000</b></p>
--	--

**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 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, Lawrence Evans, am the Sole Proprietor 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.

<b>SIGN HERE</b>	Signature: _____	Date: _____
<b>Exemption Certificate Number 2020-026936</b>		<b>Received May 21, 2020 NYS Workers' Compensation Board</b>