NYS FAIR INSURANCE INFORMATION & SAMPLES

THE FOLLOWING ITEMS ARE REQUIRED AS PART OF YOUR AGREEMENT AND MUST BE RECEIVED BY THE SPECIFIED DUE DATE. If any of the listed requirements are not received and correct by the due date you will be charged a late fee of $250.00 for EACH that is not received on time.

1. Workers’ Compensation (or exemption/waiver)
2. Disability Insurance (or exemption/waiver)
3. Liability Insurance

It is the vendor’s responsibility to submit the correct insurance documents to the NYS Fair. Insurances cannot be sent on your behalf from your insurance company.

Vendors are responsible for ensuring all requirements (Legal Business Name, Address, Endorsements, etc.) have been met. Only if the documents are correct should they be forwarded to the NYS Fair. If insurances are incorrect you must have them fixed with your insurance company before providing them to the Fair.

The only acceptable ways to submit your required insurances documents are listed below:

Mailed To: NYS Fair Licensing Office
581 State Fair Blvd.
Syracuse, NY 13209

Emailed To: sfpaperwork@agriculture.ny.gov
(This is the only acceptable email address to use)

Personally Delivered: NYS Fair Administration Building
Licensing Office (M-F 9:00AM to 4:00PM)

Please note: Faxes are NOT acceptable.
1. WORKERS’ COMPENSATION INFORMATION:

Workers’ Compensation Law (WCL) §57 & §220 requires the heads of all municipal and state entities to ensure that businesses applying for permits, licenses or contracts document that they have appropriate workers’ compensation (page 2-3) and disability benefits insurance coverage (page 6-7); or document that they are exempt from such coverage (page 4-5). These requirements apply to both original contracts and renewals, whether the governmental agency is having the work done or is simply issuing the permit, license or contract. Failure to provide proof of such coverage or a legal exemption may result in the termination of the Agreement. An ACORD form is NOT acceptable proof of workers’ compensation coverage.

To comply with the coverage requirements ONE of the following forms for Workers Compensation must be provided to the Department:

PROOF OF CERTIFICATE OF WORKERS’ COMPENSATION:

Acceptable forms for proof of Workers’ Compensation must be submitted on one of the following (OR a CE-200 Waiver see page 4-5):

- Form C-105.2
- Form U-26.3
- Form SI-12
- Form GSI-105.2

Vendors without coverage may obtain a policy for the duration of the New York State Fair from the New York State Insurance Fund.

Please direct all questions to one of the following; New York State Workers’ Compensation Board at 877-632-4996 or go to the New York State Workers’ Compensation Board’s Website: www.wcb.ny.gov or contact Walter Peretti at 518-402-8330 or email Walter.Peretti@wcb.ny.gov

See the following page for an example of a Certificate of Workers’ Compensation Coverage.
EXAMPLE OF THE C-105.2 CERTIFICATE OF WORKERS’ COMPENSATION INSURANCE COVERAGE (Obtained from your insurance carrier)

State of New York Workers’ Compensation Board

Certificate of NYS Workers’ Compensation Insurance Coverage

1a. Legal Name and address of Insured (Use street address only)
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

Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York state, i.e., a Wrap-Up Policy)

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 “1a”:
3c. Policy effective period:
3d. The Proprietor, Partner or Executive Officers are:
   - included
   - excluded
   - all excluded or certain partners/officers excluded
3e. Demission is: (Definition of Demission on Insurance)
   - included
   - excluded

This certificate represents the insurance carrier(s) has agreement to indemnify the business referenced above in box “1a” for workers’ compensation under the New York State Workers’ Compensation Law. The name of the New York (NY) must be listed under Item 3a on the INFORMATION PAGE of the workers’ compensation coverage. The Insurance Carrier or the licensed agent will send this Certificate of Insurance to the entity listed above as the certificate holder.

The Insurance Carrier will also notify the above certificate holder of any changes or cancellation. If the policy is canceled due to nonpayment of premiums or written 30 days prior to the cancellation date, there are reasons other than nonpayment of premiums that could cause the insurer to terminate the coverage indicated on this Certificate. These notices may be sent by regular mail and/or electronic mail. The Certificate is valid from the date when issued until one year after the policy expires or upon cancellation of the insurance coverage.

Please Note: Upon the cancellation of the workers’ compensation policy, the certificate holder shall be notified. If this business continues to be named on a permit, license, or contract issued by a certificate holder, the business must provide the 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:

(Signature)

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 the C-105.2 form. Insurance brokers are NOT authorized to issue.
EXEMPTION/WAIVER (if policy is not required):

Form CE-200, Certificate of Attestation for New York Entities with no employees and certain out of state entities, that New York State Workers’ Compensation and/or Disability Benefits Insurance Coverage is not required. This form can be requested online at the Workers’ Compensation Board’s website:

http://www.wcb.ny.gov/content/ebiz/wc_db_exemptions/requestExemptionOverview.jsp

- You will be brought to the following page – please follow the instructions on this page.

COMPLETE THE EXEMPTION APPLICATION FOR AN EXEMPTION CERTIFICATE APPROVED BY THE WORKERS’ COMPENSATION BOARD.

See the following page for an example of a Certificate of Workers’ Compensation Exemption.
EXAMPLE OF THE CE-200 EXEMPTION FORM (OBTAINED FROM THE WORKERS' COMPENSATION BOARD)

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 governmental officials one year after the date printed on the form.

<table>
<thead>
<tr>
<th>In the Application of</th>
<th>Business Applying For</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Legal Entity Name and Address]:</td>
<td>From: NEW YORK STATE DEPARTMENT OF AG AND MARKETS</td>
</tr>
<tr>
<td>FORM 7, SMITH</td>
<td></td>
</tr>
<tr>
<td>91 STATE FAIR BOVD</td>
<td></td>
</tr>
<tr>
<td>SYRACUSE, NY 13202</td>
<td></td>
</tr>
<tr>
<td>PHONE: 315.368.5555</td>
<td></td>
</tr>
<tr>
<td>FEIN #: XXXXXX000</td>
<td></td>
</tr>
</tbody>
</table>

Worker 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:
The business MUST be either: 1) owned by one individual, OR 2) is a partnership (including LLC, LLP, PLLP, LLP, or LP) under the laws of New York State and is not a corporation, OR 3) in a one or two person owned corporation, with these individuals owning all of the stock and holding all offices of the corporation (as 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 an NYS location. In addition, the business does not require disability benefits coverage if this time since it has not employed one or more individuals of at least 50 days in any calendar year in New York State. (Independent contractors are not considered to be employees under the Disability Benefits Law.)

I, JOHN J. SMITH, the Sole Proprietor with the above named business, I affirm that due to my position with the above named business, I have the knowledge, information and authority to make the Certificate of Attestation of Exemption. I hereby affirm that the statements made herein are true, and 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 statements, representations or omissions will subject me to felony criminal prosecution, including but not limited to, assessment of 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 hereby affirm that it is incorrect to change so that workers' compensation insurance and/or disability benefits coverage is required, the above named legal entity will immediately acquire appropriate New York State specific workers' compensation insurance and/or disability benefits coverage and also immediately furnish proof of such coverage as forms approved by the Chair of the Workers' Compensation Board to the government entity listed above.

SIGN HERE: Signature:
Exemption Certificate Number
2011-063664
Date: Received
December 1, 2011
NYS Workers' Compensation Board

CE-200 (12/2020)

(Rev. 01.17.19)
2. DISABILITY INFORMATION:

Workers’ Compensation Law (WCL) §57 & §220 requires the heads of all municipal and state entities to ensure that businesses applying for permits, licenses or contracts document that they have appropriate workers’ compensation (page 2-3) and disability benefits insurance coverage (page 6-7); or document that they are exempt from such coverage (page 4-5). These requirements apply to both original contracts and renewals, whether the governmental agency is having the work done or is simply issuing the permit, license or contract. Failure to provide proof of such coverage or a legal exemption may result in the termination of the Agreement.

To comply with the coverage requirements ONE of the following forms for Workers Compensation must be provided to the Department:

A. CERTIFICATE OF DISABILITY BENEFITS INSURANCE:

Acceptable forms for proof of Disability must be submitted on one of the following (OR a CE-200 Waiver see page 4-5):

- Form DB-120.1
- Form DB-155

Please direct all questions to one of the following: New York State Workers’ Compensation Board at 877-632-4996 or go to the New York State Workers’ Compensation Board’s Website: www.wcb.ny.gov or contact Walter Peretti at 518-402-8330 or email Walter.Peretti@wcb.ny.gov

See the following page for an example of a Certificate of Disability Coverage.
EXAMPLE OF THE DB-120.1 CERTIFICATE OF DISABILITY INSURANCE COVERAGE (This form is obtained from your insurance carrier)

The Fair cannot accept this form if this information does not match the legal business name and address as it appears on your agreement.

Enter the NYS Department of Agriculture and Markets as the Entity:
581 State Fair Blvd.
Syracuse, NY 13209

Policy must be in force for the duration of the event including move in/out.

This number must correspond with your legal business name.

The Fair cannot accept this form if this information does not match the legal business name and address as it appears on your agreement.

Enter the NYS Department of Agriculture and Markets as the Entity:
581 State Fair Blvd.
Syracuse, NY 13209

Policy must be in force for the duration of the event including move in/out.

This number must correspond with your legal business name.

The Fair cannot accept this form if this information does not match the legal business name and address as it appears on your agreement.

Enter the NYS Department of Agriculture and Markets as the Entity:
581 State Fair Blvd.
Syracuse, NY 13209

Policy must be in force for the duration of the event including move in/out.

This number must correspond with your legal business name.
3. CERTIFICATE OF LIABILITY INSURANCE:

Concessionaires, exhibitors, sponsors and promoters shall obtain and maintain public liability insurance for loss, damage and personal injury arising from their operations under the Agreement. Concessionaires, exhibitors, sponsors and promoters must provide a certificate of insurance.

In addition to basic company information, the following items must be listed on the insurance form ACORD-25:

A. List your legal business name and address. The Fair cannot accept this form if it does not match the legal business name and address as it appears on your agreement.

B. Insurance must be Commercial General Liability and if applicable, Liquor/Golf Cart/Product Liability.

C. Policy must be in force for the duration of the event, including move in/out.

D. Each occurrence should be at least $1,000,000.

E. The New York State Department of Agriculture & Markets must be listed as the additional insured.

F. The New York State Fair, Department of Agriculture and Markets must be listed as the certificate holder:

581 State Fair Blvd.
Syracuse, NY 13209

G. Concessionaires, exhibitors, sponsors and promoters shall immediately inform the New York State Fair of any insurance cancellation or material change in coverage.

Reminder: Workers’ Compensation is not acceptable on an Acord-25 form.