NYS FAIR INSURANCE INFORMATION & SAMPLES

THE FOLLOWING ITEMS ARE REQUIRED AS PART OF YOUR AGREEMENT AND MUST BE RECEIVED BY THE SPECIFIED DUE DATE.

Late Fees – Late payments will be invoiced at 5% of the unpaid invoice amount. Late paperwork will be invoiced at $50 per document (signed agreement, insurance certificates, etc.). Payments for late fees not made by the specified due date may result in cancellation of the contract and loss of space. If payments are not made by the due date and the vendor's contract is not being cancelled, additional late fees may be applied every 30-days at the discretion of the department.

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 insurance 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 or photos are <u>NOT</u> 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 518-486-3331 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)

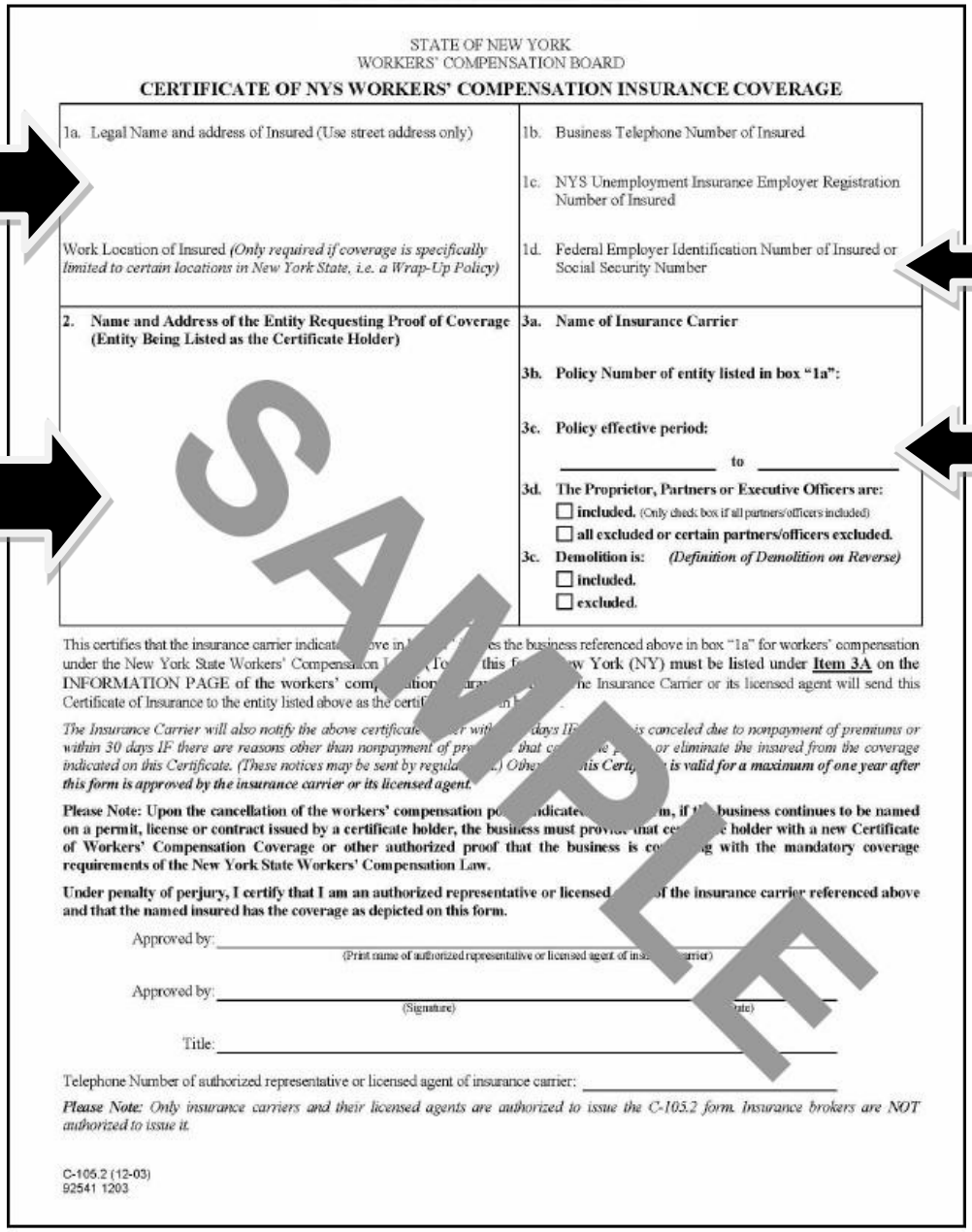
The Fair cannot accept this form if this information does not match the legal business name and address as it appears on your agreement

Enter the NYS Department of Agriculture and Markets as the Entity:

581 State Fair Blvd.
Syracuse, NY 13209

This number must correspond with your legal business name

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



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
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 "1a":** **3c. Policy effective period:** _____ to _____ **3d. The Proprietor, Partners or Executive Officers are:** ☐ **included.** (Only check box if all partners/officers included) ☐ **all excluded or certain partners/officers excluded.** **3e. Demolition is:** *(Definition of Demolition on Reverse)* ☐ **included.** ☐ **excluded.**

This certifies that the insurance carrier indicat…ove in … …es the business referenced above in box "1a" for workers' compensation under the New York State Workers' Compensation … To… this f… …w York (NY) must be listed under **Item 3A** on the INFORMATION PAGE of the workers' com… …ation … …he Insurance Carrier or its licensed agent will send this Certificate of Insurance to the entity listed above as the certi… …n …

The Insurance Carrier will also notify the above certificate… …er wit… …days IF… …is canceled due to nonpayment of premiums or within 30 days IF there are reasons other than nonpayment of pr… …that c… …e … …or eliminate the insured from the coverage indicated on this Certificate. (These notices may be sent by regula… …t.) Othe… …his Certi… …is valid for a maximum of one year after this form is approved by the insurance carrier or its licensed agent.

Please Note: Upon the cancellation of the workers' compensation po… …ndicate… …m, if t… …business continues to be named on a permit, license or contract issued by a certificate holder, the business must provi… …that ce… …e holder with a new Certificate of Workers' Compensation Coverage or other authorized proof that the business is co… …g 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 … …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 ins… …arrier)

Approved by: _____ _____
(Signature) …ate)

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 it.

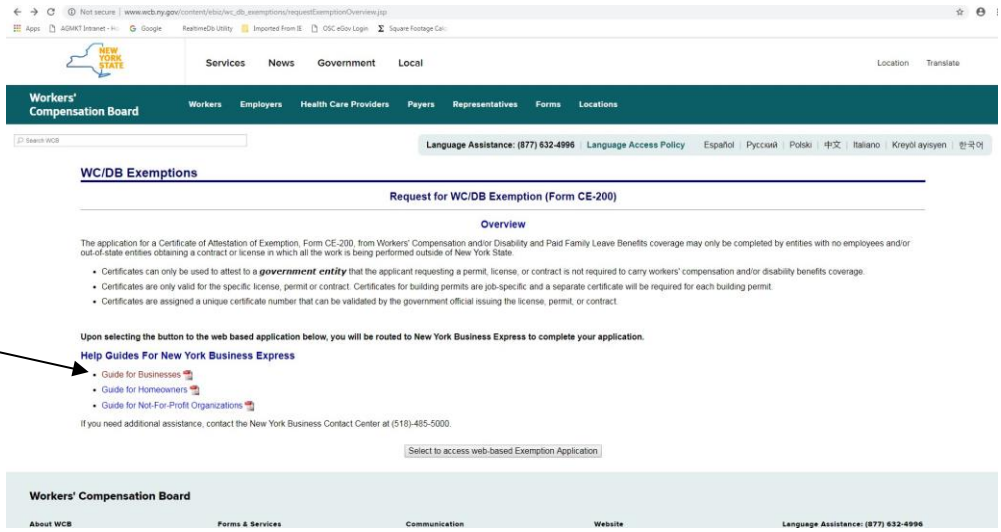
C-105.2 (12-03)
92541 1203

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

Click on "**Guide for Businesses**



- 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)

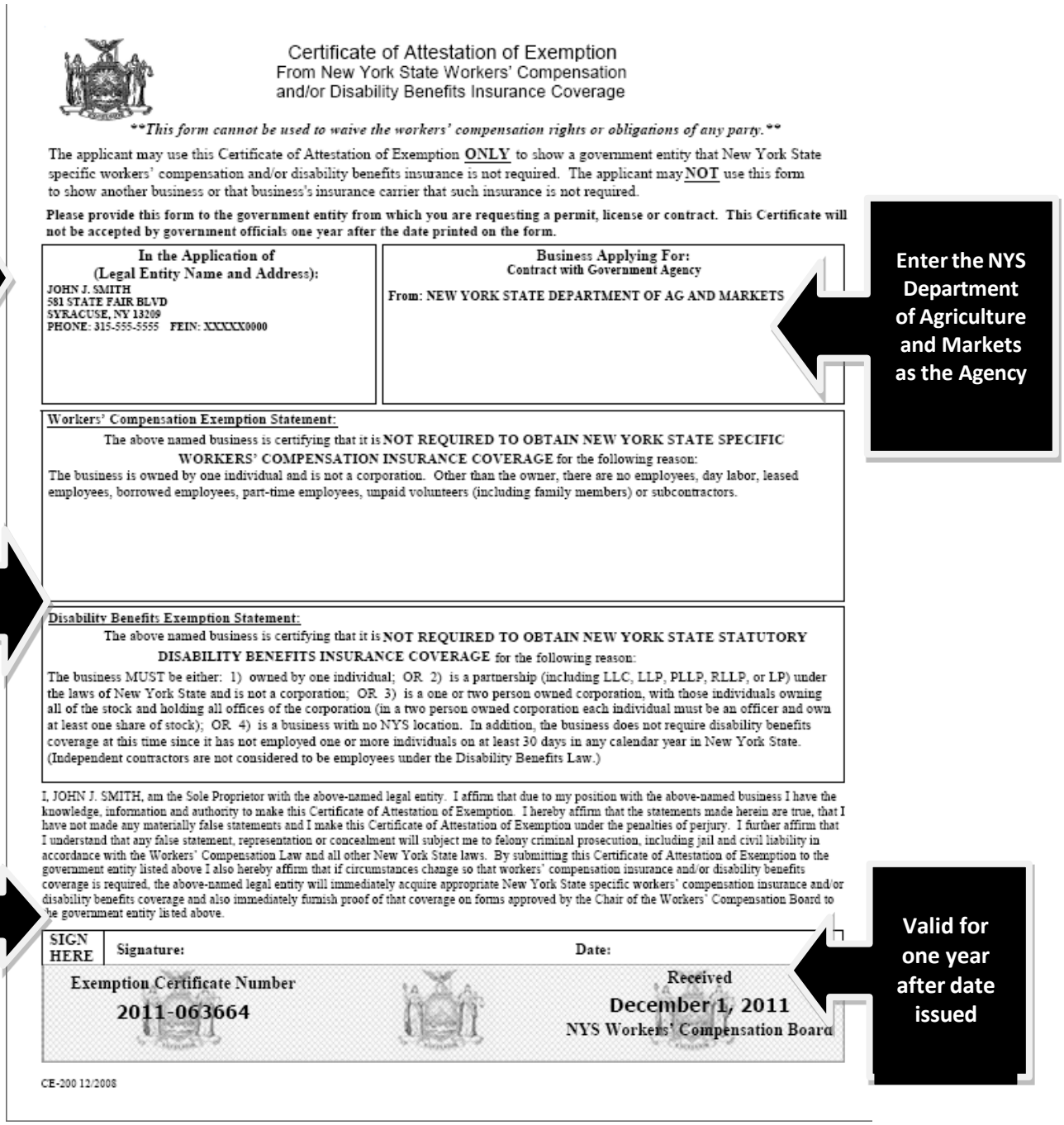
Complete information about your business – must match what is printed on your agreement. FEIN# must match with our records. PO Boxes cannot be accepted.

CE-200 can be used for exemption for Worker's Compensation, Workers' Disability, or both. This example shows exemption for both coverages

Must be signed by Vendor to be valid

Enter the NYS Department of Agriculture and Markets as the Agency

Valid for one year after date issued



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

In the Application of (Legal Entity Name and Address):	Business Applying For: Contract with Government Agency
JOHN J. SMITH 581 STATE FAIR BLVD SYRACUSE, NY 13209 PHONE: 315-555-5555 FEIN: XXXXX0000	From: NEW YORK STATE DEPARTMENT OF AG AND MARKETS

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 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, 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 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 Benefits Law.)

I, JOHN J. SMITH, 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 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 that coverage on forms approved by the Chair of the Workers' Compensation Board to the government entity listed above.

SIGN HERE	Signature:	Date:

Exemption Certificate Number
2011-063664

Received
December 1, 2011
NYS Workers' Compensation Board

CE-200 12/2008

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:

PROOF OF 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 518-486-3331 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)

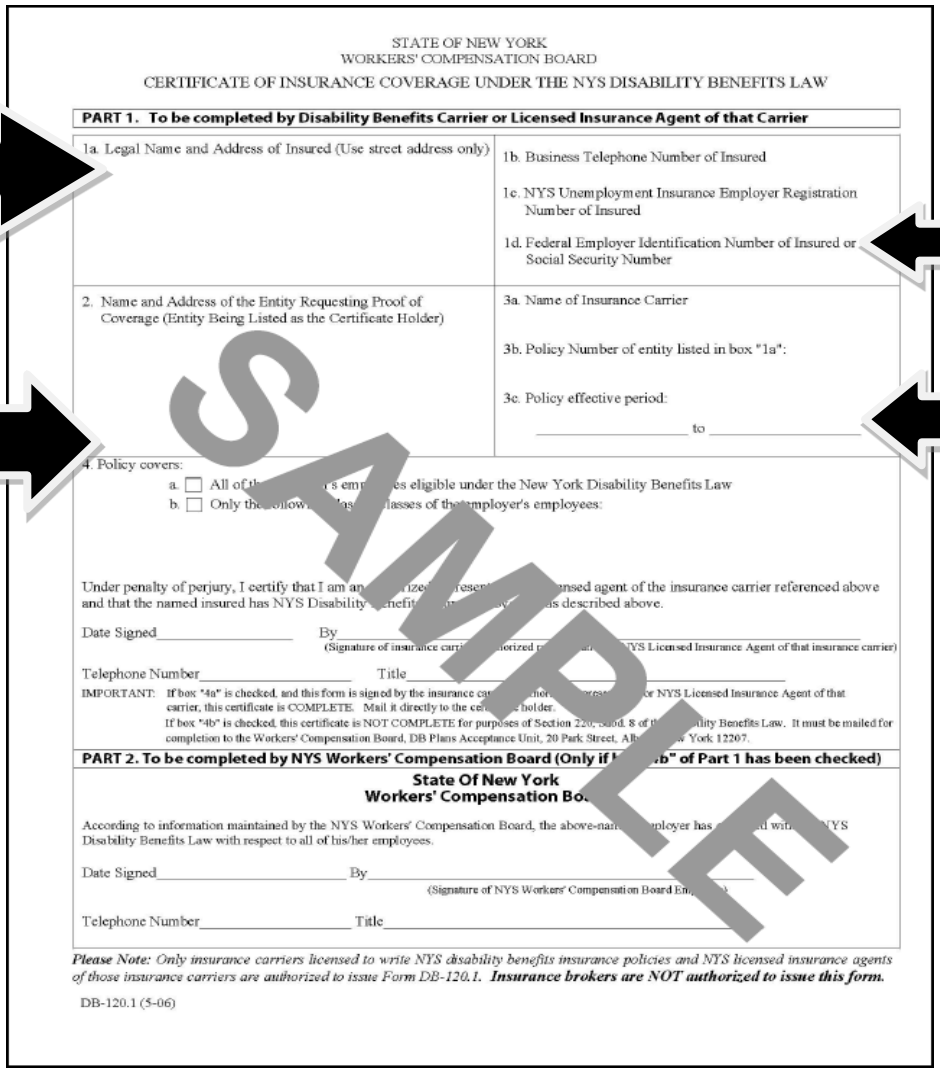
The Fair cannot accept this form if this information does not match the legal business name and address as it appears on your agreement

Enter the NYS Department of Agriculture and Markets as the Entity:

581 State Fair Blvd.
Syracuse, NY 13209

This number must correspond with your legal business name

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



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 Carrier or Licensed Insurance Agent of that Carrier

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

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:

_____ to _____

4. Policy covers:

a. ☐ All of the ... employees eligible under the New York Disability Benefits Law

b. ☐ Only the following ... classes of the employer's employees:

Under penalty of perjury, I certify that I am an ... authorized representative ... licensed agent of the insurance carrier referenced above and that the named insured has NYS Disability ... as described above.

Date Signed_____ By_____
(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number_____ Title_____

IMPORTANT: If box "4a" is 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" is checked, this certificate is NOT COMPLETE for purposes of Section 220, Subd. 8 of the Disability Benefits Law. It must be mailed for completion to the Workers' Compensation Board, DB Plans Acceptance Unit, 20 Park Street, Albany, New York 12207.

PART 2. To be completed by NYS Workers' Compensation Board (Only if box "4b" 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 Benefits Law with respect to all of his/her employees.

Date Signed_____ By_____
(Signature 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)

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.

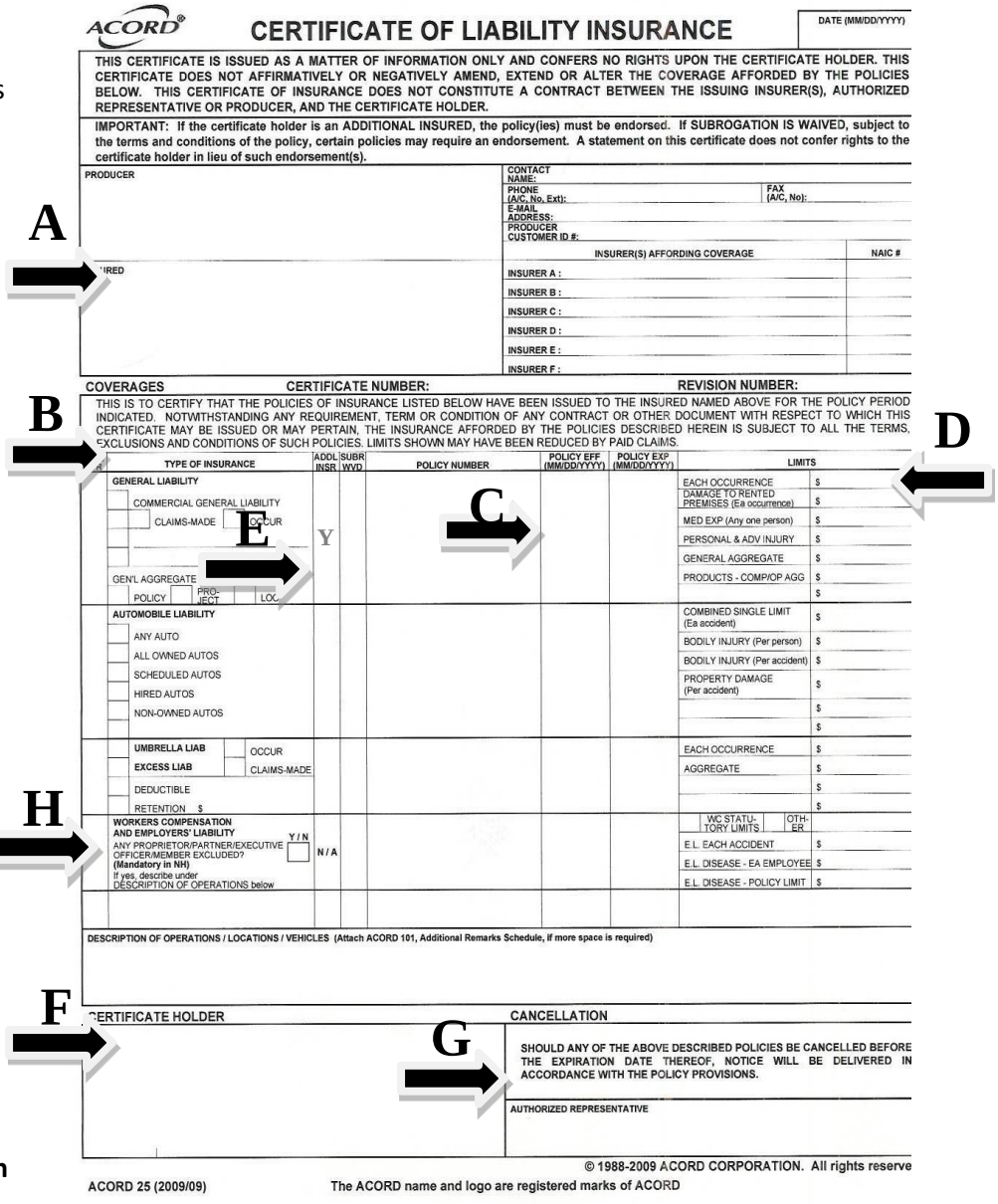
D. Each occurrence should be at least $1,000,000.

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.


ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

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 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

CONTACT NAME:
PHONE (A/C, No, Ext):
FAX (A/C, No):
E-MAIL ADDRESS:
PRODUCER CUSTOMER ID #:

INSURER(S) AFFORDING COVERAGE — NAIC #
INSURER A :
INSURER B :
INSURER C :
INSURER D :
INSURER E :
INSURER F :

A

COVERAGES — CERTIFICATE NUMBER: — REVISION NUMBER:

B

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.

TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
GENERAL LIABILITY						EACH OCCURRENCE $
COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence) $
CLAIMS-MADE OCCUR						MED EXP (Any one person) $
	Y		C			PERSONAL & ADV INJURY $
						GENERAL AGGREGATE $
GEN'L AGGREGATE LIMIT APPLIES PER: POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG $
						$
AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident) $
ANY AUTO						BODILY INJURY (Per person) $
ALL OWNED AUTOS						BODILY INJURY (Per accident) $
SCHEDULED AUTOS						PROPERTY DAMAGE (Per accident) $
HIRED AUTOS						$
NON-OWNED AUTOS						$
UMBRELLA LIAB OCCUR						EACH OCCURRENCE $
EXCESS LIAB CLAIMS-MADE						AGGREGATE $
DEDUCTIBLE						$
RETENTION $						$
WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						WC STATU-TORY LIMITS OTH-ER
ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) N / A						E.L. EACH ACCIDENT $
If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE $
						E.L. DISEASE - POLICY LIMIT $

D

H

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

F

CERTIFICATE HOLDER

CANCELLATION

G

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 25 (2009/09)