CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 2/17/2015

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: Ron Chretien
R G Wright Agency, Inc. PO Box 7008 Auburn NY 13022	PHONE (A/C, No, Ext): (315) 252-7561 FAX (A/C, No): (315) 255-0154 E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A: Erie Ins Company of NY	
INSURER B: Erie Insurance Company	26263
INSURER C:	
INSURER D:	
INSURER E:	
INSURER F:	

INSURED: Multimed Billing Service, Inc., D/B/A Multimed, P.O. Box 535, Baldwinsville NY 13027

COVERAGES **CERTIFICATE NUMBER:** CL1521701009 **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 INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY PRO-JECT LOC			Q426490011NY	6/14/2014	6/14/2015	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 $ 1,000,000 $ 5,000 $ 1,000,000 $ 2,000,000 $ 2,000,000
A	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS X HIRED AUTOS X NON-OWNED AUTOS			Q426490011NY	6/14/2014	6/14/2015	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
B	UMBRELLA LIAB X OCCUR EXCESS LIAB CLAIMS-MADE DED RETENTION $			Q30 6470012NY	6/14/2014	6/14/2015	EACH OCCURRENCE AGGREGATE	$ 5,000,000 $ 5,000,000
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y/N (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A					WC STATU-TORY LIMITS OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ $ $
A	EMPLOYEE DISHONESTY BOND INCL PROP OF OTHERS			Q426490011NY	6/14/2014	6/14/2015	$35,000 LIMIT	

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

CITY OF SARATOGA SPRINGS, NY ; ITS ELECTED AND/OR APPOINTED OFFICIALS, OFFICERS, AGENTS AND EMPLOYEES ARE ADDITIONAL INSURED ON A PRIMARY AND NON-CONTRIBUTORY BASIS.

CERTIFICATE HOLDER

City of Saratoga Springs
Office of Risk & Safety
474 Broadway
Saratoga Springs, NY 12866

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

Patty Curtis/PC Patricia S. Curtis

OP ID: JG

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 02/20/2015

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 The Savage Agency, Inc. 2700 Bellevue Ave. Syracuse, NY 13219	CONTACT NAME: PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL ADDRESS: PRODUCER CUSTOMER ID #: MULTI-1
INSURED MULTIMED BILLING SERVICE INC PO BOX 535 BALDWINSVILLE, NY 13027	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A : GENERAL CASUALTY — 381 INSURER B : HANOVER INSURANCE COMPANY — 158 INSURER C : AMERICAN INTERNATIONAL GROUP, — INSURER D : INSURER E : INSURER F :

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 INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY PRO-JECT LOC			CCS0641805	02/28/2014	02/28/2015	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 $ 100,000 $ 5,000 $ 1,000,000 $ 1,000,000 $ NO COV
	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS HIRED AUTOS NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (PER ACCIDENT)	$ $ $ $
A	UMBRELLA LIAB X OCCUR EXCESS LIAB CLAIMS-MADE DEDUCTIBLE X RETENTION $ 10000			CCU0641805	02/28/2014	02/28/2015	EACH OCCURRENCE AGGREGATE	$ 3,000,000 $ 3,000,000
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y/N (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A					WC STATU-TORY LIMITS OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ $ $
B	Crime			BDS1819030	07/20/2014	07/20/2015	LIMIT	1,000,000
C	Professional E&O			7421618	05/20/2014	05/20/2015	LIAB	1,000,000

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

CERTIFICATE HOLDER

CITY OF SARATOGA SPRINGS
OFFICE OF RISK & SAFETY
474 BROADWAY
SARATOGA SPRINGS, NY 12866

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

John D Savage

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

NOTICE OF COMPLIANCE
DISABILITY BENEFITS LAW
TO EMPLOYEES

1. If you are unable to work because of an illness or injury not work-related, you may be entitled to receive weekly benefits from your employer, or his or her insurance company, or from the Special Fund for Disability Benefits.
2. To claim benefits you must file a claim form, within 30 days from the first date of your disability, but in no event more than 26 weeks from such date.
3. Use one of the following claim forms:
   -If, when your disability begins, you are employed or are unemployed for four weeks or less, use claim form DB-450, which you may obtain from your employer, his or her insurance carrier, your health provider or any office of the Workers' Compensation Board, and send it to your employer or the insurance carrier named below.
   -If, when your disability begins, you have been unemployed more than four weeks, use claim Form DB-300, which you may obtain from any Unemployment Insurance Office, your health provider, or any office of the Workers' Compensation Board. Send completed claim form to the Workers' Compensation Board, Disability Benefits Bureau, Albany, New York 12241. **IMPORTANT:** Before filing your claim, your health provider must complete the "Health Care Provider's Statement" on the claim form, showing your period of disability.
4. You are entitled to be treated by any physician, chiropractor, dentist, nurse-midwife, podiatrist or psychologist of your choice. However, unlike workers' compensation, your medical bills will not be paid unless your employer and/or union provide for the payment of such bills under a Disability Benefits Plan or Agreement.
5. If you are ill or injured during the time you are receiving Unemployment Insurance Benefits, file a claim for Disability Benefits as soon as you sustain the injury or illness, by following the instructions outlined above.
6. If you are out of work in excess of seven days, your employer is required to send you a Disability Benefits Statement of Rights (Form DB-271S).
7. Other information about Disability Benefits may be obtained by writing or calling the nearest Workers' Compensation Board Office.

WORKERS' COMPENSATION BOARD OFFICES

Albany, 12241 - 100 Broadway - Menands - (866) 750-5157
Binghamton, 13901 - State Office Bldg. - 44 Hawley St.- (866) 802-3604
Brooklyn, 11201 - 111 Livingston St.- Brooklyn - (800) 877-1373
Buffalo, 14202 - 369 Franklin Street - (866) 211-0645
Hauppauge, 11788 - 220 Rabro Drive - Suite 100 - (866) 681-5354
Hempstead, 11550 - 175 Fulton Avenue - (866) 805-3630
New York, 10027 - 215 W.125th St. - Manhattan - (800) 877-1373
Peekskill, 10566 - 41 North Division St. - (866) 746-0552
Queens, 11432 - 168-46 91st Ave. - Jamaica - (800) 877-1373
Rochester, 14614 - 130 Main Street West - (866) 211-0644
Syracuse, 13203 935 James St.- (866) 802-3730

ESTADO DE NUEVA YORK
JUNTA DE COMPENSACION OBRERA

AVESO DE CUMPLIMENTO
LEY DE BENEFICIOS POR
INCAPACIDAD LOS EMPLEADOS

1. Si usted no puede trabajar debido a enfermedad o lesión no relacionada con el trabajo, podría tener derecho a recibir beneficios semenales de su patrón o de la compañia de seguros de él/ella o del Fondo Especial para Beneficios por Incapacidad.
2. Para reclamar beneficios usted debe presentar una forma de reclamación, dentro de 30 dias a partir de la primera fecha de su incapacidad, pero en ningun caso más de 26 semanas de dicha fecha.
3. Use una de las siguientes formas de reclamación:
   -Si, cuando comience su incapacidad usted está empleado o ha estado desempleado por cuatro semanas o menos, use la forma de reclamación (Form DB-450), la cual puede obtener de su patrón o de la compañia de seguros de él/ella, o de su proveedor de cuidados de salud, o bien de cualquier oficina de la Junta de Compensación Obrera, y enviela a su patrón o a la compañia de seguros nombreda abajo.
   -Si cuando comience su incapacidad, usted ha estado desempleado más de cuatro semanas, use la forma de reclamación (Form DB-300), la cual puede obtener en cualquier Oficina de Seguro de Desempleo, de su proveedor de salud, o bien de cualquier oficina de la Junta de Compensación Obrera. Envie la forma de reclamación, debidamente terminada, a Workers' Compensation Board, Disability Benefits Bureau, Albany, New York 12241. **IMPORTANTE:** Antes de presentat usted su reclamación, es necesario que su proveedor de salud complete la declaracion del médico ("Health Care Provider's Statement") en la Forma de relamacion, indicando el periodo de su incapacidad.
4. Usted tiene derecho a ser tratado por cualquier médico, quiropráctico, dentista, enfermera-partera, podiatra o psicólogo que usted elija. Pero, contrario ala compensación obrera, sus cuentas médicas no seran pagadas a menos que su patrón y/o Unión haga el pago de tales cuentas médicas bajo un Plan o Convenio de Beneficios por Incapacidad.
5. Si estuviera usted enfermo o lesionado durante el tiempo que esté recibiendo beneficios del Seguro de Desempleo, presente una reclamación para Beneficios por Incapacidad, siguiendo las instrucciones arriba descritas, tan pronto como sufra la lesión o la enfermedad.
6. Si usted está desempleado por mas de siete dias, su patrón está obligado a enviarle la Declaración de Derechos de Beneficios por Incapacidad (Form DB-271S).
7. Otras informaciones relativas a Beneficios por Incapacidad pueden obtenerse escribiendo o llamando ala oficina más cercana de la Junta de Compensación Obrera.

Robert E. Beloten

ROBERT E. BELOTEN
CHAIR/PRESIDENTE

www.wcb.state.ny.us

The undersigned employer is in compliance with the provisions of the Disability Benefits Law (El patron abajo firmante esta en conformidad con las disposiciones de la lay de Beneficios por Incapacidad).
Disability Benefits, when due, will be paid by (Los Beneficios por Incapacidad, cuando debidos, seran pagados por):

Name, Address and Phone No. of DB Insurance Carrier
Guardian Life Insurance Company of America
7 Hanover Square, New York NY 10004
800-268-2525

Effective: From 01/01/2006 To 12/31/2015
(En Vigor Desde) (Hasta)

Policy No. 00971335-0000
(Poliza No.)

The benefits provided are (Los beneficios provistos son)

X	Statutory		Under a Plan or Agreement

Class(es) of employees covered (Clase(s) de empleados amparados

Name of employer (Nombre del Patron)
MULTIMED BILLING SERVICE, INC.

By: **The Guardian Life Insurance Company of America**

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.
LA JUNTA DE COMPENSACION OBRERA EMPLEA Y SIRVE A PERSONAS INCAPACITADAS SIN DISCRIMINAR.

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

DB-120 (1-11) Prescribed by Chair
Workers' Compensation Board
State of New York

STATE OF NEW YORK – WORKERS' COMPENSATION BOARD

ESTADO DE NUEVA YORK - JUNTA DE COMPENSACION OBRERA

NOTICE OF COMPLIANCE TO EMPLOYEES

IMPORTANT INFORMATION FOR EMPLOYEES WHO ARE INJURED OR SUFFER AN OCCUPATIONAL DISEASE WHILE WORKING.

1. By posting this notice and information concerning your rights as an injured worker, your employer is in compliance with the Workers' Compensation Law.
2. If you do not notify your employer within 30 days of the date of your injury your claim may be disallowed, so do so immediately.
3. You are entitled to obtain any necessary medical treatment and should do so immediately.
4. You may choose any doctor, podiatrist, chiropractor or psychologist referred by a medical doctor that accepts NY State Workers' Compensation patients and is Board authorized. However, if your employer is involved in a certified preferred provider organization (PPO) you must first be treated by a provider chosen by your employer and your employer must give you a written statement of your rights concerning further medical care.
5. You should tell your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and with your employer's insurance company, which is indicated at the bottom of this form.
6. You may be entitled to lost time benefits if your work-related injury keeps you from work for more than seven days, compels you to work at lower wages or results in permanent disability to any part of your body. You may be entitled to rehabilitation services if you need help returning to work.
7. You should not pay any medical providers directly. They should send their bills to your employer's insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for the payment of the bills.
8. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire a representative do not pay him/her directly. Any fee will be set by the Board and will be deducted from your award.
9. If you have difficulty in obtaining a claim form or need help in filling it out, or if you have any other questions or problems about a job-related injury, contact any office of the Workers' Compensation Board.

WORKERS' COMPENSATION BOARD OFFICES

Albany, 12241 – 100 Broadway-Menands – (866) 750-5157
***Brooklyn, 11201 – 111 Livingston St. – Brooklyn – (800) 877-1373**
Binghamton, 13901 – State Office Bldg. – 44 Hawley St. – (866) 802-3604
Buffalo, 14202 – 295 Main Street, Suite 400 - (866) 211-0645
***Hauppauge, 11788 – 220 Rabro Drive – Suite 100 – (866) 681-5354**
***Hempstead, 11550 – 175 Fulton Avenue – (866) 805-3630**
***New York, 10027 – 215 W.125th St., Manhattan – (800)-877-1373**
***Peekskill, 10566 – 41 North Division St. (866) 746-0552**
***Queens, 11432 – 168-46 91st Ave., Jamaica (800) 877-1373**
Rochester, 14614 – 130 Main Street West – (866) 211-0644
Syracuse, 13203 – 935 James St. – (866) 802-3730

*** DOWNSTATE MAILING ADDRESS**

Claims-related mail for the Hauppauge, Hempstead, Peekskill and all NYC offices should be mailed to: **PO Box 5205 Binghamton, NY 13902-5205**

Statewide Fax: 877-533-0337

AVISO DE CUMPLIMIENTO A EMPLEADOS

INFORMACION IMPORTANTE PARA EMPLEADOS QUE SEAN LESIONADOS O SUFRAN UNA ENFERMEDAD OCUPACIONAL MIENTRAS TRABAJAN.

1. Su patrono está cumpliendo la Ley de Compensación Obrera cuando despliega este comunicado concerniente a sus derechos como trabajador lesionado.
2. Si usted no notifica a su patrono dentro del término de 30 dias de haber sufrido su lesión su reclamación podria ser desestimada, por eso notifique inmediatamente.
3. Usted tiene derecho a recibir cualquier tratamiento médico necesario relacionado con su lesión y debe gestionarlo inmediatamente.
4. Para el tratamiento de cualquier lesión o enfermedad relacionada con el trabajo, usted puede escoger cualquier médico, podiatra, quiropractico ó psicologo (si es referido por un médico autorizado) que esté autorizado y acepte pacientes de la Junta de Compensación Obrera. Sin embargo, si su patrono está autorizado a participar en una organización certificada de proveedores preferidos (PPO), usted deberá obtener tratamiento inicial para cualquier lesión o enfermedad relacionada con el trabajo de la correspondiente entidad. Patronos que participen en cualquiera de estos programas establecidos por ley estan obligados a proveer a sus empleados notificación escrita explicando sus derechos y obligaciones bajo el programa a que esté acogido.
5. Usted deberá requerir de su Médico que radique copias de los informes médicos de su caso en la Junta de Compensación Obrera y en la compañia de seguros de su patrono, que se indica al final de esta forma.
6. Usted tiene derecho a compensación si su lesión relacionada con el trabajo le impide trabajar por más de siete días, le obliga a trabajar a sueldo más bajo ó resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitación si necesita ayuda para regresar al trabajo.
7. No pague a ningun proveedor médico directamente por tratamiento de su lesión o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas al asegurador de su patrono. Si el caso es cuestionado, el proveedor deberá esperar hasta que la Junta decida el caso, antes de iniciar gestión de cobro alguna contra usted. Si usted no tramita su caso ó la Junta falla que su lesión o enfermedad no está relacionada con el trabajo, usted podría ser responsable del pago de las facturas.
8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado ó por representante licenciado si usted así lo desea. Si es representado, no pague al abogado ó al representante licenciado. Cuando la Junta decida su caso, los honorarios seran determinados por la Junta y descontados de sus beneficios.
9. Si tiene dificultad en conseguir un formulario de reclamación o necesita ayuda para llenarlo ó tiene dudas sobre cualquier situación relacionada con una lesión o enfermedad comuniquese con la oficina mas cercana de la Junta.

Robert E. Beloten

ROBERT E. BELOTEN, CHAIR/PRESIDENTE

Workers' Compensation benefits, when due, will be paid by (Los beneficios de Compensación Obrera, cuando debidos, seran pagados por):

Name, address and telephone number of licensed insurance carrier, authorized group self-insurer or main office of authorized self-insurer

MULTIMED BILLING SERVICES INC

THE TRAVELERS INSURANCE COMPANIES
P.O.BOX 466 (WC)
ALBANY, NY 12201-0466
1-800-238-6225

For Insurance Carriers ONLY: Policy No 9A179197
Policy in Force from 01-22-15 *to* 01-22-16

Name of employer (Nombre del patrono)

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

Failure by an employer to post this notice in and about the employer's place or places of business may result in a $250 penalty for each violation.

C-105 (1-11) Workers' Compensation Board Prescribed of by Chairman State New York *www.wcb.state.ny.us*

001140

W31P1N11