

**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

<p>1a. Legal Name and Address of Insured (Use street address only)</p> <p>Stilsing Electric, Inc. PO Box 27 Rensselaer, NY 12144</p>	<p>I b. Business Telephone Number of Insured (518) 463-4451</p> <p>I c. NYS Unemployment Insurance Employer Registration Number of Insured 17 12789</p> <p>I d. Federal Employer Identification Number of Insured or Social Security Number 14-1431598</p>
<p>2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) City of Saratoga Spring 474 Broadway Saratoga Springs NY 12866</p>	<p>3a. Name of Insurance Carrier ShelterPoint Life Insurance Company (Previously First Rehabilitation Life)</p> <p>3b. Policy Number of entity listed in box "1a": D114323</p> <p>3c. Policy effective period: December 31, 2014 to December 31, 2015</p>
<p>4. Policy covers:</p> <p>a. <input checked="" type="checkbox"/> All of the employer's employees eligible under the New York Disability Benefits Law</p> <p>b. <input type="checkbox"/> Only the following class or classes of the employer's employees:</p> <p>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 NYS Disability Benefits insurance coverage as described above.</p> <p>Date Signed <u>3/2/15</u> By <u><i>Laurie Teller</i></u> _____ (Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of the insurance carrier)</p> <p>Telephone Number <u>518-244-4214</u> Title <u>Assistant Vice President</u></p> <p>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.</p>	

PART 2. To be completed by the 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 _____
 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.

Additional Instructions for Form DB-120.1

By signing this form, the insurance carrier identified in box "3" on this form is certifying that it is insuring the business referenced in box "1a" for disability benefits under the New York State Disability Benefits Law. The Insurance Carrier or its licensed agent will send this Certificate of Insurance to the entity listed as the certificate holder in box "2". ***This Certificate is valid for the earlier of one year after this form is approved by the insurance carrier or its licensed agent, or the policy expiration date listed in box "3c".***

Please Note: Upon the cancellation of the disability benefits 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 NYS Disability Benefits Coverage or other authorized proof that the business is complying with the mandatory coverage requirements of the New York State Disability Benefits Law.

DISABILITY BENEFITS LAW

§220. Subd. 8

(a) The head of a state or municipal department, board, commission or office authorized or required by law to issue any permit for or in connection with any work involving the employment of employees in employment as defined in this article, and notwithstanding any general or special statute requiring or authorizing the issue of such permits, shall not issue such permit unless proof duly subscribed by an insurance carrier is produced in a form satisfactory to the chair, that the payment of disability benefits for all employees has been secured as provided by this article. Nothing herein, however, shall be construed as creating any liability on the part of such state or municipal department, board, commission or office to pay any disability benefits to any such employee if so employed.

(b) The head of a state or municipal department, board, commission or office authorized or required by law to enter into any contract for or in connection with any work involving the employment of employees in employment as defined in this article, and notwithstanding any general or special statute requiring or authorizing any such contract, shall not enter into any such contract unless proof duly subscribed by an insurance carrier is produced in a form satisfactory to the chair, that the payment of disability benefits for all employees has been secured as provided by this article.