CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

1A Legal Name and address of Insured (use street address only) Systems Management Planning Inc 1020 John St West Henrietta NY 14586 Work location of Insured (*only required if coverage is specifically limited to certain locations in NY state, i.e. Wrap-Up Policy.)*	1b. Business Telephone Number of Insured 585-475-0670 1c. NYS Unemployment Insurance Employer Registration Number of Insured 1d. Federal Employer Identification Number of Insured or Social Security Number 16-1545953
2. Name and Address of the Entity Requesting Proof of Coverage (Entity being listed as the Certificate Holder) Ontario County 20 Ontario St Canandaigua NY 14424	3a. Name of Insurance Carrier Travelers Property & Casualty 3b. Policy Number of entity listed in box "1a": UB6F415700 3c. Policy Effective period: ___03/12/15_____ to ____03/12/16_____ 3d. The Proprietor, Partners, or Executive Officers are: □ included. (only check box if all partners/officers included) x all excluded or certain partners/officers excluded. 3e. Demolition is (definition of demolition on Reverse) □ included. □ excluded.

This certifies that the insurance carrier indicated above in box "3" insures the business referenced above in box "1a" for workers' compensation under the New York State Workers' Compensation Law. (To use this form, New York (NY) must be listed under **Item 3A** on the INFORMATION PAGE of the workers' compensation insurance policy). The Insurance Carrier or its licensed agent will send this Certificate of Insurance to the entity listed above as the certificate holders in box "2".

The Insurance Carrier will also notify the above certificate holder within 10 days IF a policy is canceled due to nonpayment of premiums or within 30 days IF there are reasons other than nonpayment of premiums that cancel the policy or eliminate the insured from the coverage indicated on this Certificate. (These notices may be sent by regular mail.) Otherwise, this Certificate 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 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 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: _____Shavonne G Smith_____

(Print name of authorized representative or licensed agent of insurance carrier)

Approved by: ___  ___8/28/15_____

(Signature) (Date)

Title: ____Agent _____

Telephone number of authorized representative or licensed agent of insurance carrier: _585-265-6060_____

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)