



INSURANCE AGREEMENT– FOOD SERVICE PROVIDERS

1. Notwithstanding any terms, conditions or provisions, in any other writing between the parties, the food service provider hereby agrees to effectuate the naming of the District/BOCES as an Additional Insured on the food service provider's insurance policies, except for workers' compensation and N.Y. State Disability insurance.
2. The policy naming the District as an Additional Insured shall:
 - a. Be an insurance policy from an A.M. Best A- rated or better insurer, licensed to conduct business in New York State. A New York licensed and admitted insurer is strongly preferred. The decision to accept non-licensed and non-admitted carriers lies exclusively with the District/BOCES and may create significant vulnerability and costs for the District/BOCES.
 - b. State that the organization's coverage shall be primary and non-contributory coverage for the District/BOCES, its Board, employees and volunteers including a waiver of subrogation in favor of the District/BOCES for all coverages including workers compensation.
 - c. Additional insured status shall be provided by standard or other endorsements that extend coverage to the District/BOCES for on-going operations (CG 20 38) and products and completed operations (CG 20 37). The decision to accept an endorsement rests solely with the District/BOCES. A completed copy of the endorsements must be attached to the Certificate of Insurance.
3.
 - a. The certificate of insurance must describe the services provided by the food service provider that are covered by the liability policies.
 - b. At the District's/BOCES' request, the food service provider shall provide a copy of the declaration page of the liability and umbrella/excess policies with a list of endorsements and forms. If requested, the food service provider will provide a copy of the policy endorsements and forms.
4. The food service provider agrees to indemnify the District/BOCES for applicable deductibles and self-insured retentions.



INSURANCE AGREEMENT– FOOD SERVICE PROVIDERS (Cont'd)

5. Minimum Required Insurance:
 - a. **Commercial General Liability Insurance**
\$2,000,000 per Occurrence/ \$4,000,000 Aggregate
\$2,000,000 Products and Completed Operations
\$1,000,000 Personal and Advertising Injury
\$100,000 Fire Damage
\$10,000 Medical Expense
 - b. **Automobile Liability**
\$1,000,000 combined single limit for owned, hired, borrowed and non-owned motor vehicles.
 - c. **Workers' Compensation and NYS Disability Insurance**
Statutory Workers' Compensation (C-105.2 or U-26.3); and NYS Disability Insurance (DB-120.1) for all employees. Proof of coverage must be on the approved specific form, as required by the New York State Workers' Compensation Board. ACORD certificates are not acceptable. A person seeking an exemption must file a CE-200 Form with the state. The form can be completed and submitted directly to the WC Board online.
 - d. **Umbrella/Excess Insurance**
\$5 million each Occurrence and Aggregate. Umbrella/Excess coverage shall be on a follow-form basis over the required Auto Liability and General Liability coverages.
 - e. State that the organization's coverage shall be primary and non-contributory coverage for the District/BOCES, its Board, employees and volunteers including a waiver of subrogation in favor of the District/BOCES for all coverages including workers compensation.
6. The Food service provider acknowledges that failure to obtain such insurance on behalf of the District/BOCES constitutes a material breach of contract. The food service provider is to provide the District/BOCES with a certificate of insurance, evidencing the above requirements have been met, prior to the commencement of work.



Note to Subscribers Regarding Use of Facilities

Once again, to increase the likelihood of transferring the financial responsibility to adjust a loss from the subscriber to a facility user, we continue to recommend subscribers use the following language on all use of facilities forms or applications. Facilities users should be required to sign or agree to this language.

SAMPLE INDEMNIFICATION AGREEMENT

(NAME OF FACILITY USER) does covenant and agree to defend, indemnify and hold harmless the (*Levittown School District*) from and against any and all liability, loss, damages, claims or actions (including costs and attorney's fees) for bodily injury and/or property damage, to the extent permissible by law, arising out of or in any way connected with the actual or proposed use of (*Levittown School District*) property, facilities and/or services, including but not limited to bodily injury to any employee, invitee, guest, spectator, contractor or subcontractor of (FACILITY USER).

(FACILITY USER) understands and agrees that its use of (*Levittown School District*) property and facilities includes, but is not limited to, all areas identified in the application and/or permit, and sidewalks, walkways, parking lots, entrances, stairs, and all other areas incidental to and/or connected with the use of the premises (hereinafter referred to as "incidental areas").

(FACILITY USER) agrees that its indemnity and insurance obligations extend to the areas identified in the application and/or permit and any and all incidental areas.

FOOD SERVICE PROVIDER NAME:

FOOD SERVICE PROVIDER SIGNATURE:

DATE:

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

**ADDITIONAL INSURED – OWNERS, LESSEES OR
CONTRACTORS – COMPLETED OPERATIONS**

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART
PRODUCTS/COMPLETED OPERATIONS LIABILITY COVERAGE PART

SCHEDULE

Name Of Additional Insured Person(s) Or Organization(s)	Location And Description Of Completed Operations

Information required to complete this Schedule, if not shown above, will be shown in the Declarations.

A. Section II – Who Is An Insured is amended to include as an additional insured the person(s) or organization(s) shown in the Schedule, but only with respect to liability for "bodily injury" or "property damage" caused, in whole or in part, by "your work" at the location designated and described in the Schedule of this endorsement performed for that additional insured and included in the "products-completed operations hazard".

However:

1. The insurance afforded to such additional insured only applies to the extent permitted by law; and
2. If coverage provided to the additional insured is required by a contract or agreement, the insurance afforded to such additional insured will not be broader than that which you are required by the contract or agreement to provide for such additional insured.

B. With respect to the insurance afforded to these additional insureds, the following is added to **Section III – Limits Of Insurance:**

If coverage provided to the additional insured is required by a contract or agreement, the most we will pay on behalf of the additional insured is the amount of insurance:

1. Required by the contract or agreement; or
2. Available under the applicable Limits of Insurance shown in the Declarations;

whichever is less.

This endorsement shall not increase the applicable Limits of Insurance shown in the Declarations.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

**ADDITIONAL INSURED – OWNERS, LESSEES OR
CONTRACTORS – AUTOMATIC STATUS FOR OTHER
PARTIES WHEN REQUIRED IN WRITTEN
CONSTRUCTION AGREEMENT**

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART

A. Section II – Who Is An Insured is amended to include as an additional insured:

1. Any person or organization for whom you are performing operations when you and such person or organization have agreed in writing in a contract or agreement that such person or organization be added as an additional insured on your policy; and
2. Any other person or organization you are required to add as an additional insured under the contract or agreement described in Paragraph 1. above.

Such person(s) or organization(s) is an additional insured only with respect to liability for "bodily injury", "property damage" or "personal and advertising injury" caused, in whole or in part, by:

- a. Your acts or omissions; or
- b. The acts or omissions of those acting on your behalf;

in the performance of your ongoing operations for the additional insured described in Paragraph 1. or 2. above.

However, the insurance afforded to such additional insured described above:

- a. Only applies to the extent permitted by law; and
- b. Will not be broader than that which you are required by the contract or agreement to provide for such additional insured.

A person's or organization's status as an additional insured under this endorsement ends when your operations for the person or organization described in Paragraph 1. above are completed.

B. With respect to the insurance afforded to these additional insureds, the following additional exclusions apply:

This insurance does not apply to:

1. "Bodily injury", "property damage" or "personal and advertising injury" arising out of the rendering of, or the failure to render, any professional architectural, engineering or surveying services, including:
 - a. The preparing, approving, or failing to prepare or approve, maps, shop drawings, opinions, reports, surveys, field orders, change orders or drawings and specifications; or
 - b. Supervisory, inspection, architectural or engineering activities.

This exclusion applies even if the claims against any insured allege negligence or other wrongdoing in the supervision, hiring, employment, training or monitoring of others by that insured, if the "occurrence" which caused the "bodily injury" or "property damage", or the offense which caused the "personal and advertising injury", involved the rendering of, or the failure to render, any professional architectural, engineering or surveying services.

2. "Bodily injury" or "property damage" occurring after:
 - a. All work, including materials, parts or equipment furnished in connection with such work, on the project (other than service, maintenance or repairs) to be performed by or on behalf of the additional insured(s) at the location of the covered operations has been completed; or

b. That portion of "your work" out of which the injury or damage arises has been put to its intended use by any person or organization other than another contractor or subcontractor engaged in performing operations for a principal as a part of the same project.

C. With respect to the insurance afforded to these additional insureds, the following is added to **Section III – Limits Of Insurance:**

The most we will pay on behalf of the additional insured is the amount of insurance:

1. Required by the contract or agreement described in Paragraph A.1.; or

2. Available under the applicable limits of insurance;
whichever is less.

This endorsement shall not increase the applicable limits of insurance.

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

<p>1a. Legal Name & Address of Insured (Use street address only)</p> <p><i>Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e., a Wrap-Up Policy)</i></p>	<p>1b. Business Telephone Number of Insured</p> <p>1c. NYS Unemployment Insurance Employer Registration Number of Insured</p> <p>1d. Federal Employer Identification Number of Insured or Social Security Number</p>
<p>2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)</p>	<p>3a. Name of Insurance Carrier</p> <p>3b. Policy Number of entity listed in box "3a"</p> <p>3c. Policy effective period</p> <p>4. All Proprietor, Partners or Executive Officers are included. (Only check box if all partners/officers included)</p> <p><input type="checkbox"/> 5. All Proprietor, Partners or Executive Officers are excluded or certain partners/officers excluded.</p>

This certifies that the insurance carrier named above in box "3a" insures the business referenced above in box "1a" for workers' compensation under the New York State Workers' Compensation Law. (To be valid, 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 holder in box "2".

The Insurance Carrier will 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. Notices may be sent by regular mail. **Otherwise, this Certificate is valid for one year after this form is approved by the insurance carrier or its licensed agent, or until the policy expiration date listed in box "3c", whichever is earlier.**

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

Approved by: _____ (Signature) _____ (Date)

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 Form C-105.2. Insurance brokers are NOT authorized to issue it.

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>1b Business Telephone Number of Insured</p> <p>1c. NYS Unemployment Insurance Employer Registration Number of Insured</p> <p>1d Federal Employer Identification Number of Insured or Social Security Number</p>
<p>2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)</p> <p>Levittown Public Schools 150 Abbey Lane Levittown, NY 11756</p>	<p>3a. Name of Insurance Carrier</p> <p>3b Policy Number of entity listed in box "1a":</p> <p>3c. Policy effective period: _____ to _____</p>

4 Policy covers:

a All of the employer's employees eligible under the New York Disability Benefits Law

b Only the following class or classes of the employer's employees:

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

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.



Workers' Compensation Board

**Certificate of Attestation of Exemption
from New York State Workers' Compensation and/or
Disability and Paid Family Leave 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 and paid family leave 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.

<p align="center">In the Application of (Legal Entity Name and Address):</p>	<p align="center">Business Applying For: OTHER: Use of school facility</p> <p align="center">Levittown Public Schools 150 Abbey Lane Levittown, NY 11756</p>
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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 and Paid Family Leave Benefits Exemption Statement:

The above named business is certifying that it is **NOT REQUIRED TO OBTAIN NEW YORK STATE STATUTORY DISABILITY AND PAID FAMILY LEAVE 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 and paid family leave 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 and Paid Family Leave Benefits Law.)

I, Daniel B. Larkin, 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 and paid family leave benefits coverage is required, the above-named legal entity will immediately acquire appropriate New York State specific workers' compensation insurance and/or disability and paid family leave 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: _____
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Exemption Certificate Number

XXXX-XXXXXX

**Received
July 24, 2023
NYS Workers' Compensation Board**