

Sample of acceptable WC/DB documentation – ACORD FORMS are NOT ACCEPTABLE documentation for workers' compensation coverage

**Sample CE-200**

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.

To the Applicant of (Legal Entity Name and Address):  
 JOHN SMITH  
 112 MAIN STREET  
 ALBANY, NY 12242  
 Federal ID Number: XXXXXX789

Business Application Form BUILDING PERMIT  
 FROM: CITY OF ALBANY, DEPT OF BUILDING AND CODES  
 The location of these work will be indicated in 112 MAIN STREET, ALBANY, NY 12242.  
 Estimated date necessary to complete work associated with the building permit on from October 14, 2008 to March 31, 2009.  
 The estimated dollar amount of project is \$21,001 - \$84,000.

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 risks of the business are as employees, day labor, leased employees, temporary employees, part-time employees, unpaid volunteers or independent contractors.

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 is owned by one individual or partnership (LLC, LLP, PLLP or PLLP) under the laws of New York State and is not a corporation, it is not a 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 is a business with no NY location. In addition, the business does not require disability benefits coverage at this time since it has not employed one or more individuals on or less 10 days in any calendar year in New York State. (Out-of-state contractors are not considered to be employees under the Disability Benefits Law.)

I, JOHN SMITH, as 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 information made herein are true and 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 this document, representation or statement will subject me to future criminal prosecution, including jail and bond liabilities 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 compensation, change in the workers' compensation insurance and 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 the coverage to the State of New York. Compensation listed in the permittee entry listed above.

Signature: JOHN SMITH Date: October 2, 2008  
 Exemption Certificate Number: 2008-00197  
 NYS Workers' Compensation Board

**Sample C-105.2**

STATE OF NEW YORK WORKERS' COMPENSATION BOARD  
 CERTIFICATE OF NY'S WORKERS' COMPENSATION INSURANCE COVERAGE

1. Legal Name and Address of Insured (Use street address only)  
 2. Business Telephone Number of Insured  
 3. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)  
 4. Business Employer Identification Number or Social Security Number  
 5. NYSE Unemployment Insurance Employer Registration Number of Insured  
 6. Federal Employer Identification Number of Insured  
 7. Name of Insurance Carrier  
 8. Policy Number of Entity Being Insured  
 9. Effective Date of Policy  
 10. Proprietor, Partners or Executive Officers are included, they shall be all persons/employees included or certain persons/officers excluded.

This certifies that the insurance certificate listed above is in full force and effect. The business referenced above in box "1" for workers' compensation under the New York State Workers' Compensation Law and the Disability Benefits Law (NY Workers' Compensation Law) is in the OPERATION FROM DATE of the work as indicated in box "2". The Insurance Carrier or its licensed agent will send this Certificate of Insurance to the entity listed in box "3".

The Insurance Carrier or its licensed agent shall provide the above certificate holder within 10 days if a policy is cancelled due to nonpayment of premiums or within 30 days if a policy is renewed. If either the above certificate holder or the insurance carrier fails to provide the certificate holder with a new Certificate of Insurance as required by the New York State Workers' Compensation Law, the business must provide the certificate holder with a new Certificate of Insurance as required by 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: \_\_\_\_\_ Date: \_\_\_\_\_  
 Title: \_\_\_\_\_  
 Telephone Number of authorized representative or licensed agent of insurance carrier: \_\_\_\_\_  
 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 C-105.2. Insurance brokers are NOT authorized to issue a C-105.2 (0-07) www.wcb.ny.gov

**Sample SI-12**

STATE OF NEW YORK WORKERS' COMPENSATION BOARD  
 CERTIFICATE OF INSURANCE COVERAGE UNDER THE NY'S DISABILITY BENEFITS LAW

1. Legal Name and Address of Insured (Use street address only)  
 2. Business Telephone Number of Insured  
 3. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)  
 4. Policy Number of Entity Being Insured  
 5. Effective Date of Policy

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.

Date Signed: \_\_\_\_\_  
 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)

**Sample U-26.3**

NEW YORK STATE INSURANCE FUND  
 Workers' Compensation & Disability Benefits Insurance Fund

CERTIFICATE OF WORKERS' COMPENSATION INSURANCE

1. Legal Name and Address of Insured (Use street address only)  
 2. Business Telephone Number of Insured  
 3. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)  
 4. Policy Number of Entity Being Insured  
 5. Effective Date of Policy

This certifies that the insurance certificate listed above is in full force and effect. The business referenced above in box "1" for workers' compensation under the New York State Workers' Compensation Law and the Disability Benefits Law (NY Workers' Compensation Law) is in the OPERATION FROM DATE of the work as indicated in box "2". The Insurance Carrier or its licensed agent will send this Certificate of Insurance to the entity listed in box "3".

The Insurance Carrier or its licensed agent shall provide the above certificate holder within 10 days if a policy is cancelled due to nonpayment of premiums or within 30 days if a policy is renewed. If either the above certificate holder or the insurance carrier fails to provide the certificate holder with a new Certificate of Insurance as required by the New York State Workers' Compensation Law, the business must provide the certificate holder with a new Certificate of Insurance as required by 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.

Date Signed: \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_  
 Title: \_\_\_\_\_

**Sample GSI-105.2**

STATE OF NEW YORK WORKERS' COMPENSATION BOARD  
 CERTIFICATE OF PARTICIPATION IN WORKERS' COMPENSATION GROUP SELF-INSURANCE

1. Legal Name and Address of Business Participating in Group Self-Insurance (Use Street Address Only)  
 2. Business Telephone Number of Business referenced in box "1"  
 3. NYSE Unemployment Insurance Employer Registration Number of Business referenced in box "1"  
 4. Federal Employer Identification Number of Business referenced in box "1"  
 5. Effective Date of Membership in the Group  
 6. Proprietor, Partners or Executive Officers are included (each check box if all persons/employees included) or excluded or certain persons/officers excluded.

This certifies that the business referenced above in box "1" is in compliance with the mandatory coverage requirements of the New York State Workers' Compensation Law and the Disability Benefits Law as a member of the Group Self-Insurance listed above in box "1". The business must provide the certificate holder with a new Certificate of Insurance as required by the New York State Workers' Compensation Law.

Under penalty of perjury, I certify that I am an authorized representative of the Group Self-Insurer referenced above and that the business referenced in box "1" has the coverage as depicted on this form.

Certified by: \_\_\_\_\_ Date: \_\_\_\_\_  
 Title: \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_

**Sample DB-120.1**

STATE OF NEW YORK WORKERS' COMPENSATION BOARD  
 CERTIFICATE OF INSURANCE COVERAGE UNDER THE NY'S DISABILITY BENEFITS LAW

1. Legal Name and Address of Insured (Use street address only)  
 2. Business Telephone Number of Insured  
 3. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)  
 4. Policy Number of Entity Being Insured  
 5. Effective Date of Policy

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.

Date Signed: \_\_\_\_\_  
 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)

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Sample of acceptable WC/DB documentation – **ACORD FORMS** are **NOT ACCEPTABLE** documentation for workers' compensation coverage

Sample DB-155

04/09/2010 10:57 FAX 0403-003

STATE OF NEW YORK  
WORKERS' COMPENSATION BOARD  
SELF-INSURANCE OFFICE  
20 PARK STREET - ROOM 208  
ALBANY, NY 12207  
(518) 485-0247  
FAX (518) 462-0199

COMPLIANCE WITH DISABILITY BENEFITS LAW  
(Pursuant to Section 210, subd. 4 of the Disability Benefits Law)

EMPLOYER	FEDERAL EMPLOYER IDENTIFICATION NUMBER
	LOCATION OF OPERATION
ADDRESS (HOME OR MAIN OFFICE)	OPERATION TO BE COVERED OR ABOUT:

There are on file with the Workers' Compensation Board documents indicating that the above-named employer has complied with the Disability Benefits Law with respect to all of his or her employees in the following manner:

By approved self-insurance pursuant to Section 211, subdivision 3 of the Disability Benefits Law

By a combination of approved self-insurance pursuant to Section 211, subdivision 3 of the Disability Benefits Law and insurance with authorized insurance carrier(s).

Date: \_\_\_\_\_

By: \_\_\_\_\_  
Glen Wagner  
WC Examiner

DB-155 (1/04)  
THIS AGENCY EMPLOYEES & SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

A CE-200 – Certificate of Attestation of Exemption from NYS Workers' Compensation and/or Disability Benefits Coverage can be [applied for online](http://www.wcb.ny.gov/content/ebiz/wc_db_exemptions/requestExemptionOverview.jsp) at [http://www.wcb.ny.gov/content/ebiz/wc\\_db\\_exemptions/requestExemptionOverview.jsp](http://www.wcb.ny.gov/content/ebiz/wc_db_exemptions/requestExemptionOverview.jsp)

For more details regarding Workers Compensation and Disability compliance documentation, please see the document [Prove It to Move It](http://www.wcb.ny.gov/content/main/Employers/ProveItToMoveIt.pdf) <http://www.wcb.ny.gov/content/main/Employers/ProveItToMoveIt.pdf>