

INSURANCE AGREEMENT - USE OF FACILITIES (Athletic) (ORGANIZED ATHLETIC ACTIVITIES AND ATHLETIC & RECREATION CAMPS)

- Notwithstanding any terms, conditions or provisions, in any other writing between the
 parties, the facility user hereby agrees to effectuate the naming of the *Levittown Public Schools* as an Additional Insured on the facility user's insurance policies, except for
 workers' compensation and N.Y. State Disability insurance.
- 2. The policy naming the Levittown Public Schools 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 *Levittown Public Schools* and may create significant vulnerability and costs for the *Levittown Public Schools*.
 - b. State that the organization's coverage shall be primary and non-contributory coverage for the Levittown Public Schools, its Board, employees and volunteers with a waiver of subrogation in favor of the Levittown School District for all coverages including Worker's Compensation.
 - c. Additional insured status shall be provided by standard or other endorsements that extend coverage to the *Levittown School District* (CG 20 26) or equivalent. The decision to accept an endorsement rests solely with the *Levittown School District*. A completed copy of the endorsements must be attached to the Certificate of Insurance.
- The certificate of insurance must describe the services provided by the facility user that are covered by the liability policies.
- 4. The facility user agrees to indemnify the *Levittown School District* for applicable deductibles and self-insured retentions.



INSURANCE AGREEMENT - USE OF FACILITIES (Athletic) (ORGANIZED ATHLETIC ACTIVITIES AND ATHLETIC & RECREATION CAMPS) (Cont'd)

5. Minimum Required Insurance:

a. Commercial General Liability Insurance

\$1,000,000 per Occurrence/ \$2,000,000 Aggregate,

with no exclusions for Athletic Participants

\$1,000,000 per Occurrence/ \$2,000,000 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 (When an organization's vehicle is brought onsite)

\$1,000,000 combined single limit for owned, hired, borrowed and non-owned motor vehicles.

c. Workers' Compensation and NYS Disability Insurance (For Organizations With Employees)

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

General Use

\$1 million each Occurrence and Aggregate. Umbrella/Excess coverage shall be on a follow-form basis over the required Auto Liability and General Liability coverages.

Organized Athletic Activities and Athletic/Recreational Camps

\$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.



Carnivals and Firework Displays, etc.

\$10 million each Occurrence and Aggregate. Umbrella/Excess coverage shall be on a follow-form basis over the required Auto Liability and General Liability coverages.

6. The facility user acknowledges that failure to obtain such insurance on behalf of the *Levittown School District* constitutes a material breach of contract. The facility user is to provide the *Levittown School District* with a certificate of insurance, evidencing the above requirements have been met, prior to the event.

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.



CERTIFICATE OF LIABILITY INSURANCE

REQUIRED

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				nolicy	ies) must he	andorsad	If SUPPOGATION IS W	AIV/ED	aubiant ta	
the terms and conditions of the policy certificate holder in lieu of such endor	, cert	ain p	olicies may require an er	ndorse	ment. A stat	ement on thi	s certificate does not co	nfer r	ights to the	
PRODUCER					CONTACT NAME:					
REQUIRED					PHONE (A/C, No, Ext): (A/C, No):					
				E-MAIL ADDRESS:						
					INS	URER(S) AFFOR	DING COVERAGE		NAIC#	
				INSURER A: REQUIRED				REQUIRED		
INSURED REQUIRED				INSURER B:						
				INSURER C:						
				INSURER D:						
				INSURER E :				(4)		
COVERAGES CERTIFICATE NUMBER:				INSURER F : REVISION NUMBER:						
THIS IS TO CERTIFY THAT THE POLICIES	OF	NSUF	RANCE LISTED BELOW HAV	/E BEE	N ISSUED TO	THE INSURE	D NAMED ABOVE FOR TH	E POL	ICY PERIOD	
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NSR LTR TYPE OF INSURANCE	ADDL	SUBR WVD	POLICY NUMBER		POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	3		
GENERAL LIABILITY							EACH OCCURRENCE	s	1,000,000	
X COMMERCIAL GENERAL LIABILITY							DAMAGE TO RENTED PREMISES (Ea occurrence)	\$		
CLAIMS-MADE OCCUR							MED EXP (Any one person)	5	10,000	
	X	X	Please Provide Policy #		Dates	Dates	PERSONAL & ADV INJURY	s	1,000,000	
							GENERAL AGGREGATE	s	2,000,000	
GEN'L AGGREGATE LIMIT APPLIES PER:								s	2,000,000	
POLICY PRO- JECT LOC								5	100,000	
AUTOMOBILE LIABILITY							COMBINED SINGLE LIMIT (Ea accident)		1,000,000	
ANY AUTO					Dates	Dates		\$ \$	1,000,000	
ALL OWNED SCHEDULED	x x	x	Please Provide Policy #				7	s		
NON-OWNED		(25.5)		1 -	54.00		PROPERTY DAMAGE	s		
HIRED AUTOS AUTOS	0 8					ŀ	(Fer accident)	\$		
X UMBRELLA LIAB OCCUR		x		Dates		Dates		9.74	5,000,000	
EXCESS LIAB CLAIMS-MADE	x		Please Provide Policy #		Dates			\$	5,000,000	
DED RETENTION\$		201010			Dates			\$	0,000,000	
WORKERS COMPENSATION							WC STATU- OTH-	\$		
AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE	N/A					Dates	TORY LIMITS ER	_		
OFFICER/MEMBER EXCLUDED? (Mandatory in NH)			Attach form C-105.2 orU-2	26.3	26.3 Dates			\$		
If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE				
DESCRIPTION OF OPERATIONS DEIOW							E.L. DISEASE - POLICY LIMIT	\$		
DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICL	FS (A	ttach /	ACORD 101 Additional Remarks S	chedule	if more enace le	required)				
			TOOKD 101, Additional Remarks 3	ciledule,	ii iiiore space is	required)				
COVERAGE IS PRIMARY AND NON-CON	TRIB	UTO	RY IN FAVOR OF THE DIS	TRICT						
05071510 4 T5 1101 D 50										
CERTIFICATE HOLDER		-		CANC	ELLATION					
				SHO	III D ANY OF T	HE ABOVE D	SCRIBER POLICIES RE CA	NCEL	ED BEEODE	
LEVITTOWN PUBLIC SCHOOLS 150 ABBEY LANE					SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.					
										LEVITTOWN, NY 11756
956 L**558					AUTHORIZED REPRESENTATIVE					
750					MUST BE SIGNED					

POLICY NUMBER:

COMMERCIAL GENERAL LIABILITY

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

ADDITIONAL INSURED – DESIGNATED PERSON OR ORGANIZATION

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART.

SCHEDULE

Name of Person or Organization:

Levittown Public Schools 150 Abbey Lane Levittown, NY 11756

(If no entry appears above, information required to complete this endorsement will be shown in the Declarations as applicable to this endorsement.)

WHO IS AN INSURED (Section II) is amended to include as an insured the person or organization shown in the Schedule as an insured but only with respect to liability arising out of your operations or premises owned by or

STATE OF NEW YORK . WORKERS' COMPENSATION BOARD

CERTIFICATE OF NYS WORKERS' COMP	PENSATION INSURANCE COVERAGE
la. Legal Name & Address of Insured (Use street address only)	1b. Business Telephone Number of Insured
	1c. NYS Unemployment Insurance Employer Registration Number of Insured
Work Location of Insured (Only required if coverage is specifically timited to certain locations in New York State, i.e., a Wrap-Up Policy)	1d. Federal Employer Identification Number of Insured or Social Security Number
Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)	3a. Name of Insurance Carl 3b. Poli Number of entity listed in
This certifies that the insurance carrier 1 above in by "3" compensation under the New York State World The Constant of the New York State World The New York State Wor	Included. (Only theek box if all partners/officers are included.) excluded or certain partners/officers excluded. the business referenced above in box "la" for workers. (To this form, New York (NY) must be listed under Item 3A.
compensation under the New York State Workers' colors on the INFORMATION PAGE of the workers' colors this Certificate of Insurance to the entity listed above as the state of the Insurance Carrier will be aposity the above certificate holder with or within 30 days IF there as coverage undicated on this Certificate of the notices may be sent by this form is approved by the instrument of the workers' compensation named as a permit, license or contrict issued by a certificate hold Certificate of Workers' Compensation Goverage or other authoroverages.	thin 10 days IF a policy is canceled due to nonpayment of premiums between the cancel the policy or eliminate the instruct from the regular mail.) Otherwise, this Certificate is valid for one year after or until the policy expiration date listed in box "3c", whichever is no policy indicated on this form, if the business continues to be ler, the business must provide that certificate holder with a new rized proof that the business is complying with the mandatory
Under penalty of perjury, I comply that I am an authorized represent that the named insured has the coverage as depicted of Approved by:	esentative or licensed agent of the insurance carrier referenced on this form. the or beensed 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 as authorized to issue it	re authorized to issue Form C-105.2. Insurance brokers are NOT
C-105.2 (9-07)	www.web.state.ny us

STATE OF NEW YORK WORKERS' COMPENSATION BOARD

CERTIFICATE OF INSURANCE COVERAGE UNDER THE NYS DISABILITY BENEFITS LAW

20 De completed	by Disability Benefits Carrier	or Licensed Insurance Agent of that Comit
1a. Legal Name and Address o	f Insured (Use street address only)	or Licensed Insurance Agent of that Carrier 1b Business Telephone Number of Insured
		NYS Unemployment Insurance Employer Registration Number of Insured
		1d Federal Employer Identification Number of Insured or Social Security Number
Name and Address of the Ent Coverage (Entity Being Liste	ity Requesting Proof of d as the Certificate Holder)	3a Name of Insurance Carrier
Levittown Public S		3b Policy Number of entity listed in box "la":
150 Abbey La Levittown, NY 1	ne 1756	3c. Policy effective period:
4 Policy covers:		
Juder penalty of perjury I cartiful	that I are the character of the emplo	
Under penalty of perjury, I certify hat the named insured has NYS I	that I am an authorized representation	yer's employees:
Under penalty of perjury I cartifu	that I am an authorized representative insurance coverage by	yer's employees: /e or licensed agent of the insurance carrier referenced above an se as described above
Under penalty of perjury, I certify hat the named insured has NYS I	that I am an authorized representative insurance coverage by	yer's employees: /e or licensed agent of the insurance carrier referenced above an se as described above
Under penalty of perjury, I certify that the named insured has NYS I Date Signed Telephone Number	that I am an authorized representative bisability Benefits insurance coverage By (Signature of insurance carrier's authorized)	yer's employees: /e or licensed agent of the insurance carrier referenced above an se as described above prized representative or NYS Licensed Insurance Agent of that insurance carrier)
Under penalty of perjury, I certify that the named insured has NYS I Date Signed Telephone Number	that I am an authorized representative is ability Benefits insurance coverage By (Signature of insurance carrier's authorized insurance carrier's authorized insurance carrier's authorized in the ca	yer's employees: /e or licensed agent of the insurance carrier referenced above an ge as described above prized representative or NYS Licensed Insurance Agent of that insurance carrier)
Under penalty of perjury, I certify hat the named insured has NYS I Date Signed Telephone Number MPORTANT: If box "4a" is checked, it for "4b" is checked, the force of the second of	that I am an authorized representative insurance coverage is a coverage in the insurance coverage in the insurance carrier's authorized insurance carrier's authorized in this form is signed by the insurance carrier is a complete. Mail it directly to the ce is certificate is NOT COMPLETE for pure	yer's employees: ye or licensed agent of the insurance carrier referenced above an age as described above prized representative or NYS Licensed Insurance Agent of that insurance carrier) refer's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)
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Under penalty of perjury, I certify hat the named insured has NYS I Date Signed Telephone Number MPORTANT: If box "da" is checked, if box "4b" is checked, if for completion to the WART 2. To be completed by	that I am an authorized representative is authorized insurance coverage by the insurance coverage is complete. Mail it directly to the ce is certificate is NOT COMPLETE for pury forkers' Compensation Board, DB Plans Avives Workers' Compensation State Of New Workers' Compensation	yer's employees: Ye or licensed agent of the insurance carrier referenced above an age as described above Drized representative or NYS Licensed Insurance Agent of that insurance carrier) Trier's authorized representative or NYS Licensed Insurance Agent of that insurance Agent of that insurance Carrier) Trifficate holder. Poses of Section 220, Subd. 8 of the Disability Benefits Law. It must be mailed that the carrier of the Carrier of Section 220, Subd. 8 of the Disability Benefits Law. It must be mailed to the Carrier of Conty if box "4b" of Part 1 has been checked) To York Sation Roard
Under penalty of perjury, I certify hat the named insured has NYS I Date Signed Telephone Number MPORTANT: If box "da" is checked, if box "4b" is checked, if for completion to the WART 2. To be completed by	that I am an authorized representative is authorized insurance coverage by the insurance coverage is complete. Mail it directly to the ce is certificate is NOT COMPLETE for pury forkers' Compensation Board, DB Plans Avives Workers' Compensation State Of New Workers' Compensation	yer's employees: ye or licensed agent of the insurance carrier referenced above an age as described above prized representative or NYS Licensed Insurance Agent of that insurance carrier) priter's authorized representative or NYS Licensed Insurance Agent of that insurance Agent of that insurance Agent of the authorized representative or NYS Licensed Insurance Agent of that insurance Agent of the authorized Follows 1220, Subd. 8 of the Disability Benefits Law. It must be mailed to be acceptance Unit, 20 Park Street, Albany, New York 12207. Board (Only if box "4b" of Part 1 has been checked)
Under penalty of perjury, I certify that the named insured has NYS I Date Signed Telephone Number MPORTANT: If box "4a" is checked, the carrier, this certificate If box "4b" is checked, the for completion to the WART 2. To be completed by ecording to information maintained by isability Benefits Law with respect to	By (Signature of insurance carrier's authorized the insurance coverage of the form is signed by the insurance carrier's authorized the centre of insurance carrier's authorized the form is signed by the insurance carrier's authorized the centre of the ce	yer's employees: ye or licensed agent of the insurance carrier referenced above an age as described above prized representative or NYS Licensed Insurance Agent of that insurance carrier) prier's authorized representative or NYS Licensed Insurance Agent of that insura
Under penalty of perjury, I certify that the named insured has NYS I Date Signed Telephone Number MPORTANT: If box "4a" is checked, the carrier, this certificate if box "4b" is checked, the for completion to the WART 2. To be completed by coording to information maintained be isability Benefits Law with respect to	By (Signature of insurance carrier's authorized forms is signed by the insurance carrier's authorized forms is signed by the insurance carrier's authorized forms is signed by the insurance carrier's authorized forms is conflicted by the insurance carrier's authorized forms is signed by the insurance carrier's authorized forms is completely authorized forms in surance carrier's authorized forms in surance carrier	yer's employees: We or licensed agent of the insurance carrier referenced above and ge as described above prized representative or NYS Licensed Insurance Agent of that insurance carrier) prized representative or NYS Licensed Insurance Agent of that insurance Agent of

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)



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.

In the Application of (Legal Entity Name and Address):

Business Applying For: OTHER: Use of school facility

Levittown Public Schools 150 Abbey Lane Levitown, NY 11756

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:		
Exemption Certificate Number		Received		

July 24, 2023 NYS Workers' Compensation Board

XXXX-XXXXXX