INSURANCE AGREEMENT - USE OF FACILITIES (Non-Athletic)

1. 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*** 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 Public Schools including Worker's Compensation.

   c. Additional insured status shall be provided by standard or other endorsements that extend coverage to the ***Levittown Public Schools*** *(*CG 20 26*)* or equivalent. The decision to accept an endorsement rests solely with the ***Levittown Public Schools.*** A completed copy of the endorsements must be attached to the Certificate of Insurance.

3. 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 Public Schools*** for applicable deductibles and self-insured retentions.

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

INSURANCE AGREEMENT - USE OF FACILITIES (Non-Athletic) (Cont'd)

$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 Public Schools*** constitutes a material breach of contract. The facility user is to provide the ***Levittown Public Schools*** 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 Public Schools***) 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 Public Schools***) 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 Public Schools'***) 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.

FACILITY USER NAME: _____

FACILITY USER SIGNATURE _____

DATE: _____

INSURANCE ATTACHED: Please check documents provided:

____ ACORD FORM with General Liability/Auto/Umbrella Coverage
____ Additional Insured Endorsement Form (CG 20 26 or equivalent)
____ Worker's Comp (If applicable)
____ NYS Disability (If applicable)

August 2023

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 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 is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME:	
REQUIRED	PHONE (A/C, No, Ext):	FAX (A/C, No):
	E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : REQUIRED	REQUIRED
INSURED	INSURER B :	
REQUIRED	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS		
	GENERAL LIABILITY						EACH OCCURRENCE	$	1,000,000
	X COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$	
	CLAIMS-MADE OCCUR						MED EXP (Any one person)	$	10,000
		X	X	Please Provide Policy #	Dates	Dates	PERSONAL & ADV INJURY	$	1,000,000
							GENERAL AGGREGATE	$	2,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						PRODUCTS - COMP/OP AGG	$	2,000,000
	POLICY PRO-JECT LOC						FIRE DAMAGE	$	100,000
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$	1,000,000
	ANY AUTO						BODILY INJURY (Per person)	$	
	ALL OWNED AUTOS / SCHEDULED AUTOS	X	X	Please Provide Policy #	Dates	Dates	BODILY INJURY (Per accident)	$	
	HIRED AUTOS / NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$	
								$	
	X UMBRELLA LIAB OCCUR						EACH OCCURRENCE	$	5,000,000
	EXCESS LIAB CLAIMS-MADE	X	X	Please Provide Policy #	Dates	Dates	AGGREGATE	$	5,000,000
	DED RETENTION $							$	
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						WC STATU-TORY LIMITS OTH-ER		
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	N / A		Attach form C-105.2 orU-26.3	Dates	Dates	E.L. EACH ACCIDENT	$	
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$	
							E.L. DISEASE - POLICY LIMIT	$	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

COVERAGE IS PRIMARY AND NON-CONTRIBUTORY IN FAVOR OF THE DISTRICT

CERTIFICATE HOLDER

LEVITTOWN PUBLIC SCHOOLS
150 ABBEY LANE
LEVITTOWN, NY 11756

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
MUST BE SIGNED

ACORD 25 (2010/05)

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 rented to you.

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

1a. 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 limited to certain locations in New York State, i.e., a Wrap-Up Policy)*	1d. Federal Employer Identification Number of Insured or Social Security Number
2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)	3a. Name of Insurance Carrier 3b. Policy Number of entity listed in box "1" 3c. Policy effective period 4. The Proprietor, Partners or Executive Officers are ☐ included. (Only check box if all partners/officers included) ☐ excluded or certain partners/officers excluded.

SAMPLE

This certifies that the insurance carrier named above in box "3" 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 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 changes other than nonpayment of premiums that cancel the policy or eliminate the insured from the coverage indicated on this Certificate. (Cancellation notices may be sent by regular mail.) ***Otherwise, this Certificate is valid for one year after this form is approved by the insurance carrier, 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 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

C-105.2 (9-07) www.wcb.state.ny.us

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

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

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.***

DB-120.1 (5-06)

NEW YORK STATE | 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.**

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

XXXX-XXXXXX

Received

July 24, 2023

NYS Workers' Compensation Board

CE-200 01/2018