



**Workers' Compensation Board**

# CERTIFICATE OF INSURANCE COVERAGE DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

**PART 1. To be completed by Disability and Paid Family Leave Benefits Carrier or Licensed Insurance Agent of that Carrier**

<p>1a. Legal Name &amp; Address of Insured (use street address only) The Summit Center Inc. 150 Stahl Road Getzville, NY 14068</p> <p>Work Location of Insured <i>(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 (716) 629-3400</p> <p>1c. Federal Employer Identification Number of Insured or Social Security Number 16-1095750</p>
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<p>2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) NYSED Access- VR 89 Washington Ave Albany, NY 12234</p>	<p>3a. Name of Insurance Carrier Lincoln Life &amp; Annuity Company of New York</p> <p>3b. Policy Number of Entity Listed in box "1a" 000010266722</p> <p>3c. Policy effective period:  07/01/2021 to 07/01/2026</p>
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4. Policy provides the following benefits:

- A. Both disability and paid family leave benefits.
- B. Disability benefits only.
- C. Paid family leave benefits only.

5. Policy covers:

- A. All of the employer's employees eligible under the NYS Disability and Paid Family Leave 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 and/or Paid Family Leave Benefits insurance coverage as described above.

Date Signed \_\_\_\_\_ 01/22/2025 By Paul Martin  
(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number 800-423-2765 Name and Title Paul Martin VP, Group Claims

**IMPORTANT:** If Boxes 4A and 5A are 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, 4C or 5B is checked, this certificate is NOT COMPLETE for purposes of Section 220, Subd. 8 of the NYS Disability and Paid Family Leave Benefits Law. It must be emailed to [PAU@wcb.ny.gov](mailto:PAU@wcb.ny.gov) or it can be mailed for completion to the Workers' Compensation Board, Plans Acceptance Unit, PO Box 5200, Binghamton, NY 13902-5200.

**PART 2. To be completed by NYS Workers' Compensation Board (Only if box 4C or 5B 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 and Paid Family Leave Benefits Law (Article 9 of the Workers' Compensation Law) with respect to all of his/her employees.

Date Signed

By

\_\_\_\_\_

\_\_\_\_\_

(Signature of Authorized NYS Workers' Compensation Board Employee)

Telephone Number

Name and Title

\_\_\_\_\_

**Please Note:** Only insurance carriers licensed to write NYS disability and Paid Family Leave 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 (12-21)**

## Additional Instructions for Form DB-120.1

By signing this form, the insurance carrier identified in Box 3 on this form is certifying that it is insuring the business referenced in box 1a for disability and/or Paid Family Leave benefits under the NYS Disability and Paid Family Leave Benefits Law. The Insurance carrier or its licensed agent will send this Certificate of Insurance Coverage (Certificate) to the entity listed as the certificate holder in Box 2.

The insurance carrier must notify the above certificate holder and the Workers' Compensation Board within 10 days IF a policy is cancelled 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 coverage indicated on this Certificate. (These 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.

This Certificate is issued as a matter of information only and confers no rights upon the certificate holder. This Certificate does not amend, extend or alter the coverage afforded by the policy listed, nor does it confer any rights or responsibilities beyond those contained in the referenced policy.

This Certificate may be used as evidence of a NYS disability and/or Paid Family Leave benefits contract of insurance only while the underlying policy is in effect.

**Please Note:** Upon the cancellation of the disability and/or Paid Family Leave benefits 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 Insurance Coverage for NYS disability and/or Paid Family Leave Benefits or other authorized proof that the business is complying with the mandatory coverage requirements of the NYS Disability and Paid Family Leave Benefits Law.

## NYS DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

### §220. Subd. 8

(a) The head of a state or municipal department, board, commission or office authorized or required by law to issue any permit for or in connection with any work involving the employment of employees in employment as defined in this article, and not withstanding any general or special statute requiring or authorizing the issue of such permits, shall not issue such permit

unless proof duly subscribed by an insurance carrier is produced in a form satisfactory to the chair, that the payment of disability benefits and after January first, two thousand and twenty-one, the payment of family leave benefits for all employees has been secured as provided by this article. Nothing herein, however, shall be construed as creating any liability on the part of such state or municipal department, board, commission or office to pay any disability benefits to any such employee if so employed.

(b) The head of a state or municipal department, board, commission or office authorized or required by law to enter into any contract for or in connection with any work involving the employment of employees in employment as defined in this article and notwithstanding any general or special statute requiring or authorizing any such contract, shall not enter into any such

contract unless proof duly subscribed by an insurance carrier is produced in a form satisfactory to the chair, that the payment secured



CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

Form with fields: 1a. Legal Name and address of Insured, 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, 3a. Name of Insurance Carrier, 3b. Policy Number of entity listed in box "1a", 3c. Policy effective period, 3d. The Proprietor, Partners or Executive Officers are:

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 holder in box "2".

The insurance carrier must notify the above certificate holder and the Workers' Compensation Board 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 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.

This certificate is issued as a matter of information only and confers no rights upon the certificate holder. This certificate does not amend, extend or alter the coverage afforded by the policy listed, nor does it confer any rights or responsibilities beyond those contained in the referenced policy. This certificate may be used as evidence of a Workers' Compensation contract of insurance only while the underlying policy is in effect.

Please Note: Upon 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: William Lawley Jr. (Print name of authorized representative or licensed agent of insurance carrier)

Approved By: [Signature] 7/12/2023 (Signature) (Date)

Title: Managing Partner

Telephone Number of authorized representative or licensed agent of insurance carrier: CarrierPhone

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.