STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

CERTIFICATE OF PARTICIPATION IN WORKERS' COMPENSATION COUNTY SELF-INSURANCE PLAN

1a. Legal name and address of participant in County Self-Insurance Plan Genesee County Job Development Bureau 587 East Main Street Suite 100 Batavia, NY 14020 **1b. Effective date of membership in the Plan** 01/01/1956.	**1c. Telephone number of participant** 585-344-2042 **1d. NYS Unemployment Insurance Employer Registration Number of participant** **1e. Federal Employer Identification Number of participant** 16-6002560
2. Name and address of the entity requesting proof of coverage NYS Education Department 89 Washington Ave Albany, NY 12234	**3. Name and address of County Self-Insurer** Genesee County Self-Insurance 15 Main Street, County Building No. One Batavia, New York 14020

This certifies that the participant referenced above is complying with the mandatory coverage requirements of the New York State Workers' Compensation Law as a participating member of the County Self-Insurance Plan listed above and participation in such County Self-Insurance Plan is still in force. The County Self-Insurer's Administrator will send this Certificate of Participation to the certificate holder listed in box 2.

If the membership of the participant listed in box 1a is terminated, the County Self-Insurer's Administrator will notify the certificate holder within 10 days of termination. (These notices may be sent by regular mail.) Otherwise, this certificate is valid for a maximum of one year from the date certified by the county self-insurer.

If this certificate is no longer valid according to the above guidelines and the participant referenced in box "1a" continues to be named on a permit, license or contract issued by the certificate holder, the participant must provide the certificate holder either with a new certificate or other authorized proof the participant is complying with the mandatory coverage requirements of the New York State Workers' Compensation Law.

The County Self-Insurer must file this certificate with the Workers' Compensation Board's Self-Insurance Office. **(See reverse.)**

Under penalty of perjury, I certify that I am an authorized representative of the County Self-Insurer referenced above and that the participant has the coverage as depicted on this form.

Certified by: Dustin Watterson
(Print name of authorized representative of County Self-Insurer)

Certified by: _____ 4/26/24
(Signature) (Date)

Title: Health & Safety Coordinator

Telephone Number: 585-344-2550 Ext. 2250

SI-105.2P (1-13)