

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 1b. Effective date of membership in the Plan _____.	1c. Telephone number of participant 1d. NYS Unemployment Insurance Employer Registration Number of participant 1e. Federal Employer Identification Number of participant
2. Name and address of the entity requesting proof of eligibility	3. Name and address of County Self-Insurer

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.

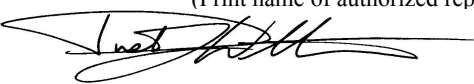
If the membership of the participant listed in box 1a is terminated, the County Self-Insurer's Administrator will notify the certificate holder within 10 days of termination. (These notices may be sent by regular mail.) Otherwise, this certificate is valid for a maximum of one year from the date certified 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If this certificate is no longer valid according to the above guidelines and the participant referenced in box "1a" continues to be named on a permit, license or contract issued by the certificate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: _____
(Print name of authorized representative of County Self-Insurer)

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

Title: _____

Telephone Number: _____