MAMARONECK BOARD OF EDUCATION
1000 West Boston Post Road
Mamaroneck, New York 10543
(914) 220-3082

APPLICATION FOR FIRST TIME FACILITIES USER

(Do not use for Memorial Field)

Required insurance documents must be provided at the time of application submission

Name of Organization or Individual: _____

Mailing Address: _____

Name of Contact Person:_____

Telephone Number of Contact Person:_____

E-mail Address of Contact Person:_____

If this organization is located within the boundaries of the Mamaroneck Union Free School District, please answer the following questions:

For-profit_____Not-for-profit_____

If not-for-profit, please attach a copy of your not-for-profit certificate.

Services provided to:____Children (18 years or under)_____Adults

Please provide a listing of members of the organization with their home addresses (e.g. roster of teams).
FAILURE TO DO SO WILL AUTOMATICALLY PUT YOU INTO GROUP 3.

I have read and understand the fee schedule as presented and would like to continue my application for Use of Facilities at the Mamaroneck Union Free School District
YOU WILL BE BILLED FOR ALL REQUESTED TIME REGARDLESS OF USE

AGREEMENT

(Name of Organization)_____ does covenant and agree to defend, indemnify and hold harmless the Mamaroneck U.F.S.D. 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 Mamaroneck U.F.S.D. property, facilities and/or services, including but not limited to bodily injury to any employee, invitee, guest, contractor or subcontractor of (Name of Organization)_____.
(Name of Organization)_____ understands and agrees that its use of Mamaroneck U.F.S.D. 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"). (Name of Organization)_____ agrees that its indemnity and insurance obligations extend to the areas identified in the application and/or permit and any and all incidental areas.

_____ _____
Signature of Organization's Representative Date of Application

OFFICE USE ONLY

Facilities Use: _____Group 1

_____Group 2

_____Group 3

Revised January 17, 2020

2023-2024 Vendor Insurance requirements

Dear Vendor, please provide the following insurance requirements: (Please see attached examples)

☐ 1) Certificate of Insurance (Acord 25 form- coverage amounts & description should match or exceed vendor Acord information)

☐ 2) Additional Insured Endorsement (CG2026 form or equivalent)

☐ 3) Primary and Non-Contributory Endorsement (CG2021 form or equivalent)

☐ 4) Waiver of Subrogation Endorsement (CG2404 form or equivalent)

☐ 5) Workers Compensation certificate (C105.2 form)

☐ 6) Disability certificate (DB120.1 form)

☐ 7) Workers Compensation & Disability Exemption (CE-200) (Only needed if no employees, if this is submitted no need to submit #5&6)

☐ 8) Vendors insurer needs to have an "A-" AM Best rating & preferably be licensed and admitted in the state of NY

Outside Vendor Insurance Requirements

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): Current

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 Insurer Information	**CONTACT NAME:** Must provide **PHONE (A/C, No, Ext):** / **FAX (A/C, No):** **E-MAIL ADDRESS:**
INSURED Vendor Information	**INSURER(S) AFFORDING COVERAGE** / **NAIC #** **INSURER A :** (AM Best Rated A- or Better) — required **INSURER B :** (NYS Licensed and Admitted Preferred) **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 INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	✓ **COMMERCIAL GENERAL LIABILITY** ☐ CLAIMS-MADE ☑ OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: ☑ POLICY ☐ PRO-JECT ☐ LOC OTHER:	✓	✓				EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ $1,000,000 $ $100,000 $ $10,000 $ $1,000,000 $ $2,000,000 $ $2,000,000
	AUTOMOBILE LIABILITY ☑ ANY AUTO ☐ ALL OWNED AUTOS ☐ SCHEDULED AUTOS ☑ HIRED AUTOS ☑ NON-OWNED AUTOS	✓	✓	Required when vendor vehicle is brought onsite			COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ $1,000,000 $ $ $
	☑ **UMBRELLA LIAB** ☑ OCCUR ☑ **EXCESS LIAB** ☐ CLAIMS-MADE DED ☐ RETENTION $	✓	✓				EACH OCCURRENCE AGGREGATE	$ $1,000,000 $ $2,000,000
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ **(Mandatory in NH)** If yes, describe under DESCRIPTION OF OPERATIONS below	N / A	✓	Workers Comp (Attach C-105.2 or U-26.3 form) Disability (Attatch DB120.1 form) A person seeking exemption must fil a CE-200 form w/ NY state			☐ PER STATUTE ☐ OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	Forms are: $ C105.2 or U26.3 $ DB120.1 $ Exempt:CE-200

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

Mamaroneck UFSD, its Board, employees, and volunteers are included as Additionally Insured on a primary and non-contributory basis for all coverage including Worker's Compensation [Attatch CG20 26 or equivalent form (additionally insured endorsement) & CG20 21 or equivalent form (Primary and non-contributory endorsement)]

Waiver of subrogation in favor of the Mamaroneck Union Free School District/Boces (Attatch CG24 04 or equivalent)

Organization agrees to indemnify the District for any applicable deductibles or self-insured retentions.

Description/ Location / Service provided

CERTIFICATE HOLDER

Mamaroneck UFSD
1000 West Boston Post Rd
Mamaroneck, NY 10543

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

Signature Required

Food Truck Insurance Requirements

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): Current

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: Must provide
Insurer Information	PHONE (A/C, No, Ext): / FAX (A/C, No):
	E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : (AM Best Rated A- or Better)	required
INSURER B : (NYS Licensed and Admitted Preferred)	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED: Vendor Information

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 INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	✓ COMMERCIAL GENERAL LIABILITY ☐ CLAIMS-MADE ☑ OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: ✓ POLICY ☐ PRO-JECT ☐ LOC OTHER:	✓	✓				EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ $1,000,000 $ $100,000 $ $10,000 $ $1,000,000 $ $2,000,000 $ $2,000,000
	AUTOMOBILE LIABILITY ✓ ANY AUTO ☐ ALL OWNED AUTOS ☐ SCHEDULED AUTOS ✓ HIRED AUTOS ☑ NON-OWNED AUTOS	✓	✓	Required when vendor vehicle is brought onsite			COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ $1,000,000 $ $ $
	☐ UMBRELLA LIAB ☐ OCCUR ☐ EXCESS LIAB ☐ CLAIMS-MADE ☐ DED ☐ RETENTION $						EACH OCCURRENCE AGGREGATE	$ $
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N ☐ **(Mandatory in NH)** If yes, describe under DESCRIPTION OF OPERATIONS below	N / A	✓	Workers Comp (Attach C-105.2 or U-26.3 form) Disability (Attatch DB120.1 form) A person seeking exemption must fil a CE-200 form w/ NY state			☐ PER STATUTE ☐ OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	Forms are: $ C105.2 or U26.3 $ DB120.1 $ Exempt:CE-200

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

Mamaroneck UFSD, its Board, employees, and volunteers are included as Additionally Insured on a primary and non-contributory basis for all coverage including Worker's Compensation [Attatch CG20 26 or equivalent form (additionally insured endorsement) & CG20 21 or equivalent form (Primary and non-contributory endorsement)]

Waiver of subrogation in favor of the Mamaroneck Union Free School District/Boces (Attatch CG24 04 or equivalent)

Organization agrees to indemnify the District for any applicable deductibles or self-insured retentions.

Description/ Location / Service provided

CERTIFICATE HOLDER

Mamaroneck UFSD
1000 West Boston Post Rd
Mamaroneck, NY 10543

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

Signature Required

Athletic/ Recreational Camps Vendor Insurance Requirements

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): Current

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: Must provide
Insurer Information	PHONE (A/C, No, Ext): / FAX (A/C, No):
	E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : (AM Best Rated A- or Better)	required
INSURER B : (NYS Licensed and Admitted Preferred)	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED: Vendor Information

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 INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	✓ COMMERCIAL GENERAL LIABILITY ☐ CLAIMS-MADE ☑ OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: ✓ POLICY ☐ PRO-JECT ☐ LOC OTHER:	✓	✓				EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ $1,000,000 $ $100,000 $ $10,000 $ $1,000,000 $ $2,000,000 $ $2,000,000
	AUTOMOBILE LIABILITY ✓ ANY AUTO ☐ ALL OWNED AUTOS ☐ SCHEDULED AUTOS ✓ HIRED AUTOS ☑ NON-OWNED AUTOS	✓	✓	Required when vendor vehicle is brought onsite			COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ $1,000,000 $ $ $
	✓ UMBRELLA LIAB ☑ OCCUR ✓ EXCESS LIAB ☐ CLAIMS-MADE DED ☐ RETENTION $	✓	✓				EACH OCCURRENCE AGGREGATE	$ $5,000,000 $ $5,000,000
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N ☐ **(Mandatory in NH)** If yes, describe under DESCRIPTION OF OPERATIONS below	N / A	✓	Workers Comp (Attach C-105.2 or U-26.3 form) Disability (Attatch DB120.1 form) A person seeking exemption must fil a CE-200 form w/ NY state			☐ PER STATUTE ☐ OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	Forms are: $ C105.2 or U26.3 $ DB120.1 $ Exempt:CE-200

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

Mamaroneck UFSD, its Board, employees, and volunteers are included as Additionally Insured on a primary and non-contributory basis for all coverage including Worker's Compensation [Attatch CG20 26 or equivalent form (additionally insured endorsement) & CG20 21 or equivalent form (Primary and non-contributory endorsement)]

Waiver of subrogation in favor of the Mamaroneck Union Free School District/Boces (Attatch CG24 04 or equivalent)

Organization agrees to indemnify the District for any applicable deductibles or self-insured retentions.

Description/ Location / Service provided

CERTIFICATE HOLDER

Mamaroneck UFSD
1000 West Boston Post Rd
Mamaroneck, NY 10543

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

Signature Required

Organized Athletic Leagues Vendor Insurance Requirements

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): Current

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: Must provide
Insurer Information	PHONE (A/C, No, Ext): / FAX (A/C, No):
	E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : (AM Best Rated A- or Better)	required
INSURER B : (NYS Licensed and Admitted Preferred)	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED

Vendor Information

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 INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	✓ COMMERCIAL GENERAL LIABILITY ☐ CLAIMS-MADE ☑ OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: ✓ POLICY ☐ PRO-JECT ☐ LOC OTHER:	✓	✓				EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ $1,000,000 $ $100,000 $ $10,000 $ $1,000,000 $ $2,000,000 $ $2,000,000
	AUTOMOBILE LIABILITY ✓ ANY AUTO ☐ ALL OWNED AUTOS ☐ SCHEDULED AUTOS ✓ HIRED AUTOS ☑ NON-OWNED AUTOS	✓	✓	Required when vendor vehicle is brought onsite			COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ $1,000,000 $ $ $
	✓ **UMBRELLA LIAB** ☑ OCCUR ✓ **EXCESS LIAB** ☐ CLAIMS-MADE ☐ DED ☐ RETENTION $	✓	✓				EACH OCCURRENCE AGGREGATE	$ $3,000,000 $ $3,000,000
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ **(Mandatory in NH)** If yes, describe under DESCRIPTION OF OPERATIONS below	N / A	✓	Workers Comp (Attach C-105.2 or U-26.3 form) Disability (Attatch DB120.1 form) A person seeking exemption must fil a CE-200 form w/ NY state			☐ PER STATUTE ☐ OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	Forms are: $ C105.2 or U26.3 $ DB120.1 $ Exempt:CE-200

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

Mamaroneck UFSD, its Board, employees, and volunteers are included as Additionally Insured on a primary and non-contributory basis for all coverage including Worker's Compensation [Attatch CG20 26 or equivalent form (additionally insured endorsement) & CG20 21 or equivalent form (Primary and non-contributory endorsement)]

Waiver of subrogation in favor of the Mamaroneck Union Free School District/Boces (Attatch CG24 04 or equivalent)

Organization agrees to indemnify the District for any applicable deductibles or self-insured retentions.

Description/ Location / Service provided

CERTIFICATE HOLDER

Mamaroneck UFSD
1000 West Boston Post Rd
Mamaroneck, NY 10543

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

Signature Required

Carnivals Vendor Insurance Requirements

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): Current

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: Must provide
Insurer Information	PHONE (A/C, No, Ext): / FAX (A/C, No):
	E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : (AM Best Rated A- or Better)	required
INSURER B : (NYS Licensed and Admitted Preferred)	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED: Vendor Information

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 INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	✓ COMMERCIAL GENERAL LIABILITY ☐ CLAIMS-MADE ☑ OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: ✓ POLICY ☐ PRO-JECT ☐ LOC OTHER:	✓	✓				EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ $1,000,000 $ $100,000 $ $10,000 $ $1,000,000 $ $2,000,000 $ $2,000,000
	AUTOMOBILE LIABILITY ✓ ANY AUTO ☐ ALL OWNED AUTOS ☐ SCHEDULED AUTOS ✓ HIRED AUTOS ☑ NON-OWNED AUTOS	✓	✓	Required when vendor vehicle is brought onsite			COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ $1,000,000 $ $ $
	✓ UMBRELLA LIAB ☑ OCCUR ✓ EXCESS LIAB ☐ CLAIMS-MADE DED ☐ RETENTION $	✓	✓				EACH OCCURRENCE AGGREGATE	$ $10,000,000 $ $10,000,000
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N ☐ **(Mandatory in NH)** If yes, describe under DESCRIPTION OF OPERATIONS below	N / A	✓	Workers Comp (Attach C-105.2 or U-26.3 form) Disability (Attatch DB120.1 form) A person seeking exemption must fil a CE-200 form w/ NY state			☐ PER STATUTE ☐ OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	Forms are: $ C105.2 or U26.3 $ DB120.1 $ Exempt:CE-200

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

Mamaroneck UFSD, its Board, employees, and volunteers are included as Additionally Insured on a primary and non-contributory basis for all coverage including Worker's Compensation [Attatch CG20 26 or equivalent form (additionally insured endorsement) & CG20 21 or equivalent form (Primary and non-contributory endorsement)]

Waiver of subrogation in favor of the Mamaroneck Union Free School District/Boces (Attatch CG24 04 or equivalent)

Organization agrees to indemnify the District for any applicable deductibles or self-insured retentions.

Description/ Location / Service provided

CERTIFICATE HOLDER

Mamaroneck UFSD
1000 West Boston Post Rd
Mamaroneck, NY 10543

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

Signature Required

POLICY NUMBER: CMP9154797 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:

Mamaroneck Union Free School District
1000 West Boston Post Road
Mamaroneck, NY 10543-3328

(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.

Policy Number: 12345678

Certificate Number: PEVD095895

Effective Dates: 5/5/2023 to 5/5/2024

Primary and Noncontributory- Other Insurance Condition
CG 20 01 04 13

Policy Amendment(s) Commercial General Liability

This endorsement modifies insurance provided under the following:

Commercial General Liability Coverage Part
Products/Completed Operations Liability Coverage Part

The following is added to the **Other Insurance** Condition and supersedes any provision to the contrary:

Primary And Noncontributory Insurance

This insurance is primary to and will not seek contribution from any other insurance available to an additional insured under your policy provided that:

(1) The additional insured is a Named Insured under such other insurance; and

(2) You have agreed in writing in a contract or agreement that this insurance shall be primary and would not seek contribution from any other insurance available to the additional insured.

This Form must be attached to Change Endorsement when issued after the policy is written.
One of the **Fireman's Fund Insurance Companies** as named in the policy

Secretary

President

WAIVER OF TRANSFER OF RIGHTS OF RECOVERY AGAINST OTHERS TO US

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART
PRODUCTS/COMPLETED OPERATIONS LIABILITY COVERAGE PART

SCHEDULE

Name Of Person Or Organization:
Mamaroneck Union Free School District
Information required to complete this Schedule, if not shown above, will be shown in the Declarations.

The following is added to Paragraph **8. Transfer Of Rights Of Recovery Against Others To Us** of **Section IV – Conditions:**

We waive any right of recovery we may have against the person or organization shown in the Schedule above because of payments we make for injury or damage arising out of your ongoing operations or "your work" done under a contract with that person or organization and included in the "products-completed operations hazard". This waiver applies only to the person or organization shown in the Schedule above.

NEW YORK STATE | Workers' Compensation Board

CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

1a. Legal Name & Address of Insured (use street address only) Vendor name & address Work Location of Insured *(Only required if coverage is specifically limited to certain locations in New York State, i.e., a Wrap-Up Policy)*	1b. Business Telephone Number of Insured 914-123-4567 1c. NYS Unemployment Insurance Employer Registration Number of Insured 1d. Federal Employer Identification Number of Insured or Social Security Number 1234567
2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) Mamaroneck UFSD 1000 West Boston Post Road Mamaroneck, NY 10543	3a. Name of Insurance Carrier Travelers Indemnity Company of CT 3b. Policy Number of Entity Listed in Box "1a" UB7W306336553A 3c. Policy effective period 4/21/2023 to 4/21/2024 3d. The Proprietor, Partners or Executive Officers are ☒ included. (Only check box if all partners/officers included) ☐ all excluded or certain partners/officers excluded.

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: Paul Sohigrerww
(Print name of authorized representative or licensed agent of insurance carrier)

Approved by:  04/21/2023
(Signature) (Date)

Title: Principal

Telephone Number of authorized representative or licensed agent of insurance carrier: 914-937-1911

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.

Workers' Compensation Law

Section 57. Restriction on issue of permits and the entering into contracts unless compensation is secured.

1. 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 a hazardous employment defined by this chapter, and notwithstanding 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 compensation for all employees has been secured as provided by this chapter. 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 compensation to any such employee if so employed.

2. 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 a hazardous employment defined by this chapter, 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 compensation for all employees has been secured as provided by this chapter.

NEW YORK STATE | Workers' Compensation Board

CERTIFICATE OF INSURANCE COVERAGE

NYS DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

PART 1. To be completed by NYS disability and Paid Family Leave benefits carrier or licensed insurance agent of that carrier

1a. Legal Name & Address of Insured (use street address only)

[redacted]

Work Location of Insured *(Only required if coverage is specifically limited to certain locations in New York State, i.e., Wrap-Up Policy)*

1b. Business Telephone Number of Insured

914-403-8064

1c. Federal Employer Identification Number of Insured or Social Security Number

[redacted]

2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)

Mamaroneck UFSD
1000 Boston Post Road
MAMARONECK, NY 10543

3a. Name of Insurance Carrier

ShelterPoint Life Insurance Company

3b. Policy Number of Entity Listed in Box "1a"

[redacted]

3c. Policy effective period

12/12/2022 to 12/11/2023

4. Policy provides the following benefits:

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

5. Policy covers:

- [x] 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 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 5/9/2023 By [signature]

(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number [redacted] Name and Title [redacted]

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 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 the NYS Workers' Compensation Board (Only if Box 4B, 4C or 5B have 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 their 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.***

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 of disability benefits and after January first, two thousand eighteen, the payment of family leave benefits for all employees has been secured as provided by this article.

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:
Beyond Music Services **430 Jefferson Ave** **Mamaroneck, NY 10543-1916** **PHONE: 914-755-0606 FEIN: XXXXX7296**	**OTHER: DJ services** **From: Mamaroneck UFSD**

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:

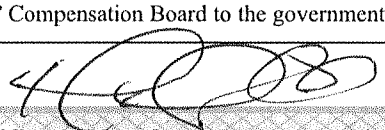
The business is a one person owned corporation, with that individual owning all of the stock and holding all offices of the corporation. Other than the corporate owner, there are no employees, day labor, leased employees, borrowed employees, part-time employees, other stockholders, unpaid volunteers (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, Rocco Ruscitto, am the President 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:** 4/14/23

Exemption Certificate Number
2023-025948

Received
April 14, 2023
NYS Workers' Compensation Board

AIM Playlist of Events

STOP: This activity if potentially excluded from your policy. Contact AIM for more details

PAUSE: Use Caution. Even thought this event is potentially covered under your policy, this is a high risk event and you need to take extra precaution when hosting.

PLAY: Covered Event

- After School Programs
- Aircraft
- All Night Lock-Ins
- Animal Rides
- Apple Bobbing
- Archery
- Arts & Crafts Activities
- Asbestos Exposure
- Athletic Leagues, Clinic, Camps
- ATVS
- Auctions
- Babysitting at Meetings
- Bake or Food Sales
- Balloon Artists
- Baseball Toss
- Beautification Projects
- Bike Rodeos
- Book Fairs
- Bounce Houses
- Bowling
- Broom Hockey
- Bungee Jumping
- Cake Walks
- Candy/Wrapping Paper Sales
- Carnivals
- Colored Sand Painting
- Concession Stands
- Confetti Eggs
- Costume Parties
- Cow Bingo
- Crossing Guards
- Drones
- Dunk Tanks
- Egg Toss
- Enrichment Programs
- Face Painting
- Family Portraits
- Fashion Shows
- Fireworks
- Fishing (from land)
- Food Sales
- Fortune Telling
- Fun Runs
- Gift Wrapping
- Golf Tournaments
- Grad Nights
- Haunted Houses
- Hayrides (Horse Drawn)
- Hobby Shows
- Hot Air Balloons
- Ice Cream Socials
- Inflatable Slides
- Jail Auction
- Line Dancing
- Litter Cleanup
- Magic Shows
- Mechanical/Motorized Rides
- Moon Walks
- One Day Athletic Events
- Open Houses
- Parent Education
- Pee Wee Golf
- Performing Arts
- Petting Zoos
- Picnics
- Pizza Night
- Ring Toss
- Rock Climbing Walls
- Rocketry
- Sale of Weapons
- Science Fairs
- Skating Rink (Roller & Skating)
- Spelling Bees
- Sumo Wrestling
- Swim Parties
- Talent Shows
- Trailers (Detached or Non-Owned)
- Transportation
- Workers Compensation
- Workshops
- Zip Lining

Note: If you do not see an event you are having on this list, please call AIM to verify coverage. This list is not all inclusive and all events are subject to the limits and exclusions in the policy. Please contact us with any questions regarding your event.

MAMARONECK UNION FREE SCHOOL DISTRICT

1000 West Boston Post Road

Mamaroneck, NY 10543

To the fullest extent permitted by law, **(Vendor Name)** _____ agrees to defend, indemnify and hold harmless the **Mamaroneck Union Free School District**, as well as any other parties which the contractor is required under the contract documents to defend, indemnify and hold harmless, their agents, servants and employees, from and against any claim, cost, expense or liability (including costs and attorneys' fees incurred in enforcing this indemnity), attributed to bodily injury, sickness, disease or death, or to damage to or destruction of property (including loss of use thereof), caused by, arising out of, resulting from or occurring in connection with the performance of the work by the contractor, its subcontractors and suppliers or their agents, servants and employees whether or not caused in part by the active or passive negligence, partial negligence or other fault of the party indemnified hereunder; provided, however, the contractor's duty hereunder shall not arise if such injury, sickness, disease, death, damage or destruction is caused by the sole negligence of the party indemnified hereunder. The contractor's obligation shall not be limited by the provisions of any Workers' Compensation Law or similar Act."

Signature of Participant

Date