

MEMORIAL FIELD - APPLICATION FOR USE

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

Name of Organization/Individual: _____

Mailing Address: _____

Category of organization (if known; if first time user, please complete First Timer User Form)

___ Outside Organization

___ Community Organization: For-Profit

___ Community Organization: Not-For-Profit, Servicing Children

___ Community Organization: Not-For-Profit, Servicing Adults

Name of Contact Person: _____ Telephone Number: _____

E-mail Address of Contact Person: _____

Date(s) of Event:

Hours of Use: From - To

Purpose of Event: _____

Admission Charges: _____

If admission is charged, is the event a fundraiser? ___ No ___ Yes

For what purpose are proceeds to be used? _____

If net proceeds will be donated to MUFSD, please provide a copy of the estimated income statement for this event, including the estimated net proceeds which will be donated.

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

The above named organization further agrees to follow the rules and regulations of the Mamaroneck Union Free School District.

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

**Mamaroneck Union Free School District
1000 W. Boston Post Road
Mamaroneck, NY 10543**

FACILITY USE REQUIREMENTS

The use of all Mamaroneck U.F.S.D. facilities shall be subject to the approval and rules of the Board of Education administered by the Building Principal or other Board designee.

1. Organizations wishing to use District facilities shall first apply to the Building Principal on the prescribed form. The Principal or his/her designee has final authority on approval.
2. In the event of inclement weather, the Principal or his/her designee has the final authority on whether facilities are usable.
3. Intoxicants shall not be brought onto District facilities at any time.
4. All posted rules must be adhered to.
5. Profanity, objectionable language, disorderly acts or illegal activities of any kind are absolutely prohibited, and those violating this prohibition will be ejected from the premises.
6. Any damage to District facilities shall be promptly repaired at the user's expense. No exceptions. If maintenance personnel are not available, make sure all doors are locked and lights are turned out when leaving.
7. Organizations using the facilities must clean-up afterwards.
8. Permits may be revoked at any time.
9. Any organization with youth under 18 years old requires the presence of adequate adult supervision at all times.
10. The fee for use is determined and invoiced by the business office which is to be paid before event.
11. The emergency telephone number for the Police and Fire Department is 911.
12. Smoking or other use of tobacco products is not allowed on District property.
13. Facilities are not available if in conflict with school use. No unauthorized vehicles are allowed on school property. No field or building alterations (lining of fields or gymnasiums, erecting permanent goal posts or structures, etc.) are allowed without prior approval.
14. The District does not discriminate on the basis of race, color, national origin, physical impairment or sex in its educational programs or employment services.
15. Prior to the start of the event, an announcement should be made to your group regarding emergency evacuation procedures. For example, pointing out posted procedures, directions for exiting, how to respond to a fire alarms, etc.
16. In the event of an accident, please notify the custodian on duty, or call the business office the next morning.

INSURANCE AGREEMENT – USE OF FACILITIES

All users must provide insurance prior to using the facilities.

FAILURE TO DO SO PRIOR TO USE WILL RESULT IN REVOCATION OF YOUR PERMIT:

Please refer to 1500-R Public Use of School Facilities Regulations for detail



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





CERTIFICATE OF LIABILITY INSURANCE

 DATE (MM/DD/YYYY)
 Current

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	E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	
INSURED	INSURER A:	(AM Best Rated A- or Better)
	INSURER B:	(NYS Licensed and Admitted Preferred)
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	E-MAIL ADDRESS:	
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INSURED Vendor Information	INSURER A: (AM Best Rated A- or Better)	
	INSURER B: (NYS Licensed and Admitted Preferred)	
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Signature Required



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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
<input checked="" type="checkbox"/>	COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC <input type="checkbox"/> OTHER:	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>				EACH OCCURRENCE \$ \$1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ \$100,000 MED EXP (Any one person) \$ \$10,000 PERSONAL & ADV INJURY \$ \$1,000,000 GENERAL AGGREGATE \$ \$2,000,000 PRODUCTS - COMP/OP AGG \$ \$2,000,000 \$
<input checked="" type="checkbox"/>	AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Required when vendor vehicle is brought onsite			COMBINED SINGLE LIMIT (Ea accident) \$ \$1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
<input checked="" type="checkbox"/>	UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR <input checked="" type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>				EACH OCCURRENCE \$ \$10,000,000 AGGREGATE \$ \$10,000,000 \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y / N <input type="checkbox"/>	N / A <input checked="" type="checkbox"/>	Workers Comp (Attach C-105.2 or U-26.3 form) Disability (Attach DB120.1 form) A person seeking exemption must fil a CE-200 form w/ NY state			PER STATUTE OTH-ER Forms are: E.L. EACH ACCIDENT \$ C105.2 or U26.3 E.L. DISEASE - EA EMPLOYEE \$ DB120.1 E.L. DISEASE - POLICY LIMIT \$ 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 (Attach 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 (Attach CG24 04 or equivalent)

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

Description/ Location / Service provided

CERTIFICATE HOLDER

CANCELLATION

Mamaroneck UFSD
1000 West Boston Post Rd
Mamaroneck, NY 10543

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.

CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

<p>1a. Legal Name & Address of Insured (use street address only)</p> <p>Vendor name & address</p> <p><i>Work Location of Insured (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</p> <p>914-123-4567</p> <p>1c. NYS Unemployment Insurance Employer Registration Number of Insured</p> <p>1d. Federal Employer Identification Number of Insured or Social Security Number</p> <p>1234567</p>
<p>2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)</p> <p>Mamaroneck UFSD</p> <p>1000 West Boston Post Road</p> <p>Mamaroneck, NY 10543</p>	<p>3a. Name of Insurance Carrier</p> <p>Travelers Indemnity Company of CT</p> <p>3b. Policy Number of Entity Listed in Box "1a"</p> <p>UB7W306336553A</p> <p>3c. Policy effective period</p> <p style="text-align: center;">4/21/2023 to 4/21/2024</p> <p>3d. The Proprietor, Partners or Executive Officers are</p> <div style="margin-left: 40px;"> <input checked="" type="checkbox"/> included. (Only check box if all partners/officers included) <input type="checkbox"/> all excluded or certain partners/officers excluded. </div>

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 Sohigrenww
(Print name of authorized representative or licensed agent of insurance carrier)

Approved by: _____ (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.

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 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 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.



**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):**

Beyond Music Services
430 Jefferson Ave
Mamaroneck, NY 10543-1916
PHONE: 914-755-0606 FEIN: XXXXX7296

**Business Applying For:
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 is potentially excluded from your policy. Contact AIM for more details

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

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