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

<u>APPLICATION FOR USE OF SCHOOL FACILITIES</u> Do not use for Memorial Field YOU WILL BE BILLED FOR ALL REQUESTED TIME REGARDLESS OF USE Required insurance documents must be provided at the time of application submission

Name of School Desired			
Space required (i.e., Gymnasium, Classroom, Auditorium functions):			
Date of Event:		To	
(Please enter additional dates on attached sheet)			
Total Participants expected:	Admission Charges:		
Purpose of Event:			
Equipment Required (tables, chairs, etc.):			
Technology Needs (IT Technician will be required for a	ll Technologyneeds):		
Name of Person in Charge of Event:			
Address:	Telephone ;	#:	
E-mail address:			
Name of Organization:			
Address:	Telephone	e #:	
I have read and understand the fee schedule as pres Use of School Facilities at the Mam			plication for

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.

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APPLICATION FOR USE OF SCHOOL FACILITIES Do not use for Memorial Field YOU WILL BE BILLED FOR ALL REQUESTED TIME REGARDLESS OF USE

Additional Event Dates:

Date of Event:	From	To	(Hours)
Date of Event:	From	To	(Hours)
Date of Event:	From	To	(Hours)
Date of Event:	From	To	(Hours)
Date of Event:	From	To	(Hours)
Date of Event:	From	To	(Hours)
Date of Event:	From	To	(Hours)
Date of Event:	From	To	(Hours)
Date of Event:	From	To	(Hours)
Additional Notes:			

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. <u>No exceptions.</u> 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)

 \square 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									
ACORD [®] C	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.							POLICIES		
IMPORTANT: If the certificate holder the terms and conditions of the policy certificate holder in lieu of such endor	olicies may require an er								
PRODUCER		. ,		CONTA NAME:	wust p	rovide			
Insurer Information				PHONE (A/C, No E-MAIL ADDRE	o, Ext):		FAX (A/C, No):		
					INS	URER(S) AFFOR			NAIC #
INSURED				INSURE	A. (st Rated A- or Bet	,		required
INSURED				INSURE		icensed and Admi	tted Preferred)		
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THIS IS TO CERTIFY THAT THE POLICIES INDICATED. NOTWITHSTANDING ANY RI CERTIFICATE MAY BE ISSUED OR MAY EXCLUSIONS AND CONDITIONS OF SUCH	equif Pert Poli	reme 'Ain, Cies.	NT, TERM OR CONDITION THE INSURANCE AFFORDI LIMITS SHOWN MAY HAVE	OF AN ED BY	Y CONTRACT	OR OTHER I S DESCRIBEI	DOCUMENT WITH RESPE	ст то	WHICH THIS
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							MED EXP (Any one person)	\$\$10,	
							PERSONAL & ADV INJURY	\$\$1,0	00,000
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DED RETENTION \$							PER OTH-	\$	
AND EMPLOYERS' LIABILITY Y / N			Workers Comp (Attach C-105.2 U-26.3 form)	or			PER OTH- STATUTE ER		ms are: 5.2 or U26.3
ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	N / A	\checkmark	Disability (Attatch DB120.1 form)				E.L. EACH ACCIDENT		
If yes, describe under DESCRIPTION OF OPERATIONS below			A person seeking exemption must CE-200 form w/ NY state	st fil a			E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT		npt:CE-200
DESCRIPTION OF OPERATIONS / LOCATIONS / VEHIC Mamaroneck UFSD, its Board, employees, and volunteer equivalent form (additionally insured endorsement) & CG	s are in	cluded	as Additionally Insured on a primar	y and non	-contributory basi			Attatch	CG20 26 or
Waiver of subrogation in favor of the Mamaroneck Union					/-				
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Organization agrees to indemnify the District for any appli Description/ Location / Service provided	cable d	leductil	oles or self-insured retentions.						
CERTIFICATE HOLDER				CANC	ELLATION				
				CAN					
Mamaroneck UFSD 1000 West Boston Po	st F	۶d		THE	EXPIRATION	DATE THE	ESCRIBED POLICIES BE C EREOF, NOTICE WILL Y PROVISIONS.		
Mamaroneck, NY 105				AUTHO	RIZED REPRESE	NTATIVE			
					Sign	ature Re	quired		

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Food Truck Insurance Requirements

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) Current

THIS CERTIFICATE IS ISSUED AS A M CERTIFICATE DOES NOT AFFIRMATI BELOW. THIS CERTIFICATE OF INS REPRESENTATIVE OR PRODUCER, AM	VEL` URA ID TI	Y OF NCE HE C	R NEGATIVELY AMEND, DOES NOT CONSTITUT ERTIFICATE HOLDER.	EXTEN E A CO	D OR ALT ONTRACT	ER THE CO BETWEEN T	VERAGE AFFORDED BY HE ISSUING INSURER(S	Y THE S), AU	POLICIES
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PRODUCER		. ,		CONTAC NAME:	T Must p	rovide			
				PHONE (A/C, No,	Ext):		FAX (A/C, No):		
Insurer Information			-	É-MAIL ADDRES	S:				
					INS	SURER(S) AFFOR	DING COVERAGE		NAIC #
				INSURE	RA: (AM Be	st Rated A- or Bet	ter)		required
INSURED			-	INSURE	RB: (NYSL	icensed and Admi	tted Preferred)		
Vendor Information			-	INSURE	R C :				
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							PRODUCTS - COMP/OP AGG	_{\$} \$2,00	00,000
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AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE			U-26.3 form)						5.2 or U26.3
OFFICER/MEMBER EXCLUDED?	N/A	\checkmark	Disability (Attatch DB120.1 form)					s DB12	
If yes, describe under DESCRIPTION OF OPERATIONS below			A person seeking exemption must CE-200 form w/ NY state	tfila					npt:CE-200
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DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICL	.ES (A	CORE	0 101, Additional Remarks Schedul	le, may be	attached if mo	re space is requir	ed)		
Mamaroneck UFSD, its Board, employees, and volunteers equivalent form (additionally insured endorsement) & CG2						s for all coverage	including Worker's Compensation	Attatch (CG20 26 or
Waiver of subrogation in favor of the Mamaroneck Union F	ree So	nool C	istrict/Boces (Attatch CG24 04 or eq	quivalent)					
Organization agrees to indemnify the District for any applic	able d	eductil	bles or self-insured retentions.						
Description/ Location / Service provided									
CERTIFICATE HOLDER				CANC	ELLATION				
Mamaroneck UFSD				THE	EXPIRATIO	N DATE THE	ESCRIBED POLICIES BE CA EREOF, NOTICE WILL BI CY PROVISIONS.		
1000 West Boston Pos	st F	۲d	l						
Mamaroneck, NY 1054				AUTHOR	IZED REPRESE	NTATIVE			
					Sign	ature Re	quired		
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					© 19	88-2014 AC	ORD CORPORATION. A	All righ	nts reserved.

A	thle	tic/	Recreational Camps	Vend	dor Insura	nce Requi	rements		
ACORD [®] C	ER'	TIF	ICATE OF LIA	BILI		URANC	E	DATE Curr	(MM/DD/YYYY) ent
THIS CERTIFICATE IS ISSUED AS A CERTIFICATE DOES NOT AFFIRMAT BELOW. THIS CERTIFICATE OF IN REPRESENTATIVE OR PRODUCER, A	IVEL` SURA ND TI	Y OF NCE HE C	R NEGATIVELY AMEND, DOES NOT CONSTITUT ERTIFICATE HOLDER.	EXTE TE A C	ND OR ALTI CONTRACT I	ER THE CO' BETWEEN T	VERAGE AFFORDED HE ISSUING INSURE	BY THI R(S), AI	e policies Jthorized
IMPORTANT: If the certificate holder the terms and conditions of the policy certificate holder in lieu of such endor	, cert	ain p	olicies may require an er						
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					INS		DING COVERAGE		NAIC #
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INSR LTR TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER		POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIN	NITS	
COMMERCIAL GENERAL LIABILITY	\checkmark	\checkmark					EACH OCCURRENCE DAMAGE TO RENTED	• • •	00,000
							PREMISES (Ea occurrence)	\$\$100	-
							MED EXP (Any one person)	\$\$10,	000
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AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE	N/A		U-26.3 form)				E.L. EACH ACCIDENT		5.2 or U26.3
OFFICER/MEMBER EXCLUDED? (Mandatory in NH)			Disability (Attatch DB120.1 form) A person seeking exemption mus				E.L. DISEASE - EA EMPLOY	_{EE} _{\$} DB1	20.1
If yes, describe under DESCRIPTION OF OPERATIONS below			CE-200 form w/ NY state	, and			E.L. DISEASE - POLICY LIMI	T SEXE	mpt:CE-200
DESCRIPTION OF OPERATIONS / LOCATIONS / VEHIC	LES (A	ACORE	D 101, Additional Remarks Schedu	ıle, may b	e attached if mor	e space is requir	ed)		
Mamaroneck UFSD, its Board, employees, and volunteer	s are in	cluded	as Additionally Insured on a primar	y and nor	n-contributory basi		•	on [Attatch	CG20 26 or
equivalent form (additionally insured endorsement) & CG			· · ·						
Waiver of subrogation in favor of the Mamaroneck Union	Free So	chool D	District/Boces (Attatch CG24 04 or en	quivalent))				
Organization agrees to indemnify the District for any appl	icable d	eductit	oles or self-insured retentions.						
Description/ Location / Service provided									
CERTIFICATE HOLDER				CAN	CELLATION				
Mamaroneck UFSD	- 4 6	- - I		SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.					
1000 West Boston Po		۲d		AUTHO	RIZED REPRESE	NTATIVE			
Mamaroneck, NY 105	43						quired		
					Sign	ature Re	quireu		

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Organized Athletic Leagues Vendor Insurance Requirements										
ACORD [®] CI	ER'	TIF	ICATE OF LIA	BILI		URANC	E		DATE (Curre	(MM/DD/YYYY) ent
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 the terms and conditions of the policy certificate holder in lieu of such endors	, cert	ain p	olicies may require an er							
PRODUCER				CONTA NAME:	ст Must pi	rovide				
				PHONE (A/C, No	o, Ext):		F/ (A	AX VC, No):		
Insurer Information				È-MAIL ADDRE	SS:					
										NAIC #
INSURED				INSURE	A. (st Rated A- or Bet	,			required
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THIS IS TO CERTIFY THAT THE POLICIES INDICATED. NOTWITHSTANDING ANY RE CERTIFICATE MAY BE ISSUED OR MAY EXCLUSIONS AND CONDITIONS OF SUCH	EQUIF PERT	REME AIN,	NT, TERM OR CONDITION THE INSURANCE AFFORD	OF AN' ED BY	Y CONTRACT	OR OTHER I S DESCRIBEI	DOCUMENT WITH F D HEREIN IS SUBJI	RESPECT	т то у	WHICH THIS
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	\checkmark	\checkmark					EACH OCCURRENCE		\$1,00	00,000
CLAIMS-MADE 🗸 OCCUR	v	ľ					DAMAGE TO RENTED PREMISES (Ea occurre	ence)	\$100	
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ALL OWNED AUTOS	\checkmark	\checkmark					BODILY INJURY (Per a			
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								9	-	
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DED RETENTION \$							AGGREGATE		,	
WORKERS COMPENSATION			Workers Comp (Attach C-105.2)	or			PER STATUTE	OTH- ER	For	ms are:
ANY PROPRIETOR/PARTNER/EXECUTIVE	N/A	,	U-26.3 form) Disability (Attatch DB120.1 form)				E.L. EACH ACCIDENT		·	5.2 or U26.3
(Mandatory in NH) If yes, describe under	-	\checkmark	A person seeking exemption mus				E.L. DISEASE - EA EM	PLOYEE \$	₅DB12	20.1
DESCRIPTION OF OPERATIONS below			CE-200 form w/ NY state				E.L. DISEASE - POLIC	Y LIMIT	₅Exen	npt:CE-200
DESCRIPTION OF OPERATIONS / LOCATIONS / VEHIC	LES (A	ACORE	0 101, Additional Remarks Schedu	ile, may b	e attached if mor	e space is requir	ed)			
Mamaroneck UFSD, its Board, employees, and volunteer equivalent form (additionally insured endorsement) & CG2						s for all coverage	including Worker's Comp	ensation [Attatch	CG20 26 or
Waiver of subrogation in favor of the Mamaroneck Union	Free So	chool D	istrict/Boces (Attatch CG24 04 or en	quivalent))					
Organization agrees to indemnify the District for any appli	cable d	eductit	bles or self-insured retentions.							
Description/ Location / Service provided										
CERTIFICATE HOLDER				CANO	ELLATION					
Mamaroneck UFSD 1000 West Boston Po	st F	Rd		SHO THE	ULD ANY OF T	DATE THE	ESCRIBED POLICIE: EREOF, NOTICE V CY PROVISIONS.			
Mamaroneck, NY 105				AUTHO	RIZED REPRESE	NTATIVE				
			Signature Required							

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Carnivals Vendor Insurance Requirements

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) Current

	<u> </u>		•••						Curre	ent
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the t	ORTANT: If the certificate holder terms and conditions of the policy, ficate holder in lieu of such endors	cert	ain p	olicies may require an er						
PRODUC		Serric	11(3)		CONTA	ст Must p	rovide			
					NAME: PHONE	•	TOVIDE	FAX		
	Insurer Information				(A/C, No E-MAIL			(A/C, No):		
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	-				INSURE	NA. \	st Rated A- or Bet	,		required
INSURE					INSURE	RB: (NYSL	icensed and Admi	tted Preferred)		
	Vendor Information				INSURE	RC:				
	Vender information				INSURE	RD:				
					INSURE	RE:				
					INSURE	RF:				
			-	NUMBER:				REVISION NUMBER:		
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V	COMMERCIAL GENERAL LIABILITY	\checkmark	<		Ţ			EACH OCCURRENCE	\$\$1,0	00,000
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								MED EXP (Any one person)	_{\$} \$10,0	000
								PERSONAL & ADV INJURY	_{\$} \$1,00	00,000
G	EN'L AGGREGATE LIMIT APPLIES PER:							GENERAL AGGREGATE	\$\$2,00	00,000
								PRODUCTS - COMP/OP AGG	_{\$} \$2,00	00,000
	OTHER:								\$	
A	JTOMOBILE LIABILITY			Deguired when yender ye	hiala ia			COMBINED SINGLE LIMIT (Ea accident)	\$\$1	,000,000
	ANY AUTO			Required when vendor ve brought onsite	nicie is			BODILY INJURY (Per person)	\$	
Ť	ALL OWNED SCHEDULED AUTOS	. /	,	0				BODILY INJURY (Per accident)	\$	
	HIRED AUTOS	\mathbf{v}	\checkmark					PROPERTY DAMAGE (Per accident)	\$	
ľ									\$	
	UMBRELLA LIAB							EACH OCCURRENCE	\$ \$1(0.000.000
,	EXCESS LIAB	./	. /					AGGREGATE		0,000,000
×	DED RETENTION \$	v	$\mathbf{\vee}$						\$	-,,
w	DRKERS COMPENSATION			Workers Comp (Attach C-105.2 c	or			PER OTH- STATUTE ER		ms are:
	ID EMPLOYERS' LIABILITY IY PROPRIETOR/PARTNER/EXECUTIVE			U-26.3 form)				E.L. EACH ACCIDENT		5.2 or U26.3
OF	FICER/MEMBER EXCLUDED?	N / A	\checkmark	Disability (Attatch DB120.1 form)				E.L. DISEASE - EA EMPLOYEE	\$ DB12	
lf v	res, describe under SCRIPTION OF OPERATIONS below			A person seeking exemption mus CE-200 form w/ NY state	st fil a			E.L. DISEASE - POLICY LIMIT	•	npt:CE-200
	SCRIPTION OF OPERATIONS below							E.L. DISEASE - POLICT LIMIT	3 _ //011	
	PTION OF OPERATIONS / LOCATIONS / VEHICI	•								0000 60
	neck UFSD, its Board, employees, and volunteers nt form (additionally insured endorsement) & CG2						s for all coverage	including worker's Compensation	Attatch	CG20 26 or
Waiver o	f subrogation in favor of the Mamaroneck Union F	ree So	hool D	istrict/Boces (Attatch CG24 04 or ed	quivalent)					
Organiza	ation agrees to indemnify the District for any applic	able d	eductih	les or self-insured retentions.						
-	ion/ Location / Service provided									
CERT	IFICATE HOLDER				CANC	ELLATION				
	Mamaroneck UFSD 000 West Boston Pos	st E	24		THE	EXPIRATION	N DATE THE	ESCRIBED POLICIES BE CA EREOF, NOTICE WILL E Y PROVISIONS.		
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						© 19	88-2014 AC	ORD CORPORATION.	All rial	nts reserved.

ACORD

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

ulle a. Dem

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 "productscompleted operations hazard". This waiver applies only to the person or organization shown in the Schedule above.

CERTIFICATE OF Compensation NYS WORKERS' COMPENSATION INSURANCE COVERAGE

1a. Legal Name & Address of Insured (use street address only) Vendor name & address	1b. Business Telephone Number of Insured 914-123-4567
	1c. NYS Unemployment Insurance Employer Registration Number of Insured
Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e., a Wrap-Up Policy)	1d. Federal Employer Identification Number of Insured or Social Security Number 1234567
2. Name and Address of Entity Requesting Proof of Coverage	3a. Name of Insurance Carrier
(Entity Being Listed as the Certificate Holder) Mamaroneck UFSD	Travelers Indemnity Company of CT
1000 West Boston Post Road Mamaroneck, NY 10543	3b. Policy Number of Entity Listed in Box "1a" UB7W306336553A
	3c. Policy effective period
	4/21/2023 to <u>4/21/2024</u>
	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	r licensed agent of insurance carrier)
Approved by:	How Pr.	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'

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.



PART 1. To be co	mpleted by NYS disability an	nd Paid Family Le	ave benefits carrier or licensed insurance agent of that carrier				
1a. Legal Name & A 888888888888888 888888888888888 888888	ddress of Insured (use street addre 88888888888888888888888888888888888	ess only)	1b. Business Telephone Number of Insured				
			1c. Federal Employer Identification Number of Insured or Social Security Number				
	ured (Only required if coverage is spec v York State, i.e., Wrap-Up Policy)	ifically limited to	88888888888888888888888888888888888888				
	s of Entity Requesting Proof of Cov d as the Certificate Holder)	verage	3a. Name of Insurance Carrier ShelterPoint Life Insurance Company				
			3b. Policy Number of Entity Listed in Box "1a"				
			8888888888				
			3c. Policy effective period				
			to				
5. Policy covers: A. All of the B. Only the f	ollowing class or classes of employ	ver's employees: d representative or l enefits insurance co	and Paid Family Leave Benefits Law.				
Telephone Number	8888888888888	Name and Title 8	888888888888888888888888888888888888888				
Lice	ensed Insurance Agent of that of	carrier, this certific	gned by the insurance carrier's authorized representative or NYS ate is COMPLETE. Mail it directly to the certificate holder.				
Dis	ability and Paid Family Leave E	Benefits Law. It mu	T COMPLETE for purposes of Section 220, Subd. 8 of the NYS ust be emailed to PAU@wcb.ny.gov or it can be mailed for ans Acceptance Unit, PO Box 5200, Binghamton, NY 13902-5200.				
PART 2. To be co	mpleted by the NYS Worke	ers' Compensati	on Board (Only if Box 4B, 4C or 5B have been checked)				
	nation maintained by the NYS \	orkers' Comp Workers' Compen	New York Densation Board sation Board, the above-named employer has complied with the Workers' Compensation Law) with respect to all of their employees.				
Date Signed	Ву		Signature of Authorized NYS Workers' Compensation Board Employee)				
Please Note: Only in	surance carriers licensed to write l	NYS disability and p	aid family leave benefits insurance policies and NYS licensed insurance				

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.

STATE 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 <u>NOT</u> 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: OTHER: DJ services
Beyond Music Services 430 Jefferson Ave Mamaroneck, NY 10543-1916 PHONE: 914-755-0606 FEIN: XXXXX7296	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: </th <th>í</th> <th>JB)</th> <th>Date:</th> <th>4/14/</th> <th>23</th>	í	JB)	Date:	4/14/	23
Exer	nption Certifica	XXXXXXXXXX			C (X X X X	eceived
	2023-0259	948				14, 2023 Compensation Board

AIM Playlist of Events

I 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	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, C	amps 🜔 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-
Bungee Jumping	Hot Air Balloons	Owned)
Cake Walks	Ice Cream Socials	Transportation
Candy/Wrapping Paper S	ales 🛛 🕕 Inflatable Slides	Workers Compensation
Carnivals	Jail Auction	Workshops
Colored Sand Painting	Line Dancing	Zip Lining
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