CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 4/18/2024

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 have ADDITIONAL INSURED provisions or 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
MVR Insurance Agency
477 Ashford Ave
Ardsley NY 10502

CONTACT NAME: [redacted]
PHONE (A/C, No, Ext): 914-693-3500 FAX (A/C, No): 914-693-3980
E-MAIL ADDRESS: [redacted]

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Preferred Mutual Ins. Co.	15024
INSURER B : Shelter Point Life Insurance	524210
INSURER C : Sequoia Insurance Company	22985
INSURER D :	
INSURER E :	
INSURER F :	

INSURED [redacted] ROADGRU-01

COVERAGES **CERTIFICATE NUMBER:** 76830157 **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	
A	X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY [ ] PRO-JECT [ ] LOC OTHER:	Y	Y	[redacted]	3/10/2024	3/10/2025	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 $ 50,000 $ 10,000 $ 1,000,000 $ 2,000,000 $ 2,000,000 $
A	AUTOMOBILE LIABILITY ANY AUTO OWNED AUTOS ONLY HIRED AUTOS ONLY [X] SCHEDULED AUTOS NON-OWNED AUTOS ONLY	Y	Y	[redacted]	2/4/2024	2/4/2025	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) $	$ 1,000,000 $ $ $ $
A	X UMBRELLA LIAB [X] OCCUR EXCESS LIAB [ ] CLAIMS-MADE DED [X] RETENTION $ 10,000	Y	Y	[redacted]	3/10/2024	3/10/2025	EACH OCCURRENCE AGGREGATE $	$ 1,000,000 $ 1,000,000 $
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [ ] (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N / A		[redacted]	3/31/2024	3/31/2025	X PER STATUTE [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ 1,000,000 $ 1,000,000 $ 1,000,000
B	Disability			[redacted]	5/4/2023	5/4/2024	Statutory	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
The Somers Central School District is additional insured with respect to General Liability as per forms BP0448 and BP1402, for Auto Liability and for Umbrella Liability. Primary and non contributory basis applies in favor of the District, its Board, Employees and Volunteers, with respect to General Liability as per form BP9523 , with respect to Auto Liability as per form CA3539 and Umbrella Liability as per form CU9908, Waiver of Subrogation applies with respect to General Liability as per form BP0497, for Auto Liability as per form CA3541 and for Umbrella Liability as per form CU2403 (forms are attached)

CERTIFICATE HOLDER

Somers Central School District
250 Route 202
Somers NY 10589

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

POLICY NUMBER: [redacted]

BUSINESSOWNERS
BP 04 48 01 06

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

ADDITIONAL INSURED – DESIGNATED PERSON OR ORGANIZATION

This endorsement modifies insurance provided under the following:

BUSINESSOWNERS COVERAGE FORM

SCHEDULE

Name Of Additional Insured Person(s) Or Organization(s):
SOMERS CENTRAL SCHOOL DISTRICT
Information required to complete this Schedule, if not shown above, will be shown in the Declarations.

The following is added to Paragraph **C. Who Is An Insured** in **Section II – Liability:**

3. Any person(s) or organization(s) shown in the Schedule is also an additional insured, but only with respect to liability for "bodily injury", "property damage" or "personal and advertising injury" caused, in whole or in part, by your acts or omissions or the acts or omissions of those acting on your behalf in the performance of your ongoing operations or in connection with your premises owned by or rented to you.

POLICY NUMBER: [redacted]

BUSINESSOWNERS
BP 14 02 01 10

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

ADDITIONAL INSURED – OWNERS, LESSEES OR CONTRACTORS – COMPLETED OPERATIONS

This endorsement modifies insurance provided under the following:

BUSINESSOWNERS COVERAGE FORM

SCHEDULE

Name Of Additional Insured Person(s) Or Organization(s)	Location And Description Of Completed Operations
SOMERS CENTRAL SCHOOL DISTRICT	VARIOUS
Information required to complete this Schedule, if not shown above, will be shown in the Declarations.	

The following is added to Paragraph **C. Who Is An Insured** in **Section II – Liability:**

Any person(s) or organization(s) shown in the Schedule is also an additional insured, but only with respect to liability for "bodily injury" or "property damage" caused, in whole or in part, by "your work" at the location designated and described in the Schedule of this endorsement performed for that additional insured and included in the "products-completed operations hazard".

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

PRIMARY AND NON-CONTRIBUTORY COVERAGE

This endorsement modifies insurance provided under the following:

BUSINESSNOWNERS COVERAGE FORM

The following is added to **SECTION II – LIABILITY, H. Other Insurance**:

With respect to any Additional Insured on the policy, this insurance is considered to be primary or primary and non-contributory with the insurance issued directly to additional protected persons if:

1. Your contract specifically requires that we consider this insurance to be primary or primary and non-contributory; or

2. You request before a loss that we consider this insurance to be primary or primary and non-contributory insurance.

POLICY NUMBER: [redacted]

BUSINESSOWNERS
BP 04 97 01 06

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

WAIVER OF TRANSFER OF RIGHTS OF RECOVERY AGAINST OTHERS TO US

This endorsement modifies insurance provided under the following:

BUSINESSOWNERS COVERAGE FORM

SCHEDULE

Name Of Person Or Organization:
As required by written contract with the named insured.
Information required to complete this Schedule, if not shown above, will be shown in the Declarations.

Paragraph **K. Transfer Of Rights Of Recovery Against Others To Us** in **Section III – Common Policy Conditions** is amended by the addition of the following:

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.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

PRIMARY AND NONCONTRIBUTORY – OTHER INSURANCE CONDITION

This endorsement modifies insurance provided under the following:

GARAGE COVERAGE FORM
BUSINESS AUTO COVERAGE FORM
MOTOR CARRIER COVERAGE FORM
TRUCKERS COVERAGE FORM

With respect to coverage provided by this endorsement, the provisions of the Coverage Form apply unless modified by the endorsement.

A. The following is added to the **Other Insurance** Condition in the Business Auto Coverage Form and the Garage Coverage Form and the **Other Insurance – Primary And Excess Insurance Provisions** in the Motor Carrier Coverage Form and the Truckers Coverage Form and supersedes any provision to the contrary:

This Coverage Form's Covered Autos Liability Coverage is primary to and will not seek contribution from any other insurance available to an "insured" under your policy provided that:

1. Such "insured" is a Named Insured under such other insurance; and
2. You have agreed in writing in a contract or agreement that this insurance would be primary and would not seek contribution from any other insurance available to such "insured".

POLICY NUMBER: [redacted]

COMMERCIAL AUTO
CA 35 41 03 10

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

WAIVER OF TRANSFER OF RIGHTS OF RECOVERY AGAINST OTHERS TO US (WAIVER OF SUBROGRATION)

This endorsement modifies insurance provided under the following:

BUSINESS AUTO COVERAGE FORM
BUSINESS AUTO PHYSICAL DAMAGE COVERAGE FORM
GARAGE COVERAGE FORM
MOTOR CARRIER COVERAGE FORM
TRUCKERS COVERAGE FORM

With respect to coverage provided by this endorsement, the provisions of the Coverage Form apply unless modified by the endorsement.

This endorsement changes the policy effective on the inception date of the policy unless another date is indicated below.

Named Insured: [redacted]

Endorsement Effective Date: 02/04/2024

SCHEDULE

Name(s) Of Person(s) Or Organization(s):
Anyone with whom you have a written contract as required by this endorsement.
Information required to complete this Schedule, if not shown above, will be shown in the Declarations.

The **Transfer Of Rights Of Recovery Against Others To Us** Condition does not apply to the person(s) or organization(s) shown in the Schedule, but only to the extent that subrogation is waived prior to the "accident" or the "loss" under a contract with that person or organization.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

PRIMARY AND NON-CONTRIBUTORY COVERAGE

This endorsement modifies insurance provided under the following:

COMMERCIAL LIABILITY UMBRELLA COVERAGE FORM

The following is added to item **5. Other Insurance** of **SECTION IV - CONDITIONS:**

This insurance applies in excess of the "underlying insurance". However, with respect to an Additional Insured under this policy, this insurance is considered to be primary or primary and non-contributory with the insurance issued directly to such additional insured persons if:

1. Your contract specifically requires that we consider this insurance to be primary or primary and non-contributory, or
2. You request before a loss that we consider this insurance to be primary or primary and non-contributory insurance.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

WAIVER OF TRANSFER OF RIGHTS OF RECOVERY AGAINST OTHERS TO US

This endorsement modifies insurance provided under the following:

COMMERCIAL LIABILITY UMBRELLA COVERAGE PART

SCHEDULE

Name Of Person Or Organization:
As required by written contract with the named insured.

(If no entry appears above. information required to complete this endorsement will be shown in the Declarations as applicable to this endorsement.)

The **Transfer Of Rights Of Recovery Against Others To Us** Condition under **Section IV - Conditions** is amended by the addition of the following:

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 opeations 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

Insured Detail

1a. Legal Name and address of Insured (Use street address only) [redacted] Work Location of Insured *(Only required if coverage is specifically limited to certain location in New York State, i.e. a Wrap-Up Policy)*	**1b. Business Telephone Number of Insured** [redacted] **1c. NYS Unemployment Insurance Employer Registration Number of Insured** **1d. Federal Employer Identification Number of Insured or Social Security Number** [redacted]
2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) Somers Central School District 250 Route 202 Somers, NY 10589	**3a.Name of Insurance Carrier** Sequoia Insurance Company **3b. Policy Number of entity listed in box "1a":** [redacted] **3c. Policy effective period:** 3/31/2024 to 3/31/2025 **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: Matt Zender
(Print name of authorized representative or licensed agent of insurance carrier)

Approved By: _____ 4/3/2024
(Signature) (Date)

Title: Senior Vice President

Telephone Number of authorized representative or licensed agent of insurance carrier: 877-528-7878

Please Note: Only insurance carriers and their licensed agents are authorized to issue the C-105.2 form . Insurance brokers are NOT authorized to issue it.

C-105.2 (9-17) **www.wcb.ny.gov**

Workers' Compensation Law

Section 57. Restriction on issue of permits and the entering 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.

C-105.2 (9-17) REVERSE

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

[redacted]

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)

Somers Central School District
250 Route 202
Somers, NY 10589

3a. Name of Insurance Carrier

ShelterPoint Life Insurance Company

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

[redacted]

3c. Policy effective period

05/04/2023 to 05/03/2025

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 4/15/2024 By _____

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

Telephone Number 516-829-8100 Name and Title Richard White, Chief Executive Officer

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.