NEW YORK STATE | Workers' Compensation Board

CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

1a. Legal Name & Address of Insured (use street address only) Home Care Therapies d/b/a Horizon Healthcare Staffing 20 Jerusalem Avenue Hicksville NY 11801 Work Location of Insured (Only required if coverage is specifically limited to *certain locations in New York State, i.e., a Wrap-Up Policy)*	1b. Business Telephone Number of Insured 516-358-4141 1c. NYS Unemployment Insurance Employer Registration Number of Insured 1d. Federal Employer Identification Number of Insured or Social Security Number 113407141
2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) Hicksville Union Free School District; Administration Building 200 Division Avenue Hicksville NY 11801-0000	3a. Name of Insurance Carrier QBE Insurance Company (UK) Limited 3b. Policy Number of Entity Listed in Box "1a" WHC0200155 3c. Policy effective period 2/11/2023 to 2/11/2024 3d. The Proprietor, Partners or Executive Officers are ☒ included. (Only check box if all partners/officers included) ☐ all excluded or certain partners/officers excluded.

This certifies that the insurance carrier indicated above in box "3" insures the business referenced above in box "1a" for workers' compensation under the New York State Workers' Compensation Law. (To use this form, New York (NY) must be listed under Item 3A **on the INFORMATION PAGE of the workers' compensation insurance policy). The Insurance Carrier or its licensed agent will send** this Certificate of Insurance to the entity listed above as the certificate holder in box "2".

Will the carrier notify the certificate holder within 10 days of a policy being cancelled for non-payment of premium or within 30 days if cancelled for any other reason or if the insured is otherwise eliminated from the coverage indicated on this certificate prior to the end of the policy effective period? ☐YES ☒NO

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: Richard Famigletti
(Print name of authorized representative or licensed agent of insurance carrier)

Approved by: [signature] 2/9/2023
(Signature) (Date)

Title: Branch Manager

Telephone Number of authorized representative or licensed agent of insurance carrier: 516-622-2403

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.