

Insurance



Workers' Compensation Board

CERTIFICATE OF INSURANCE COVERAGE DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

PART 1. To be completed by Disability and Paid Family Leave Benefits Carrier or Licensed Insurance Agent of that Carrier

1a. Legal Name & Address of Insured (use street address only) ELI CONSTRUCTION SERVICES INC PO BOX 366 SHIRLEY, NY 11967 <small>Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e., Wrap-Up Policy)</small>	1b. Business Telephone Number of Insured 631-332-0883
1c. Federal Employer Identification Number of Insured or Social Security Number 461550346	2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) Town of Brookhaven One Independence Hill Farmingville, NY 11738
3a. Name of Insurance Carrier ShelterPoint Life Insurance Company	3b. Policy Number of Entity Listed in Box "1a" DBL615984
3c. Policy effective period 06/03/2020 to 06/02/2021	

4. Policy provides the following benefits:

A. Both disability and paid family leave benefits.
 B. Disability benefits only.
 C. Paid family leave benefits only.

5. Policy covers:

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 6/3/2020 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 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 4C or 5B of Part 1 has 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 with respect to all of his/her 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.



Insurance



8 CORPORATE CENTER DR, 3RD FLR, MELVILLE, NEW YORK 11747-3129
| nysif.com

CERTIFICATE OF WORKERS' COMPENSATION INSURANCE

***** 461550346
COTTEN COVERAGE INSURANCE
530 HORSEBLOCK RD
PO BOX 557
FARMINGVILLE NY 11738



SCAN TO VALIDATE
AND SUBSCRIBE

POLICYHOLDER ELI CONSTRUCTION SERVICES INC P O BOX 366 SHIRLEY NY 11967		CERTIFICATE HOLDER TOWN OF BROOKHAVEN ONE INDEPENDENCE HILL FARMINGVILLE NY 11738	
POLICY NUMBER 11412 494-5	CERTIFICATE NUMBER 263165	POLICY PERIOD 02/23/2020 TO 02/23/2021	DATE 6/3/2020

THIS IS TO CERTIFY THAT THE POLICYHOLDER NAMED ABOVE IS INSURED WITH THE NEW YORK STATE INSURANCE FUND UNDER POLICY NO. 1412 494-5, COVERING THE ENTIRE OBLIGATION OF THIS POLICYHOLDER FOR WORKERS' COMPENSATION UNDER THE NEW YORK WORKERS' COMPENSATION LAW WITH RESPECT TO ALL OPERATIONS IN THE STATE OF NEW YORK, EXCEPT AS INDICATED BELOW, AND, WITH RESPECT TO OPERATIONS OUTSIDE OF NEW YORK, TO THE POLICYHOLDER'S REGULAR NEW YORK STATE EMPLOYEES ONLY.

IF YOU WISH TO RECEIVE NOTIFICATIONS REGARDING SAID POLICY, INCLUDING ANY NOTIFICATION OF CANCELLATIONS, OR TO VALIDATE THIS CERTIFICATE, VISIT OUR WEBSITE AT [HTTPS://WWW.NYSIF.COM/CERT/CERTVAL.ASP](https://www.nysif.com/cert/certval.asp). THE NEW YORK STATE INSURANCE FUND IS NOT LIABLE IN THE EVENT OF FAILURE TO GIVE SUCH NOTIFICATIONS.

THIS POLICY DOES NOT COVER CLAIMS OR SUITS THAT ARISE FROM BODILY INJURY SUFFERED BY THE OFFICERS OF THE INSURED CORPORATION.

ELI CADENILLAS PRESIDENT
OF A ONE PERSON CORPORATION
ELI CONSTRUCTION SERVICES INC

THE POLICY INCLUDES A WAIVER OF SUBROGATION ENDORSEMENT UNDER WHICH NYSIF AGREES TO WAIVE ITS RIGHT OF SUBROGATION TO BRING AN ACTION AGAINST THE CERTIFICATE HOLDER TO RECOVER AMOUNTS WE PAID IN WORKERS' COMPENSATION AND/OR MEDICAL BENEFITS TO OR ON BEHALF OF AN EMPLOYEE OF OUR INSURED IN THE EVENT THAT, PRIOR TO THE DATE OF THE ACCIDENT, THE CERTIFICATE HOLDER HAS ENTERED INTO A WRITTEN CONTRACT WITH OUR INSURED THAT REQUIRES THAT SUCH RIGHT OF SUBROGATION BE WAIVED.

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS NOR INSURANCE COVERAGE UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICY.

NEW YORK STATE INSURANCE FUND

DIRECTOR, INSURANCE FUND UNDERWRITING

VALIDATION NUMBER: 564507578



