CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 11/28/2022

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	CONTACT NAME:	
SAMPLE	PHONE (A/C, No, Ext):	FAX (A/C, No):
	E-MAIL ADDRESS:	

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : National Union Fire Ins Co Pittsburgh PA	19445
INSURER B : N/A	N/A
INSURER C : N/A	N/A
INSURER D :	
INSURER E :	
INSURER F :	

INSURED: SAMPLE

COVERAGES **CERTIFICATE NUMBER:** NYC-011519179-01 **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			703-24-62	10/01/2022	10/01/2023	EACH OCCURRENCE	$ 1,000,000
	CLAIMS-MADE [X] OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 100,000
	X XCU						MED EXP (Any one person)	$ 5,000
	X Contractual						PERSONAL & ADV INJURY	$ 1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 2,000,000
	X POLICY [ ] PRO-JECT [ ] LOC						PRODUCTS - COMP/OP AGG	$ 2,000,000
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	OWNED AUTOS ONLY / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS ONLY / NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB [ ] OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB [ ] CLAIMS-MADE						AGGREGATE	$
	DED [ ] RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N						PER STATUTE [ ] OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)						E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Incorporated Village of Bellerose, all elected and appointed officials, employees and volunteers are included as primary and non-contributory additional insureds per the General Liability including Contractual Liability, Automobile Liability, and Excess Liability (if Excess Liability is applicable). Waiver of Subrogation is included on the Workers Compensation and General Liability in favor of the Additional Insured.

CERTIFICATE HOLDER

Incorporated Village of Bellrose
50 Superior Road
Bellerose, NY 11001

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

Marsh USA Inc.

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NYSIF
New York State Insurance Fund

8 CORPORATE CENTER DR, 2ND FLR, MELVILLE, NEW YORK 11747-3166
| nysif.com

CERTIFICATE OF WORKERS' COMPENSATION INSURANCE

^^^^^^ 208342140
F.V. CONTRACTING, INC.
480 DOVER STREET
WESTBURY NY 11590

SCAN TO VALIDATE
AND SUBSCRIBE

POLICYHOLDER	CERTIFICATE HOLDER
F.V. CONTRACTING, INC. 480 DOVER STREET WESTBURY NY 11590	INC VILLAGE OF BELLEROSE 50 SUPERIOR RD BELLEROSE VILLAGE NY 11001

POLICY NUMBER	CERTIFICATE NUMBER	POLICY PERIOD	DATE
H1386 806-2	376992	04/25/2020 TO 04/25/2021	7/15/2020

THIS IS TO CERTIFY THAT THE POLICYHOLDER NAMED ABOVE IS INSURED WITH THE NEW YORK STATE INSURANCE FUND UNDER POLICY NO. 1386 806-2, 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. 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.

PRESIDENT
JUAN FREDY ZUNIGA
VICE-PRESIDENT
JOSE LUIS VENTURA
F.V. CONTRACTING, INC.
A TWO-PERSON CORPORATION

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: 605569741

U-26.3

NEW YORK STATE | 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) F V CONTRACTING INC 480 DOVER ST WESTBURY, NY 11590 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) 338-4733 1c. Federal Employer Identification Number of Insured or Social Security Number 208342140
2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) INC. VILLAGE OF BELLEROSE 50 SUPERIOR RD BELLEROSE VILLAGE, NY 11001	3a. Name of Insurance Carrier **New York State Insurance Fund (NYSIF)** 3b. Policy Number of Entity Listed In Box "1a" DBL 5731 98 - 0 3c. Policy effective period 07/10/2020 to 07/10/2021

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 7/15/2020 By _____

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

Telephone Number (866) 697-4332 Name and Title **Melissa Jensen, Director of Disability Insurance Unit**

IMPORTANT: If Box 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, DB 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.***

DB-120.1 (10-17)

Certificate Number 605397