



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

3/6/2023

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 Arthur J. Gallagher Risk Management Services, LLC 4000 Midlantic Drive Suite 200 Mount Laurel NJ 08054	CONTACT NAME: Max Fetter PHONE (A/C, No, Ext): 856-675-2382 E-MAIL ADDRESS: CherryHill.BSD.CertM@AJG.com FAX (A/C, No): 856-482-1888												
INSURED QualTek Wireless LLC 475 Sentry Parkway E Ste 200 Blue Bell, PA 19422	INSURER(S) AFFORDING COVERAGE <table><tr><td>INSURER A: Liberty Mutual Fire Insurance Company</td><td>NAIC # 23035</td></tr><tr><td>INSURER B: AXIS Insurance Company</td><td>37273</td></tr><tr><td>INSURER C: Hartford Fire Insurance Company</td><td>19682</td></tr><tr><td>INSURER D: Berkley Specialty Insurance Company</td><td>31295</td></tr><tr><td>INSURER E: Navigators Insurance Company</td><td>42307</td></tr><tr><td>INSURER F: Westchester Surplus Lines Insurance Co</td><td>10172</td></tr></table>	INSURER A: Liberty Mutual Fire Insurance Company	NAIC # 23035	INSURER B: AXIS Insurance Company	37273	INSURER C: Hartford Fire Insurance Company	19682	INSURER D: Berkley Specialty Insurance Company	31295	INSURER E: Navigators Insurance Company	42307	INSURER F: Westchester Surplus Lines Insurance Co	10172
INSURER A: Liberty Mutual Fire Insurance Company	NAIC # 23035												
INSURER B: AXIS Insurance Company	37273												
INSURER C: Hartford Fire Insurance Company	19682												
INSURER D: Berkley Specialty Insurance Company	31295												
INSURER E: Navigators Insurance Company	42307												
INSURER F: Westchester Surplus Lines Insurance Co	10172												

COVERAGES**CERTIFICATE NUMBER:** 1355429774**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	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PRO-JECT <input checked="" type="checkbox"/> LOC <input type="checkbox"/> OTHER:			TB2-631-510650-042	11/30/2022	11/30/2023	EACH OCCURRENCE \$2,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$100,000 MED EXP (Any one person) \$10,000 PERSONAL & ADV INJURY \$2,000,000 GENERAL AGGREGATE \$4,000,000 PRODUCTS - COMP/OP AGG \$4,000,000 \$
A	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY			AS2-631-510650-032	11/30/2022	11/30/2023	COMBINED SINGLE LIMIT (Ea accident) \$2,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ Comp/Collision Ded \$1,000/1,000
B	<input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR <input checked="" type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> DED <input type="checkbox"/> RETENTION \$			P-001-000073672-05 BCS 8800151-10 NY22EXCZ03HAGIV G47374911 001	11/30/2022 11/30/2022 11/30/2022 11/30/2022	11/30/2023 11/30/2023 11/30/2023 11/30/2023	EACH OCCURRENCE \$30,000,000 AGGREGATE \$30,000,000 \$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N	N/A	WA7-63D-510650-012	11/30/2022	11/30/2023	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$1,000,000 E.L. DISEASE - EA EMPLOYEE \$1,000,000 E.L. DISEASE - POLICY LIMIT \$1,000,000
C	Installation Floater			QT-630-9T676607-TIL-22	11/30/2022	11/30/2023	Limit Deductible 5,000,000 5,000

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

Cyber Liability (Primary)
Policy #01-CY-0005511569-01
Policy Period: 11/30/2022 - 11/30/2023
Carrier: Hartford Steam Boiler Inspection & Insurance Co.
Limit: \$5,000,000

Cyber Liability (Excess)
Policy #2-CIA-PA-17E-S0104722-01
See Attached...

CERTIFICATE HOLDER**CANCELLATION**

City of Kingston
420 Broadway
Kingston NY 12401

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

© 1988-2015 ACORD CORPORATION. All rights reserved.



ADDITIONAL REMARKS SCHEDULE

AGENCY Arthur J. Gallagher Risk Management Services, LLC		NAMED INSURED QualTek Wireless LLC 475 Sentry Parkway E Ste 200 Blue Bell, PA 19422
POLICY NUMBER		
CARRIER	NAIC CODE	EFFECTIVE DATE:

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,

FORM NUMBER: 25 **FORM TITLE:** CERTIFICATE OF LIABILITY INSURANCE

Policy Period: 11/30/2022 - 11/30/2023

Carrier: Accredited Specialty Insurance Company

Limit: \$5MM x \$5MM

Cyber Liability (Excess)

Policy #720000574-0001

Policy Period: 11/30/2022 - 11/30/2023

Carrier: Homeland Insurance Company of Delaware

Limit: \$5MM x \$10MM

Cyber Liability (Excess)

Policy #EEU 13866 02

Policy Period: 11/30/2022 - 11/30/2023

Carrier: Hudson Excess Insurance Company

Limit: \$5MM x \$15MM

Professional Liab/E&O/Pollution

Policy # 0311-0596

Policy Period: 11/30/2022 - 11/30/2023

Carrier: Allied World Assurance Company, Ltd.

Occurrence/Aggregate: \$5MM/5MM

Travelers Property Casualty Company of America

Inland Marine Policy

Eff Date: 11/30/22 - Exp Date: 11/30/23

Policy # QT-630-9T676607-TIL-22

Installation Operations - LIMIT: \$5,000,000/ DEDUCTIBLE: \$5,000

In Transit - LIMIT: \$1,000,000/ DEDUCTIBLE: \$5,000

In Temporary Storage - LIMIT: \$15,000,000/ DEDUCTIBLE: \$5,000

Leased/Rented Equipment:

Limit: \$1,500,000

Deductible: \$5,000

Workers Compensation (WI)

Carrier: Liberty Insurance Corporation

Policy #: WC7-631-510650-052

Policy Period: 11/30/2022 - 11/30/2023

Bodily Injury by Accident: \$1,000,000 each accident

Bodily Injury by Disease: \$1,000,000 policy limit

Bodily Injury by Disease: \$1,000,000 each employee

RE: Scope of work being performed:

Proposed Antenna config: Confirm 3' antenna separation and no antenna skewing (bump out if needed)

A-D'2A'D'D' 7TRD'8TRD'2TR9TR_77G77D_Ft_7de,

- Install (1) NNH4-65C-R6N17 12ports in position one with (1) 4449 B5/B12 (850/700) Radios.

- Reconnect existing RRUS 32 B66 (AWS) Radio and RRUS 32 B2 (PCS) Radio to new 12port.

- Install (1) AIR 6449 B77D + (1) AIR 6419 B77G STACKED in position 2

B-D'2A'D' Ft_77G77D_7TRD'8TRD'2TR,

- Install (1) AIR 6449 B77D + (1) AIR 6419 B77G STACKED in position 2

- Install (1) NNH4-65C-R6N17 12port in position four with (1) 4449 B5/B12 (850/700), reconnect existing RRUS 32 B66 (AWS)

C-DD'2A'D' 7de9TR_Ft9TR_77G77D_7TRD'8TRD'2TR3TR

- Install (1) AIR 6449 B77D + (1) AIR 6419 B77G STACKED in position 3

- Install (1) NNH4-65C-R6N17 12ports in position four and reconnect existing 4449 B5/B12 (850/700) Radios

- Reconnect existing RRUS 32 B66 (AWS) Radios and RRUS 32 B30 (WCS) Radios to new 12port



CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

<p>1a. Legal Name & Address of Insured (use street address only)</p> <p>QualTek Wireless LLC 475 Sentry Parkway E Ste 200 Blue Bell, PA 19422</p> <p>Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e., a Wrap-Up Policy)</p>	<p>1b. Business Telephone Number of Insured</p> <p>484-804-4500</p> <p>1c. NYS Unemployment Insurance Employer Registration Number of Insured</p> <p>1d. Federal Employer Identification Number of Insured or Social Security Number</p> <p>46-1348019</p>
<p>2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)</p> <p>City of Kingston 420 Broadway Kingston NY 12401</p>	<p>3a. Name of Insurance Carrier</p> <p>Liberty Mutual Fire Insurance Company</p> <p>3b. Policy Number of Entity Listed in Box "1a"</p> <p>WA7-63D-510650-012</p> <p>3c. Policy effective period</p> <p style="text-align: center;">11/30/2022 to 11/30/2023</p> <p>3d. The Proprietor, Partners or Executive Officers are</p> <p><input checked="" type="checkbox"/> included. (Only check box if all partners/officers included)</p> <p><input type="checkbox"/> all excluded or certain partners/officers excluded.</p>

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: Dan Tropp
(Print name of authorized representative or licensed agent of insurance carrier)

Approved by:  3/6/2023
(Signature) (Date)

Title: Mid-Atlantic Regional President

Telephone Number of authorized representative or licensed agent of insurance carrier: 856-675-2382

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' 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.

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

<p>1a. Legal Name & Address of Insured (use street address only) QUALTEK WIRELESS LLC (NEW YORK EMPLOYEES) 475 SENTRY PARKWAY E, SUITE 200 BLUE BELL, PA 19422</p> <p><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></p>	<p>1b. Business Telephone Number of Insured 4848044570</p> <p>1c. Federal Employer Identification Number of Insured or Social Security Number 82-2496529</p>
<p>2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) City of Kingston 420 Broadway Kingston, NY 12401</p>	<p>3a. Name of Insurance Carrier Standard Security Life Insurance Company of New York</p> <p>3b. Policy Number of Entity Listed in Box "1a" R05857-003</p> <p>3c. Policy effective period 11/30/2017 to 3/4/2024</p>

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 3/6/2023 By 
(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number (212) 355-4141 Name and Title **SUPERVISOR-DBL/POLICY SERVICES**

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.**



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 New York State Disability and Paid Family Leave Benefits Law. The Insurance Carrier or its licensed agent will send this Certificate of Insurance 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 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 NYS Disability and/or Paid Family Leave Benefits Coverage or other authorized proof that the business is complying with the mandatory coverage requirements of the New York State Disability and Paid Family Leave Benefits Law.

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 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 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.



CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

<p>1a. Legal Name & Address of Insured (use street address only)</p> <p>QualTek Wireless LLC 475 Sentry Parkway Suite 200 Blue Bell PA 19422</p> <p><i>Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e., a Wrap-Up Policy)</i></p>	<p>1b. Business Telephone Number of Insured</p> <p style="text-align: center;">484-804-4500</p> <p>1c. NYS Unemployment Insurance Employer Registration Number of Insured</p> <p>1d. Federal Employer Identification Number of Insured or Social Security Number</p> <p style="text-align: center;">82-2496529</p>
<p>2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)</p> <p style="text-align: center;">City of Kingston 420 Broadway Kingston, NY 12401</p>	<p>3a. Name of Insurance Carrier</p> <p style="text-align: center;">Liberty Insurance Corporation</p> <p>3b. Policy Number of Entity Listed in Box "1a"</p> <p style="text-align: center;">WA7-63D-510650-012</p> <p>3c. Policy effective period</p> <p style="text-align: center;">11/30/2022 to 11/30/2023</p> <p>3d. The Proprietor, Partners or Executive Officers are</p> <p><input checked="" type="checkbox"/> included. (Only check box if all partners/officers included)</p> <p><input type="checkbox"/> all excluded or certain partners/officers excluded.</p>

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: Diane Beaudoin
(Print name of authorized representative or licensed agent of insurance carrier)

Approved by: *Diane Beaudoin* 11/22/2022
(Signature) (Date)

Title: Sr. Customer Service Coordinator

Telephone Number of authorized representative or licensed agent of insurance carrier: 401-248-9924

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.

C-105.2 (9-17)

www.wcb.ny.gov

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.