**STATE OF NEW YORK**
**WORKER'S COMPENSATION BOARD**

# CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

| | |
|---|---|
| **1a. Legal Name and address of Insured (Use street address only)**<br>BBQ Pit Boys, Inc.<br>625 Culver Road<br>Rochester, NY 14609-0000<br><br>**DBA:** Sticky Lips Pit BBQ<br><br>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**<br>585-271-2135<br><br>**1c. NYS Unemployment Insurance Employer Registration Number of Insured**<br>4672952<br><br>**1d. Federal Employer Indentification Number of Insured or Social Security Number**<br>200166096 |
| **2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)**<br>Monroe County Dept of Health<br>111 Westfall Rd.<br><br>Rochester, NY 14620 | **3a.Name of Insurance Carrier**<br>Technology Insurance Company<br><br>**3b. Policy Number of entity listed in box "1a":**<br>TWC3384396<br><br>**3c. Policy effective period:**<br>12/31/2013 to 12/31/2014<br><br>**3d. The Proprietor, Partners or Executive Officers are:**<br>☐ **included** (Only check box if all partners/officers included)<br><br>☐ **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 Certification of Insurance to the entity listed above as the certificate holder in box "2".

*The Insurance Carrier will also notify the above certificate holder 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.*

**Please Note: Upon the 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: Henry C. Sibley
(Print name of authorized representative or licensed agent of insurance carrier)

Approved By: Henry C Sibley 12/31/2013
(Signature) (Date)

Title: Underwriting Manager

Telephone Number of authorized representative or licensed agent of insurance carrier: CarrierPhone

*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 (9-07)**

## 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 (9-07) Reverse**

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

# CERTIFICATE OF INSURANCE COVERAGE UNDER THE NYS DISABILITY BENEFITS LAW

## PART 1. To be completed by Disability Benefits Carrier or Licensed Insurance Agent of that Carrier

| | |
|---|---|
| 1a. Legal Name and Address of Insured (Use street address only)<br>THE BBQ PIT BOYS INC DBA<br>STICKY LIPS PIT BBQ<br>625 CULVER ROAD<br>ROCHESTER, NY 14609 | 1b. Business Telephone Number of Insured<br>(585) 288 - 1910<br>1c. NYS Unemployment Insurance Employer Registration Number of Insured 4672952<br>1d. Federal Employer Identification Number of Insured or Social Security Number 200166096 |
| 2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)<br>MONROE COUNTY DEPT OF HEALTH<br>111 WESTFALL RD.<br>ROOM 1020<br>ROCHESTER, NY 14620 | 3a. Name of Insurance Carrier<br>NATIONAL BENEFIT LIFE INSURANCE COMPANY<br>3b. Policy Number of entity listed in box "1a":<br>8-910-0196191<br>3c. Policy effective period:<br>12/31/2013 to 12/31/2015 |

4. Policy covers:

a. ☒ All of the employer's employees eligible under the New York Disability Benefits Law

b. ☐ Only the following class or classes of the 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 Benefits insurance coverage as described above.

Date Signed 12/31/2013 By Kathleen Reha

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

Telephone Number 800-535-2711 Title Vice President

IMPORTANT: If box "4a" is 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" is checked, this certificate is NOT COMPLETE for purposes of Section 220, Subd. 8 of the Disability Benefits Law. It must be mailed for completion to the Workers' Compensation Board, DB Plans Acceptance Unit, 20 Park Street, Albany, New York 12207.

## PART 2. To be completed by NYS Workers' Compensation Board (Only if box "4b" 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 Benefits Law with respect to all of his/her employees.

Date Signed _____ By _____

(Signature of NYS Workers' Compensation Board Employee)

Telephone Number _____ Title _____

***Please Note:*** *Only insurance carriers licensed to write NYS disability 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 benefits under the New York State Disability 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". ***This Certificate is valid for the earlier of one year after this form is approved by the insurance carrier or its licensed agent, or the policy expiration date listed in box "3c".***

Please Note: Upon the cancellation of the disability 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 Benefits Coverage or other authorized proof that the business is complying with the mandatory coverage requirements of the New York State Disability Benefits Law.

## DISABILITY 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 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 for all employees has been secured as provided by this article.

**STATE OF NEW YORK**
**WORKER'S COMPENSATION BOARD**

# CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

| | |
|---|---|
| **1a. Legal Name and address of Insured (Use street address only)**<br>HBD Jefferson LLC<br>830 Jefferson Road<br>Rochester, NY 14623<br><br>**DBA:** Sticky Lips Pit BBQ<br><br>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**<br>585-288-1910<br><br>**1c. NYS Unemployment Insurance Employer Registration Number of Insured**<br><br>**1d. Federal Employer Indentification Number of Insured or Social Security Number**<br>271881441 |
| **2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)**<br>Monroe County Dept. of Public Health<br>111 Westfall Road<br>Room 1020<br>Rochester, NY 14620 | **3a.Name of Insurance Carrier**<br>Technology Insurance Company<br><br>**3b. Policy Number of entity listed in box "1a":**<br>TWC3373445<br><br>**3c. Policy effective period:**<br>8/12/2013 to 8/12/2014<br><br>**3d. The Proprietor, Partners or Executive Officers are:**<br>[ ] **included** (Only check box if all partners/officers included)<br><br>[ ] **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 Certification of Insurance to the entity listed above as the certificate holder in box "2".

*The Insurance Carrier will also notify the above certificate holder 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.*

**Please Note: Upon the 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: Henry C. Sibley
(Print name of authorized representative or licensed agent of insurance carrier)

Approved By: Henry C Sibley 12/31/2013
(Signature) (Date)

Title: Underwriting Manager

Telephone Number of authorized representative or licensed agent of insurance carrier: CarrierPhone

*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 (9-07)**

## 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 (9-07) Reverse**

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

# CERTIFICATE OF INSURANCE COVERAGE UNDER THE NYS DISABILITY BENEFITS LAW

## PART 1. To be completed by Disability Benefits Carrier or Licensed Insurance Agent of that Carrier

| | |
|---|---|
| 1a. Legal Name and Address of Insured (Use street address only)<br>HBD JEFFERSON LLC DBA<br>STICKY LIPS PIT BBQ<br>830 JEFFERSON ROAD<br>ROCHESTER, NY 14623 | 1b. Business Telephone Number of Insured<br>(585) 292 - 5544<br>1c. NYS Unemployment Insurance Employer Registration Number of Insured<br><br>1d. Federal Employer Identification Number of Insured or Social Security Number 271881441 |
| 2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)<br>MONROE COUNTY DEPT OF HEALTH<br>111 WESTFALL RD.<br>ROOM 1020<br>ROCHESTER, NY 14620 | 3a. Name of Insurance Carrier<br>NATIONAL BENEFIT LIFE INSURANCE COMPANY<br>3b. Policy Number of entity listed in box "1a":<br>8-910-0235117<br>3c. Policy effective period:<br>12/31/2013 to 12/31/2015 |

4. Policy covers:

a. ☒ All of the employer's employees eligible under the New York Disability Benefits Law

b. ☐ Only the following class or classes of the 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 Benefits insurance coverage as described above.

Date Signed 12/31/2013 By Kathleen Reilly

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

Telephone Number 800-535-2711 Title Vice President

IMPORTANT: If box "4a" is 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" is checked, this certificate is NOT COMPLETE for purposes of Section 220, Subd. 8 of the Disability Benefits Law. It must be mailed for completion to the Workers' Compensation Board, DB Plans Acceptance Unit, 20 Park Street, Albany, New York 12207.

## PART 2. To be completed by NYS Workers' Compensation Board (Only if box "4b" 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 Benefits Law with respect to all of his/her employees.

Date Signed _____ By _____

(Signature of NYS Workers' Compensation Board Employee)

Telephone Number _____ Title _____

***Please Note:*** *Only insurance carriers licensed to write NYS disability 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 (5-06)

# 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 ir box "1a" for disability benefits under the New York State Disability Benefits Law. The Insurance Carrier or its licensed agent will senc this Certificate of Insurance to the entity listed as the certificate holder in box "2". ***This Certificate is valid for the earlier of one yea after this form is approved by the insurance carrier or its licensed agent, or the policy expiration date listed in box "3c".***

Please Note: Upon the cancellation of the disability benefits policy indicated on this form, if the business continues to be named on a permit, license o contract issued by a certificate holder, the business must provide that certificate holder with a new Certificate of NYS Disability Benefits Coverage o other authorized proof that the business is complying with the mandatory coverage requirements of the New York State Disability Benefits Law.

## DISABILITY BENEFITS LAW

## §220. Subd. 8

(a) The head of a state or municipal department, board, commission or office authorized or required by law t issue any permit for or in connection with any work involving the employment of employees in employment a defined in this article, and not withstanding any general or special statute requiring or authorizing the issue o such permits, shall not issue such permit unless proof duly subscribed by an insurance carrier is produced in form satisfactory to the chair, that the payment of disability benefits for all employees has been secured a provided by this article. Nothing herein, however, shall be construed as creating any liability on the part of suc state or municipal department, board, commission or office to pay any disability benefits to any such employe if so employed.

(b) The head of a state or municipal department, board, commission or office authorized or required by law t enter into any contract for or in connection with any work involving the employment of employees i employment as defined in this article, and notwithstanding any general or special statute requiring or authorizin any such contract, shall not enter into any such contract unless proof duly subscribed by an insurance carrier i produced in a form satisfactory to the chair, that the payment of disability benefits for all employees has bee secured as provided by this article.