



Workers'
Compensation
Board

CERTIFICATE OF INSURANCE COV DISABILITY AND PAID FAMILY LEAVE BENE

DEPT BLDGS Job No. 321925244



Scan Code ESHS8225870

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)

GRAMERCY GROUP, INC.
3000 BURNS AVENUE
WANTAGH, NY 11793

Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e., Wrap-Up Policy)

1b. Business Telephone Number of Insured

5168760020

1c. Federal Employer Identification Number of Insured
or Social Security Number

13-3546842

2. Name and Address of Entity Requesting Proof of Coverage
(Entity Being Listed as the Certificate Holder)

New York City Department of Buildings
Attn: Licensing & Exams Unit
280 Broadway, 1st Floor
New York, NY 10007

3a. Name of Insurance Carrier

Standard Security Life Insurance Company of New York

3b. Policy Number of Entity Listed in Box "1a"

R93829-000

3c. Policy effective period

1/1/2014

to

8/19/2020

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 8/21/2019

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.

