



Workers'
Compensation
Board

CERTIFICATE OF INSURANCE COVERAGE

NYS DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

PART 1. To be completed by NYS disability and Paid Family Leave benefits carrier or licensed insurance agent of that carrier

1a. Legal Name & Address of Insured (use street address only)
THREE GLOVES CONSTRUCTION INC.
219 -11 131St Ave Springfield Gardens NY 11413
MALVERNE, NY 11565

1b. Business Telephone Number of Insured
917-731-7720

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

1c. Federal Employer Identification Number of Insured or Social Security Number
275299221

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

NYC DEPARTMENT OF BUILDINGS
280 BROADWAY, 6TH FL
NEW YORK NY 10007

3a. Name of Insurance Carrier

ShelterPoint Life Insurance Company

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

DBL468447

3c. Policy effective period

06/16/2023 to 06/15/2025

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 5/17/2024

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 Leston Welsh, 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 emailed to PAU@wcb.ny.gov or it can 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 4B, 4C or 5B have 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 (Article 9 of the Workers' Compensation Law) with respect to all of their employees.

Date Signed

By

(Signature of Authorized NYS Workers' Compensation Board Employee)

Telephone Number

Name and Title

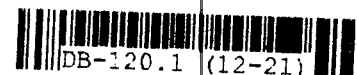
Please Note: Only insurance carriers licensed to write NYS disability and paid family leave benefits insurance policies and NYS licensed insurance agents of those insurance carriers are authorized to issue Form DB-120.1. Insurance brokers are NOT authorized to issue this form.

DB-120.1 (12-21)

DEPT BLDGS Job No. 321970382



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DB-120.1 (12-21)