AURORA INC/PHS
301 WOODS PARK DRIVE
CLINTON NY 13323

COUNTY OF CORTLAND
60 CENTRAL AVE
CORTLAND NY 13045

CERTIFICATE OF LIABILITY INSURANCE

LMG R054

DATE (MM/DD/YYYY) 3/10/2017

THIS CERTIFICATEIS 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:	
AURORA INC/PHS 111155 P:(866) 467-8730 F:(888) 443-6112 301 WOODS PARK DRIVE CLINTON NY 13323	PHONE (A/C, No, Ext): (866) 467-8730	FAX (A/C, No): (888) 443-6112
	E-MAIL ADDRESS:	

INSURER(S) AFFORDING COVERAGE	NAIC#
INSURER A: Hartford Casualty Ins Co	29424
INSURER B: Twin City Fire Ins Co	29459
INSURER C:	
INSURER D:	
INSURER E:	
INSURER F:	

INSURED

NEW YORK STATE DEFENDERS ASSOCIATION
194 WASHINGTON AVE STE 500
ALBANY NY 12210

COVERAGES **CERTIFICATE NUMBER:** **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 INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	COMMERCIAL GENERAL LIABILITY CLAIMS-MADE [X] OCCUR [X] General Liab GEN'L AGGREGATE LIMIT APPLIES PER: POLICY [ ] PRO-JECT [X] LOC OTHER:			01 SBA IB5472	06/28/2016	06/28/2017	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$1,000,000 $300,000 $10,000 $1,000,000 $2,000,000 $2,000,000
A	AUTOMOBILE LIABILITY ANY AUTO OWNED AUTOS ONLY [ ] SCHEDULED AUTOS [X] HIRED AUTOS ONLY [X] NON-OWNED AUTOS ONLY			01 SBA IB5472	06/28/2016	06/28/2017	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$1,000,000 $ $ $
A	[X] UMBRELLA LIAB [X] OCCUR EXCESS LIAB [ ] CLAIMS-MADE DED [X] RETENTION $ 10,000			01 SBA IB5472	06/28/2016	06/28/2017	EACH OCCURRENCE AGGREGATE	$1,000,000 $1,000,000
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N [ ] If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		01 WEC VO3492	06/28/2016	06/28/2017	[X] PER STATUTE [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE- EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $100,000 $100,000 $500,000

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

Those usual to the Insured's Operations.

CERTIFICATE HOLDER

COUNTY OF CORTLAND
60 CENTRAL AVE
CORTLAND, NY 13045

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

Marc Maillou

NEW YORK STATE | **Workers' Compensation Board**

LMG
R054

CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

1a. Legal Name and address of Insured (use street address only) NEW YORK STATE DEFENDERS ASSOCIATION 194 WASHINGTON AVE STE 500 ALBANY NY 12210 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 518-465-3524 1c. NYS Unemployment Insurance Employer Registration Number of Insured 1d. Federal Employer Identification Number of Insured or Social Security Number 112461900
2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) COUNTY OF CORTLAND 60 CENTRAL AVE CORTLAND, NY 13045	3a. Name of Insurance Carrier Twin City Fire Ins Co 3b. Policy Number of Entity listed in Box "1a": 01 WEC VO3492 3c. Policy effective period: 06/28/2016 to 06/28/2017 3d. The Proprietor, Partners or Executive Officers are: [ ] included. (Only check box if all partners/officers included) [X] 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 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 X 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 Worker's 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: Danielle Clausen
(print name of authorized representative or licensed agent of insurance carrier)

Approved by: Danielle Clausen 3/10/2017
(Signature) (Date)

Title: Operations Manager

Telephone Number of authorized representative or licensed agent of insurance carrier: 866-467-8730

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.

NEW YORK STATE | 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 & Address of Insured (use street address only) NEW YORK STATE DEFENDERS ASSOCIATION INC 194 WASHINGTON AVE SUITE 500 ALBANY NY 12210 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 518-465-3524 1c. NYS Unemployment Insurance Employer Registration Number of Insured 1d. Federal Employer Identification Number of Insured or Social Security Number 11-2461900
2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) Cortland County 60 Central Avenue Cortland NY 13045	3a. Name of Insurance Carrier LINCOLN LIFE AND ANNUITY OF NEW YORK 3b. Policy Number of Entity Listed in Box "1a" 00352-00 3c. Policy effective period 01/01/2017 to 01/01/2018

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 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 03/13/2017 By Mary Ellen Huss

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

Telephone Number 1-855-239-8831 Title POLICY ADMINISTRATOR

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, 328 State Street, Schenectady, NY 12305

PART 2. To be completed by the 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 (9-15)