FORM A

New York State Consultant Services
Contractor's Planned Employment
From Contract Start Date Through the End of the Contract Term

State Agency Name: State University of New York - System Administration
State Agency Department ID: SNY01 Agency Business Unit: 2877
Contractor Name: Research Foundation for SUNY Contract Number: C004196
Contract Start Date: 6/1/2024 Contract End Date: 3/31/2030

Employment Category	Number of Employees	Number of Hours to be Worked	Amount Payable Under the Contract
11-9199.00 Office and Administrative Support Workers, All Other	2.00	23,400.00	$1,459,928.00
	0.00	0.00	$0.00
	0.00	0.00	$0.00
	0.00	0.00	$0.00
	0.00	0.00	$0.00
	0.00	0.00	$0.00
	0.00	0.00	$0.00
	0.00	0.00	$0.00
	0.00	0.00	$0.00
	0.00	0.00	$0.00
	0.00	0.00	$0.00
	0.00	0.00	$0.00
	0.00	0.00	$0.00
	0.00	0.00	$0.00
	0.00	0.00	$0.00
	0.00	0.00	$0.00
	0.00	0.00	$0.00
Total this Page	2.00	23,400.00	$1,459,928.00
Grand Total	2.00	23,400.00	$1,459,928.00

Name of person who prepared this report: Kristine Choppa
Title: Contracts & Grants Manager Kristine Choppa Digitally signed by Kristine Choppa Date: 2024.06.26 15:58:39 -04'00' Phone #: 518-434-7042
Preparer's Signature: _____
Date Prepared: 6/26/2024

(Use additional pages, if necessary)

NEW YORK STATE | Workers' Compensation Board

CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

1a. Legal Name & Address of Insured (use street address only) The Research Foundation for The State University of New York 35 State Street, PO Box 9 Albany, NY 12201 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)434-7045 1c. NYS Unemployment Insurance Employer Registration Number of Insured 04-54705 1d. Federal Employer Identification Number of Insured or Social Security Number 14-1368361
2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) State University of New York State University Plaza, 353 Broadway Albany, NY 12246 COI #1697	3a. Name of Insurance Carrier ACE American Insurance Co. 3b. Policy Number of Entity Listed in Box "1a" 71644923 3c. Policy effective period 7/01/2024 to 7/01/2025 3d. The Proprietor, Partners or Executive Officers are ☒ included. (Only check box if all partners/officers included) ☐ 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".

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: Guy Alonge, III
(Print name of authorized representative or licensed agent of insurance carrier)

Approved by: _____ 6/20/24
(Signature) (Date)

Title: President - Amsure, Albany Division

Telephone Number of authorized representative or licensed agent of insurance carrier: (518)458-1800

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.

NEW YORK STATE | Workers' Compensation Board

CERTIFICATE OF INSURANCE COVERAGE
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)
The Research Foundation for the State University of New York
35 State Street
Albany, NY 12207

1b. Business Telephone Number of Insured
518-434-7132

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
141-36-8361

2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)
State of University of New York
State University Plaza, 353 Broadway
Albany, NY 12246
Blanket COI# 1697

3a. Name of Insurance Carrier
The Standard Life Insurance Company of New York
333 Westchester Avenue, West Building, Suite 300
White Plains, New York 10604

3b. Policy Number of Entity Listed in Box "1a"
762055

3c. Policy effective period
01/01/2024 to **01/01/2027**

4. Policy provides the following benefits:
- [x] A. Both disability and Paid Family Leave benefits.
- [ ] B. Disability benefits only.
- [ ] C. Paid Family Leave benefits only.

5. Policy covers:
- [x] 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 **01/03/2024** By Stephanie Mayeux
(Signature of insurance carrier's authorized representative or NYS licensed insurance agent of that insurance carrier)

Telephone Number **(971) 321-7520** Name and Title **Stephanie Mayeux, Client Manager National Accounts**

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.***