STATE OF NEW YORK WORKERS' COMPENSATION BOARD

DISABILITY BENEFITS LAW

CERTIFICATE/CANCELLATION OF INSURANCE

Filed on behalf of Employer in compliance with Article 9 of the Workers' Compensation Law

[X] Initial [ ] Cancellation [ ] Reinstatement [ ] Supersedes Transaction Effective Date: 01/01/2018

A. INSURER/CARRIER

1. INSURER/CARRIER NAME	2. INSURER/CARRIER CODE	3. INSURER/CARRIER TELEPHONE NO.
ShelterPoint Life Insurance Company	B069508	(516) 829-8100

4. CONTACT NAME	5. TITLE	6. TODAY'S DATE
Customer Service Department	Customer Service Representative	12/07/2017

B. CURRENT - EMPLOYER INFORMATION

7. WCB EMPLOYER NUMBER	8. NYS UIER NUMBER	9. EMPLOYER FEIN
		131740114

10. EMPLOYER'S LEGAL NAME, INCLUDING (DBA/AKA/TA)
MONTEFIORE MEDICAL CENTER
ATTN: EILEEN MONTALTO

13. LEGAL STATUS: 03

11. ADDRESS: 555 S BROADWAY, BLDG A

14. # OF EMPLOYEES: 12909

12. CITY	STATE	ZIP CODE	15. TELEPHONE NO.
TARRYTOWN	NY	10591	---

C. POLICY

* *If policyholder is an Association, Union or Trustee for which Form DB-820.3 is filed, do not complete items 16 and 18.*

16. POLICY NUMBER*	17. POLICY EFFECTIVE DATE	18. POLICY FORM NUMBER*
DBL520186	01/01/2018	GDBL-1

19. WCB PLAN NUMBER (Only for Assoc., Union or Trustee with Form DB-801 on file.)	20. PREMIUM AMOUNT
--	$ 0.00

D. REASONS FOR CANCELLATION

- [ ] Non-Payment of Premium
- [ ] Other
- [ ] Not Subject/No Eligible Employees Date: _____
- [ ] Out of Business..... Date: _____
- [ ] Seasonal..... Date: _____

CANCELLATION OR TERMINATION SENT TO EMPLOYER: Date:

E. Complete if SUPERSEDES box is checked at top of form.

21. EMPLOYER'S LEGAL NAME, INCLUDING (DBA/AKA/TA)

22. ADDRESS

23. CITY STATE ZIPCODE

24. EMPLOYER FEIN

25. POLICY EFFECTIVE DATE

26. POLICY NUMBER

F. POLICYHOLDER - If different from Employer.

27. POLICYHOLDER NAME

28. POLICYHOLDER ADDRESS

29. CITY STATE ZIPCODE

30. POLICYHOLDER FEIN

G

1. **The policy covers Employer's employees as follows:**
   - a. ..X... All employees eligible under the New York State Disability Benefits Law.
   - b. ..... All employees eligible under the New York State Disability Benefits Law except those classes of employees eligible to receive benefits under another policy or plan accepted by the Chair.
   - c. ..... Only the following class or classes of employees:

2. **The employee contributions required and benefits insured are:**
   - a. ..X... The same in all respects as under Section 204 and not in excess of those authorized under Section 209.
   - b. ..... As described in the attached supplement, Form DB820.1.
   - c. ..... As described in Employer's Application for Acceptance of a Plan, Form DB800, filed with and accepted by the Chair.
   - d ..... As described in Certificate of Insurance, Form DB820.3, filed on behalf of the Association, Union or Trustees (policyholders) on ..... (DATE) or amended Form DB820.3 filed thereafter.

To be filed by Insurance Carrier on behalf of Employer to provide, through insurance, exactly statutory benefits, (Section 204) OR benefits under a plan accepted by the Chairman.