THE COMMUNITY SYNAGOGUE

160 Middle Neck Road | Port Washington, NY 11050 | 516.883.3144 **T** | 516.883.4203 **F** | www.commsyn.org

Ref: Insurance Requirements

To Whom It May Concern:

Before you may work or provide services at The Community Synagogue, we must receive a Certificate of Insurance that is acceptable to the synagogue. The Certificate of Insurance must show the following:

(1) Your company's limits of liability (sample attached) and must state, **"It is understood and agreed that The Community Synagogue is Included as Additional Named Insured."** This wording should be listed under the Description of Operations.

(2) A copy of the actual endorsement adding The Community Synagogue-Temple Beth Am as an additional insured must accompany the certificate of insurance.

(3) Proof of State Disability (for those companies based in New York).

(4) For any company/corporation we must receive a Certificate indicating you have **Worker's Compensation.** If your company uses The State Insurance Fund, we must receive a separate certificate from them (sample attached).

The above required documents are to be submitted to the synagogue a minimum of two (2) weeks before you work at the synagogue / use the synagogue. Documents should be sent to my attention and reference the name and date of the event.

Please contact me directly if you have any questions.

Thank you for your cooperation.

Annette M. Rosalia
Office Manager
516-883-3144 ext. 322

ACORD CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
Month/Date/Year

PRODUCER

Insurnce Agent/Broker Name
Insurnce Agent/Broker Street Address or P.O. Box
Insurnce Agent/Broker City, State & Zip Code
Contact & Phone Number

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 POLICIES BELOW.

INSURED

Vendor Name
Vendor Street Address or P.O. Box
Vendor City, State & Zip Code

INSURERS AFFORDING COVERAGE		NAIC #
INSURER A:	Name of Insurance Company	Enter NAIC#
INSURER B:	Name of Insurance Company (if applicable)	Enter NAIC#
INSURER C:		
INSURER D:		
INSURER E:		

COVERAGES

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. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	ADD'L INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS	
A	☒	GENERAL LIABILITY ☒ COMMERICAL GENERAL LIABILITY ☐ CLAIMS MADE ☒ OCCUR ☐ ____ ☐ ____ GEN'L AGGREGATE LIMIT APPLIES PER: ☒ POLICY ☐ PROJECT ☐ LOC	Enter Policy #	Enter Effective Date	Enter Expiration Date	EACH OCCURENCE	$1,000,000
						DAMAGE TO RENTED PREMISES (Ea occurrence)	$100,000
						MED EXP (Any one person)	$5,000
						PERSONAL & ADV INJURY	$1,000,000
						GENERAL AGGREGATE	$2,000,000
						PRODUCTS - COMP/OP AGG	$2,000,000
							$
A	☐	AUTOMOBILE LIABILITY ☐ ANY AUTO ☐ ALL OWNED AUTOS ☐ SCHEDULED AUTOS ☐ HIRED AUTOS ☐ NON-OWNED AUTOS ☐ ____ ☐ ____	Enter Policy #	Enter Effective Date	Enter Expiration Date	COMBINED SINGLE LIMIT (Each Occurrence)	$
						BODILY INJURY (Per person)	$
						BODILY INJURY (Per accident)	$
						PROPERTY DAMAGE (Per accident)	$
A	☐	GARAGE LIABILITY ☐ ANY AUTO ☐ ____	Enter Policy # (if required)	Enter Effective Date	Enter Expiration Date	AUTO ONLY - EA ACCIDENT	$
						OTHER THAN AUTO ONLY: EA ACC	$
						AGG	$
A	☐	EXCESS/UMBRELLA LIABILITY ☐ OCCUR ☐ CLAIMS MADE ☐ DEDUCTIBLE ☐ RETENTION $Enter Amount	Enter Policy # (if required)	Enter Effective Date	Enter Expiration Date	EACH OCCURRENCE	$Enter Limit
						AGGREGATE	$Enter Limit
							$
							$
							$
A	☒	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below	Enter Policy #	Enter Effective Date	Enter Expiration Date	☒ WC STATUTORY LIMITS ☐ OTHER	
						E.L. EACH ACCIDENT	$100,000
						E.L. DISEASE - EA EMPLOYEE	$100,000
						E.L. DISEASE - POLICY LIMIT	$500,000
	☐	OTHER					LIQUOR LIABILITY 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS

It is understood and agreed that The Community Synagogue is Included as Additional Named Insured.

CERTIFICATE HOLDER

The Community Synagogue
160 Middle Neck Road
Port Washington, NY 11050

Phone: 516-883-3144
Fax: 516-883-4203

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE INSURER AFFORDING COVERAGE WILL ENDEAVOR TO MAIL 30 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

ADDITIONAL INSURED – DESIGNATED PERSON OR ORGANIZATION

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART

Schedule

Name of Additional Insured Person(s) or Organization(s):

Per individual Certificate of Coverage.

Information required to complete this Schedule, if not shown above, will be shown in the Declarations.

A. **SECTION II - WHO IS AN INSURED** is amended to include as an Additional Insured the person(s) or organization(s) shown in the Schedule, but only with respect to liability for "bodily injury," "property damage" or "personal and advertising injury" caused, in whole or in part, by your acts or omissions or the acts or omissions of those acting on your behalf:

1. in the performance of your ongoing operations; or

2. in connection with your premises owned by or rented to you.

However:

1. the insurance afforded to such additional insured only applies to the extent permitted by law; and

2. if coverage provided to the Additional Insured is required by a contract or agreement, the insurance afforded to such additional insured will not be broader than that which you are required by the contract or agreement to provide for such additional insured.

B. With respect to the insurance afforded to these Additional Insureds, the following is added to **SECTION III – LIMITS OF INSURANCE:**

If coverage provided to the Additional Insured is required by a contract or agreement, the most we will pay on behalf of the Additional Insured is the amount of insurance:

1. required by the contract or agreement; or

2. available under the applicable Limits of Insurance shown in the Declarations;

whichever is less.

This endorsement shall not increase the applicable Limits of Insurance shown in the Declarations.

NYSIF® **New York State Insurance Fund**

Workers' Compensation & Disability Benefits Specialists Since 1914

199 CHURCH STREET, NEW YORK, N.Y. 10007-1100
Phone: (888) 997-3863

CERTIFICATE OF WORKERS' COMPENSATION INSURANCE

Sample

POLICYHOLDER	CERTIFICATE HOLDER
Your Firm's Name Here	The Community Synagogue 160 Middle Neck Road Port Washington, NY 11050

POLICY NUMBER	CERTIFICATE NUMBER	PERIOD COVERED BY THIS CERTIFICATE	DATE
G 960 730-0	295004	09/30/2012 TO 09/30/2013	11/26/2012

THIS IS TO CERTIFY THAT THE POLICYHOLDER NAMED ABOVE IS INSURED WITH THE NEW YORK STATE INSURANCE FUND UNDER POLICY NO. 960 730-0 UNTIL 09/30/2013, COVERING THE ENTIRE OBLIGATION OF THIS POLICYHOLDER FOR WORKERS' COMPENSATION UNDER THE NEW YORK WORKERS' COMPENSATION LAW WITH RESPECT TO ALL OPERATIONS IN THE STATE OF NEW YORK, EXCEPT AS INDICATED BELOW.

IF SAID POLICY IS CANCELLED, OR CHANGED PRIOR TO 09/30/2013 IN SUCH MANNER AS TO AFFECT THIS CERTIFICATE, 10 DAYS WRITTEN NOTICE OF SUCH CANCELLATION WILL BE GIVEN TO THE CERTIFICATE HOLDER ABOVE. NOTICE BY REGULAR MAIL SO ADDRESSED SHALL BE SUFFICIENT COMPLIANCE WITH THIS PROVISION. THE NEW YORK STATE INSURANCE FUND DOES NOT ASSUME ANY LIABILITY IN THE EVENT OF FAILURE TO GIVE SUCH NOTICE.

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS NOR INSURANCE COVERAGE UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICY.

NEW YORK STATE INSURANCE FUND

Sherwin Taylor

DIRECTOR, INSURANCE FUND UNDERWRITING

This certificate can be validated on our web site at https://www.nysif.com/cert/certval.asp or by calling (888) 875-5790
VALIDATION NUMBER: 528904968

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