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:** 04/27/2015

A. INSURER/CARRIER

1. INSURER/CARRIER NAME	2. INSURER/CARRIER CODE	3. INSURER/CARRIER TELEPHONE NO.
STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK	B 150 001	(212)355-4141

4. CONTACT NAME	5. TITLE	6. TODAY'S DATE
BEBI A. ISHMAIL	SUPERVISOR-DBL ADMINISTRATION	04/27/2015

B. CURRENT - EMPLOYER INFORMATION

7. WCB EMPLOYER NUMBER	8. NYS UIER NUMBER	9. EMPLOYER FEIN
	PENDING	26-2415229

10. EMPLOYER'S LEGAL NAME, INCLUDING (DBA/AKA/TA)	13. LEGAL STATUS (SEE BACK OF FORM)
BROOKLYN SERVICES GROUP LLC	
11. ADDRESS	**14. # OF EMPLOYEES**
12. CITY STATE ZIP CODE	**15. TELEPHONE NO.**

C. POLICY

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

16. POLICY NUMBER	17. POLICY EFFECTIVE DATE	18. POLICY FORM NUMBER*
L79358-000	04/27/2015	NYDBL-60
19. WCB PLAN NUMBER (Only for Assoc., Union or Trustee with Form DB-801 on file.)		**20. PREMIUM AMOUNT** $60.00

D. REASONS FOR CANCELLATION

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

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 ZIP CODE	
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 ZIP CODE
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 the Chairman.

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

GA Code: S901 Sub. Producer Code: 2243 Agent/Agency Name: NIVLA INSURANCE AGENCY 2 LLC

LEGAL STATUS – (INSURED LEGAL STATUS)

01 INDIVIDUAL	10 LIMITED LIABILITY COMPANY (LLC)
02 PARTNERSHIP	11 TRUST OR ESTATE
03 CORPORATION	12 EXECUTOR OR TRUSTEE
04 ASSOCIATION, LABOR UNION, RELIGIOUS ORGANIZATION	13 LIMITED LIABILITY PARTNERSHIP (LLP)
05 LIMITED PARTNER	99 OTHER
06 JOINT VENTURE	

STATE OF NEW YORK
Andrew Cuomo, Governor

WORKERS' COMPENSATION BOARD
Robert E. Beloten, Chair

STATEMENT OF RIGHTS – DISABILITY BENEFITS LAW

IF YOU ARE UNABLE TO WORK BECAUSE OF A NON-OCCUPATIONAL ILLNESS OR INJURY, YOU MAY BE ENTITLED TO DISABILITY BENEFITS

1. Your employer is required by law to provide for the payment of Disability Benefits to his/her employees.

2. Statutory Disability Benefits are payable for any non-work related injury or illness (including disability due to pregnancy) beginning with the 8th consecutive day of disability. Benefits are payable for up to 26 weeks. Benefit payments are based on your average weekly wages for the eight weeks immediately prior to your disability, and are subject to the maximum allowable by the law in effect on the initial day of disability. Your employer or union may provide for different benefits which are at least as favorable as statutory benefits under an approved Disability Benefits Plan or Agreement.

3. TO CLAIM BENEFITS you should file written notice and proof of disability (Claim Form DB-450) with your employer or the insurance carrier named below within 30 days from the first day of your disability, or all or part of your claim may be rejected. In no event should you wait more than 26 weeks from that date to file a claim. You may obtain Form DB-450 from your employer, its insurance carrier, your health care provided or any office of the Workers' Compensation Board. (See addresses and telephone numbers below.). **Do not** assume that your employer has filed a claim on your behalf; **claim filing is your responsibility.**

4. You are entitled to be treated by any physician, chiropractor, dentist, nurse-midwife, podiatrist or psychologist of your choice. Unlike workers' compensation, your medical bills will **not** be paid by your employer or the insurance carrier, unless your employer and/or union provides for the payment of medical bills under an approved Disability Benefits Plan or Agreement.

5. Disability Benefits are to be paid **directly** to you by the insurance carrier, **not through your employer**, unless your employer is an approved self-insurer.

6. If your employer or the insurance carrier contends that you are not entitled to the payment of Disability Benefits, they are required to send you a Notice of Rejection, within 45 days of the filing of your claim, telling you the reasons benefits are not being paid. If you disagree with their rejection, you have a **legal right** to request a review of the rejection by the Workers' Compensation Board. **IMPORTANT:** If within 45 days of filing your claim you do not receive benefits and do not receive a notice of rejection (Form DB-451), promptly contact any office of the Workers' Compensation Board.

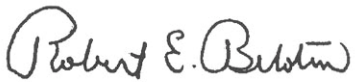
7. **If your disability is the result of an automobile accident** and you have filed a claim for no-fault benefits, you must also file a claim (Form DB-450) for disability benefits. **If you do not file for disability benefits, the no-fault insurer may reduce your no-fault payments. IMPORTANT:** In such cases, if you are not entitled to disability benefits, immediately advise the no-fault insurance carrier.

8. Your employer may not ask you to waive your right to disability benefits nor may your employer deduct more than 60 cents a week (unless the additional contribution is part of an approved plan) from your pay to contribute to the payment of disability benefits insurance premiums. **You cannot be discharged or discriminated against for filing a claim for disability benefits.**

IF YOU HAVE DIFFICULTY IN OBTAINING A CLAIM FORM OR NEED HELP IN FILLING IT OUT, OR IF YOU HAVE ANY OTHER QUESTIONS OR PROBLEMS ABOUT A NON-WORK RELATED INJURY OR ILLNESS, CONTACT ANY OFFICE OF THE WORKERS' COMPENSATION BOARD.

This information is a simplified presentation of your rights as required by Section 229 of the Disability Benefits Law. Your employer's disability benefits insurance carrier is:

STANDARD SECURITY
485 MADISON AVENUE. 6TH FLOOR
NEW YORK NY 10022



ROBERT E. BELOTEN
CHAIR

100 Broadway	StafeOffice Building	111 Livingston St.		220 Rabro Drive		215 W. 125th Street		168-46 91st Ave.		
Menands	44 Hawley Street	22nd Floor	369 Franklin Street	Suite 100	175 Fulton Avenue	3rd Floor	41 North Division St.	3rd Floor	130 Main Street W.	935 James St.
ALBANY 12241	BINGHAMTON 13901	BROOKLYN 11201	BUFFALO 14202	HAUPPAUGE 11788	HEMPSTEAD 11550	NEW YORK 10027	PEEKSKILL 10566	QUEENS 11432	ROCHESTER 14614	SYRACUSE 13203
(866) 750-5157	(866) 802-3604	(800) 877-1373	(866) 211-0645	(866) 681-5354	(866) 805-3630	(800) 877-1373	(866) 746-0552	(800) 877-1373	(866) 211-0644	(866) 802-3730

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.
ESTE RESUMEN ESTA ESCRITO EN ESPANOL AL DORSO.

ESTADO DE NUEVAYORK
Andrew Cuomo, Gobernador

JUNTADE COMPENSACION OBRERA
Robert E. Beloten, Presidente

DECLARACION DE DERECHOS – LEY DE BENEFICIOS POR INCAPACIDAD

SI USTED NO PUEDE TRABAJAR A CAUSA DE ENFERMEDAD O LESION NO RELACIONADA CON EL TRABAJO PUEDE TENER DERECHO A BENEFICIOS POR INCAPACIDAD

1. Su patrono está obligado por ley a proveer pagos de Beneficios por Incapacidad a sus empleados.

2. Beneficios por Incapacidad establecidos por ley son pagados por cualquier lesión o enfermedad no relacionada con el trabajo (inclyendo incapacidad debida a embarazo) comenzando a partir del octavo dia consecutivo de incapacidad. Los beneficios son pagados por 26 semanas. Los pagos de beneficios por incapacidad se basan en el promedio de su sueldo semanal durante las ocho semanas inmediatamente anteriores a su incapacidad y estan limitados al maximo permitido por ley el inicial de su incapacidad. Su patrono ó unión podran proveer en un plan o en un covenio beneficios diferentes que sean al menos tan favorables como las establecidos por ley.

3. PARA RECLAMAR BENEFICIOS **usted** deberá radicar una notificación y prueba de incapacidad (Formulario DB450) con su patrono ó con la compañia de seguros nombrada abajo denro del plazo de 30 dias desde el primer dia de incapacidad o toda o parte de su reclamación podra ser rechazada. Bajo ninguna circunstancia usted debe esperar mas de 26 semanas desde esa fecha para fadicar su reclamación. El formulario DB-450 lo puede conseguir a traves de su patrono, la compañia de seguros, el proveedor de servicios médicos o cualquier oficina de la Junta de Compensación Obrera. (Direcciones y telefonos mas abajo). **No** asuma que su patrono ha radicado la reclamación por usted. **La radicación de la reclamación es su** responsabilidad.

4. Usted tiene el derecho de ser atendido por cualquier médico, quiropractico, dentista, enfermera-partera, podiatra o psicologo que usted seleccione. Contrario a como en compensación obrera sus cuentas médicas **no** seran pagadas por su patrono o su compañía de seguros a menos que el patrono y o la unión lo hayan dispuesto mediante un plan de beneficios o cenvenio.

5. Los beneficios por incapacidad le seran pagados a usted **directamente** por la compañía de seguros, **no a traves de su patrono,** salvo en los casos en que su patrono sea aprobado como auto asegurado.

6. Si su patrono ó la compañía de seguros reclama que usted no tiene derecho al pago de Beneficios por Incapacidad ellos tienen la obligación de enviarle un Aviso de Rechazo, dentro de los 45 dias siguientes ala radicación de su reclamoción, explicandole las razones para no pagar los beneficios. Si usted no está de acuerdo con el rechazo, **tiene el derecho** de solicitar una revisión del mismo por la Junta de Compensación Obrera. **IMPORTANTE:** Si dentro del término de 45 dias de haber radicado su reclamación no recibe los beneficios ni tampoco recibe un Aviso de Rechazo (Formulario DB-451) comuniquese inmediatamente con cualquier oficina de la Junta de Compensación Obrera.

7. Si **su incapacidad es el resultado de un accidente automovilístico** y usted ha radicado una reclamación para beneficios por 'no-fault' tambien deberá radicar una reclamación (Formulario DB-450) para beneficios por incapacidad. **Si no radica reclamación para beneficios por incapacidad, la compañia de seguro podria reducir los pagos 'no fault' que le correspondan**. **IMPORTANTE:** en estos casos, si no tiene derecho a beneficios por incapacidad, avise inmediatamente a la compañia de suguros.

8. Su patrono no puede pedirle que renuncie a su derechode recibir beneficios por incapacidad ni tampoco puede descontar mas de 60 centavos semanales (a menos que la contribución adicional sea parte de un acuerdo) de su paga para contribuir al pago de las primas de seguro para los beneficios por incapacidad. **Usted no puede ser despedido ni discriminado por radicar una reclamación de beneficios por incapacidad.**

SI TIENE DIFICULTAD EN CONSEGUIR UN FORMULARIO DE RECLAMACIÓN O NECESITA AYUDA PARA LLENARLO, O TIENE CUALQUIER OTRO PROBLEMA ACERCA DE UNA LESION O ENFERMEDAD NO RELACIONADA CON EL TRABAJO COMUNIQUESE CON CUALQUIER OFICINA DE LA JUNTA DE COMPENSACIÓN OBRERA.

Este es un breve resumen de sus derechos como lo requiere la Sección 229 de la Ley de Beneficios por Incapacidad. La compañia de seguro de su patrono para beneficios por incapacidad es :

STANDARD SECURITY
485 MADISON AVENUE. 6TH FLOOR
NEW YORK NY 10022

Robert E. Beloten

ROBERT E. BELOTEN
CHAIR

100 Broadway Menands ALBANY 12241 (866) 750-5157	StafeOffice Building 44 Hawley Street BINGHAMTON 13901 (866) 802-3604	111 Livingston St. 22nd Floor BROOKLYN 11201 (800) 877-1373	369 Franklin Street BUFFALO 14202 (866) 211-0645	220 Rabro Drive Suite 100 HAUPPAUGE 11788 (866) 681-5354	175 Fulton Avenue HEMPSTEAD 11550 (866) 805-3630	215 W. 125th Street 3rd Floor NEW YORK 10027 (800) 877-1373	41 North Division St. PEEKSKILL 10566 (866) 746-0552	168-46 91st Ave. 3rd Floor QUEENS 11432 (800) 877-1373	130 Main Street W. ROCHESTER 14614 (866) 211-0644	935 James St. SYRACUSE 13203 (866) 802-3730

ESTA ENTIDAD EMPLEA Y SIRVE A PERSONAS CON INPEDIMENTOS SIN DISCRIMINAR EN SU CONTRA.
THIS NOTICE IS WRITTEN IN ENGLISH ON THE REVERSE SIDE.

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

NOTICE OF COMPLIANCE

DISABILITY BENEFITS LAW TO EMPLOYEES

1. If you are unable to work because of an illness or injury not work-related, you may be entitled to receive weekly benefits from your employer, or his or her insurance company, or from the Special Fund for Disability Benefits.

2. To claim benefits you must file a claim form,within 30 days from the first date of your disability, but in no event more than 26 weeks from such date.

3. Use one of the following claim forms:
   -If, when your disability begins, you are employed or are unemployed for four weeks or less, use claim Form DB-450, which you may obtain from your employer, his or her insurance carrier, your health provider, the Workers' Compensation Board's website (www.wcb.state.ny.us) or any office of the Board, and send it to your employer or the insurance carrier named below.
   -If, when your disability begins, you have been unemployed more than four weeks, use claim Form DB-300, which you may obtain from any Unemployment Insurance Office, your health provider, the Workers' Compensation Board's website (www.wcb.state.ny.us) or any office of the Board. Send completed claim form to the Workers' Compensation Board, Disability Benefits Bureau, Albany, New York 12241. **IMPORTANT:** Before filing your claim, your health provider must complete the "Health Care Provider's Statement" on the claim form, showing your period of disability.

4. You are entitled to be treated by any physician,chiropractor, dentist, nurse-midwife, podiatrist or psychologist of your choice. However, unlike workers' compensation, your medical bills will not be paid unless your employer and/or union provide for the payment of such bills under a Disability Benefits Plan or Agreement.

5. If you are ill or injured during the time you are receiving Unemployment Insurance Benefits, file a claim for Disability Benefits as soon as you sustain the injury or illness, by following the instructions outlined above.

6. If you are out of work in excess of seven days, your employer is required to send you a Disability Benefits Statement of Rights (Form DB-271S).

7. Other information about Disability Benefits may be obtained by writing or calling the nearest Workers' Compensation Board Office.

WORKERS' COMPENSATION BOARD OFFICES

Albany, 12241 - 100 Broadway-Menands - (866) 750-5157
Binghamton, 13901 - State Office Bldg. -44 Hawley St.- (866) 802-3604
Brooklyn, 11201 - 111 Livingston St.- Brooklyn - (800) 877-1373
Buffalo, 14203 - 295 Main Street, Suite 400 - (866) 211-0645
Hauppauge, 11788 - 220 Rabro Drive - Suite 100 - (866) 681-5354
Hempstead, 11550 - 175 Fulton Avenue - (866) 805-3630
New York, 10027 - 215 W.125th St. - Manhattan - (800) 877-1373
Peekskill, 10566 - 41 North Division St. - (866) 746-0552
Queens, 11432 - 168-46 91st Ave. - Jamaica - (800) 877-1373
Rochester, 14614 - 130 Main Street West - (866) 211-0644
Syracuse, 13203 - 935 James St.- (866) 802-3730

ESTADO DE NUEVA YORK
JUNTA DE COMPENSACION OBRERA

AVISO DE CUMPLIMIENTO

LEY DE BENEFICIOS POR INCAPACIDAD A LOS EMPLEADOS

1. Si usted no puede trabajar debido a enfermedad o lesión no relacionada con el trabajo, podría tener derecho a recibir beneficios semenales de su patrón o de la compañia de seguros de él/ella o del Fondo Especial para Beneficios por Incapacidad.

2. Para reclamar beneficios usted debe presentar una forma de reclamación, dentro de 30 dias a partir de la primera fecha de su incapacidad, pero en ningun caso más de 26 semanas de dicha fecha.

3. Use una de las siguientes formas de reclamación:
   -Si, cuando comience su incapacidad usted está empleado o ha estado desempleado por cuatro semanas o menos, use la forma de reclamación (Form DB-450), la cual puede obtener de su patrón o de la compañia de seguros de él/ ella, o de su proveedor de cuidados de salud, o bien de cualquier oficina de la Junta de Compensación Obrera, y enviela a su patrón o a la compañia de seguros nombreda abajo.
   -Si cuando comience su incapacidad, usted ha estado desempleado más de cuatro semanas, use la forma de reclamación (Form DB-300), la cual puede obtener en cualquier Oficina de Seguro de Desempleo, de su proveedor de salud, o bien de cualquier oficina de la Junta de Compensación Obrera. Envie la forma de reclamación, debidamente terminada, a Workers' Compensation Board, Disability Benefits Bureau, Albany, New York 12241. **IMPORTANTE:** Antes de presentat usted su reclamación, es necesario que su proveedor de salud complete la declaracion del médico ("Health Care Provider's Statement") en la forma de relamacion, indicando el periodo de su incapacidad.

4. Usted tiene derecho a ser tratado por cualquier médico, quiropráctico, dentista, enfermera-partera, podiatra o psicólogo que usted elija. Pero, contrario ala compensación obrera, sus cuentas médicas no seran pagadas a menos que su patrón y/o Unión haga el pago de tales cuentas médicas bajo un Plan o Convenio de Beneficios por Incapacidad.

5. Si estuviera usted enfermo o lesionado durante el tiempo que esté recibiendo beneficios del Seguro de Desempleo, presente una reclamación para Beneficios por Incapacidad, siguiendo las instrucciones arriba descritas, tan pronto como sufra la lesión o la enfermedad.

6. Si usted está desempleado por mas de siete dias, su patrón está obligado a enviarle la Declaración de Derechos de Beneficios por Incapacidad (Form DB-271S).

7. Otras informaciones relativas a Beneficios por Incapacidad pueden obtenerse escribiendo o llamando ala oficina más cercana de la Junta de Compensación Obrera.

Robert E. Beloten

ROBERT E. BELOTEN
CHAIR/PRESIDENTE

www.wcb.state.ny.us

Employers must post DB-120s so that all classes of their employees know who will pay their Disability Benefits.
Disability Benefits, when due, will be paid by (Los Beneficios por Incapacidad, cuando debidos, seran pagados por):

STANDARD SECURITY

485 MADISON AVENUE. 6TH FLOOR
NEW YORK NY 10022

Effective: From 04/27/2015 To 04/30/2016
(En Vigor Desde) (Hasta)

Policy No. L79358-000
(Poliza No.)

The benefits provided are (Los beneficios provistos son)

X	Statutory		Under a Plan or Agreement

Class(es) of employees covered (Clase(s) de empleados amparados)

ALL EMPLOYEES ELIGIBLE UNDER THE NEW YORK STATE DISABILITY BENEFITS LAW.

BROOKLYN SERVICES GROUP LLC

Name of employer (Nombre del Patron)

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

LA JUNTA DE COMPENSACION OBRERA EMPLEA Y SIRVE A PERSONAS INCAPACITADAS SIN DISCRIMINAR.

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

DB-120 (1-11)

Prescribed by Chair
Workers' Compensation Board
State of New York

Standard Security Life Insurance Company
Independence Holding Group

485 Madison Avenue, 14th Floor, New York, NY 10022-5872
www.sslicny.com

NEW YORK DISABILITY BENEFITS LAW POLICY

INSURING CLAUSE

We agree to pay the disability benefits to which each employee of a covered Employer is entitled to receive under the Law. This policy is issued in consideration of the payment by the Policyholder of premiums as provided below.

SCHEDULE

Policyholder Name & Address BROOKLYN SERVICES GROUP LLC NY 11207	**Policy Number** L79358-000 **NY U.I. #** PENDING
	☐ Corporation ☒ Partnership
Policy Effective Date 04/27/2015	☐ Proprietorship ☐ Other
Covered Employees – All employees eligible under the disability benefits law. ALL EMPLOYEES ELIGIBLE UNDER THE NEW YORK STATE DISABILITY BENEFITS LAW.	**No. of Covered Employees** **Males** 1 **Females** 0 **Total** 1

Premium Rates – (Minimum Quarterly Premium is $ 0.00). (Minimum Annual Premium is $ 60.00).

☒ **ANNUAL POLICY** Premium for annual policies are payable in advance.
Males-$** 18.00 **Females-$ 39.60 **Prop / Partner - $** 0.00

☐ QUARTERLY POLICY Premiums are payable to the Company quarterly,premium being due on the last day of the calendar quarter.
Monthly Rate **Males-$** 0.00 **Females-$** 0.00 **Prop / Partner - $** 0.00

☐ **PER PAYROLL**
$ _____ per $100 of monthly payroll, subject to a maximum of $ _____ per week.

EMPLOYEE CONTRIBUTION: ☐ None ☒ Yes, maximum of $ .60 per week ☐ Other _____

INDEX

Billing Address :

Legal Name	:	BROOKLYN SERVICES GROUP LLC
Contact Name	:	JAMES BRADLEY
Title	:	PRESIDENT
Street		
City	:	
State	:	
Zip		

DEFINITIONS

"We," "Our" or "Us" – Standard Security Life Insurance Company of New York.

"You" or "Your" – the Policyholder named in the Policy Schedule.

"Employer" – the Policyholder named in the Policy Schedule, and any additional covered Employer shown in a rider attached to this Policy, whose employees are covered under this Policy.

"Board" – the Workers' Compensation Board of the State of New York.

"Chairman" - the Chairman of the Workers' Compensation Board.

"Employee" – any employee insured under this policy.

"Law"- the Disability Benefits Law of the State of New York. The term "Law" includes any amendments or supplements to the Law which may take effect while this Policy is in force.

POLICY TERMS AND CONDITIONS

This Policy provides benefits only:

a. for a disability which commences during the continuance of this Policy; or

b. with respect to any Employee whose employment with an Employer terminates during the continuance of this Policy, for a disability which commences within four weeks after such termination and prior to the first day after such termination on which the Employee performs any work for remuneration or profit in employment with an employer, other than an Employer named herein, who is a covered employer under the Law.

Insurance under this Policy is subject to all the terms and conditions set below. All of the provisions of the Law shall be and remain a part of this Policy, as if they were written herein.

You may act for and on behalf of any and all Employers named in this Policy in all matters related to this insurance. All such acts shall be binding on all such Employers.

This contract consists of this Policy, and attached copy of Your application, and any attached riders. This policy has been issued based upon the statements on Your application. All statements in Your application are representations and not warranties. No statement will be used to void this Policy or to defend a claim unless it is in the attached copy of Your application. No agent may change any terms of this Policy. No agent may accept overdue premiums or extend the due date of any premium. No change in this Policy shall be valid unless it is contained in a rider issued by Us.

SPECIAL PROVISION RELATING TO EMPLOYEE CONTRIBUTIONS

Any excess of the total contributions of Employees applied to the payment of premium for this Policy shall be paid to You and be applied or disposed of as prescribed in Section 216 of the Law.

POLICY ASSIGNMENT

Your interest under this Policy may not be assigned or transferred without Our written consent.

POLICY CANCELLATION

We may cancel this Policy by not less than 30 days written notice to You, the Employer and the Chairman when cancellation is due to any reason other than non-payment of premium. When cancellation is due to non-payment of premium, We may cancel this Policy by not less than 10 days written notice to You, the Employer and the Chairman. We may cancel coverage under this Policy with respect to any one Employer by giving notice in the same manner. If insurance with another carrier becomes effective prior to the day of cancellation stated in any such notice, the cancellation shall be effective as of the effective date of such other insurance.

You may cancel insurance under this Policy with respect to one or more covered Employers by a written request to Us not less than 40 days prior to any premium due date. Upon receipt of such request, We shall effect such cancellation by exercising the cancellation privilege set forth above. Such cancellation shall be effective as of the next following premium due date.

You shall be liable to Us for the payment of all premiums due up to the date of any such cancellation.

Notice of cancellation will be given by delivering or mailing, by registered mail, to Your last known place of business. A copy of such notice shall also be mailed to all other Employers.

PROVISION REQUIRED BY STATUTE

As between an Employee and Us:

1. **Notice to or knowledge on the part of his or her Employer of the occurrence of any injury or sickness suffered by the Employee shall be deemed notice to or knowledge, as the case may be, on Our part; and**

2. **Jurisdiction of the Employer shall, for the purpose of the Law, be jurisdiction of Us; and**

3. **We shall in all things be bound by and subject to the orders, findings or decisions rendered in connection with the payment of benefits under the provisions of said Law.**

The Chairman shall have the right to enforce in the name of the People of the State of New York for the benefit of the person entitled to the benefits insured by this Policy, either by filing a separate application or by making Us a party to the original application, Our liability in whole or in part for the payment of benefits afforded hereunder; provided, however, that payment in whole or in part of such benefits by either You, the Employer, or Us shall to the extent thereof be a bar to the recovery against the others of the amount so paid.

Your bankruptcy or insolvency or that of an Employer shall not relieve Us of any of Our obligations under this Policy.

Notwithstanding any other provision of this Policy or any rider, benefits payable under this Policy or any rider shall be payable at least to the extent and in the manner required by the Law.

INFORMATION REQUIRED

You or the Employer shall furnish Us all information which We may reasonably require with regard to any matters pertaining to the insurance afforded by this Policy. All documents, books, and records which may have a bearing on the insurance or premiums under this Policy, shall be open for inspection by Us at all reasonable times while this Policy is in force and within three years after the final termination of this Policy.

NOTICE AND PROOF OF CLAIM

You, the Employer or the Chairman if disabled while unemployed, must be given a written notice of a claim within 30 days after a period of disability begins for an Employee. You or the Chairman or the Employer must notify Us or Our agent as soon as reasonably possible after the first day for which benefits become payable to an Employee. The notice should give Your name, and the Employer's name, and Policy Number. Such notice should also contain the name and address of the Employee. When We receive notice, We will send You forms for filing proof of claim. If We fail to send forms within 30 days, then You or the Employer may give Us other written proof of claim, showing what happened and the extent of the disability.
The Employee must give written proof of such disability to You, the Employer, the Chairman, or Us not later than 30 days after such disability begins. If such proof is given to You, the Employer, or the Chairman it should be given to Us as soon as possible. You, the Employer, the Chairman or We may require additional proof at reasonable intervals, but not more often than once a week. Such written proof must contain a statement of disability by either the Employee's attending physician, podiatrist, chiropractor, dentist, or certified nurse midwife. In the case of an Employee who adheres to the faith or teachings of any church or denomination, and whose creed, tenets or principles depends for healing upon prayer through spiritual means alone in the practice of religion, by an accredited practitioner, such written proof must contain facts and opinions as to such disability in compliance with the regulations of the Chairman.

If notice or proof of claim is not furnished within the time and manner described above, the claim will not be invalidated but benefits will only be paid for the two (2) week period prior to the date on which the required proof is furnished; unless it is shown to the Chairman that it was not reasonably possible to furnish such notice or proof and that such notice or proof was furnished as soon as possible. No benefits shall be paid unless the required proof of disability is furnished within 26 weeks after the disability begins.

If any suit or other proceeding begins against You or an Employer, every summons, notice or other process must be sent to Us immediately.

PREMIUM COMPUTATION AND PAYMENT

The premium rate(s) for this Policy is shown in the Policy Schedule. Premiums are payable as of the last day of each calendar quarter while this policy is in force, with a grace period of 31 days. We may set new premium rates for subsequent premiums:

1. **as of the effective date of any change in the Law which affects coverage under this Policy. Any such change will be stated in a rider by issued Us;**

2. **as of the first day of any calendar quarter upon giving You at least fifteen (15) days notice of a change in the premium rate.**

STATUTORY ASSESSMENTS

We will pay the assessments levied on the covered payrolls of insured Employees pursuant to Section 214-2, 214-3, and 228 of the Law.

EFFECTIVE DATE OF EMPLOYEE'S INSURANCE

Each Employee shall become insured on the date he becomes eligible for benefits under the Law.

IN WITNESS WHEREOF, STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK has caused this policy to be signed by its President and Secretary.

Rachel Lipari
President

Adam C. Vandervoort
Secretary

LiDAC
EMPLOYEE BENEFIT SOLUTIONS

1010 Northern Blvd. -Ste 324 - Great Neck NY 11

Tel: 516-482-2696 Fax: 516-482-7281

New York State

Application - DBL & Enriched DBL

Carrier	STANDARD SECURITY
Effective Date	04/27/2015
Policy Number	L79358-000
Carrier Rep	N/A
LiDAC Rep	BRIDDA

Agency / Agent

NIVLA INSURANCE AGENCY 2 LLC

Broker Code 2243 **GA Code** S901

Employer Information

[x]	New Application	[ ]	Add Employer	[ ]	Sole Proprietor	[ ]	Partners	[ ]	Out of State

1.Today's Date:	2. Employer Legal Name filed with the NYS Depart. of Labor, Unemployment Insur. Div.:	3. Telephone / Ext:	4. Fax Number:
04/27/2015	BROOKLYN SERVICES GROUP LLC	(718)772-7415	(___)___-____

5. Name under which Employer's business is conducted, if different from above (D/B/A Name):	6. N.Y. Employer Registration Number:	7. Employer Federal I.D:	8. Company Website:
	PENDING	26-2415229	

9. Legal Street Address:	Suite / Floor	City:	State:	Zip Code:
		BROOKLYN		

10. Billing Address (if different from above):	Suite / Floor	City (Billing):	State (Billing):	Zip Code (Billing):

11. Type of Organization:	12. Industry Code:	13. Nature of Business:
LLC	1751	CARPENTRY WORK-CONTRACTOR

14. Last Name:	First Name:	Job Title:	E-mail Address:
BRADLEY	JAMES	PRESIDENT	BROOKLYN.SERVICES.GROUP@GMAIL.COM

15. Previous Carrier's Name:	Previous Policy Number:	Termination Date:

Policy Underwriting Information

16. Policy Exclusion: [ ]	Local Union #: [ ]	Spouse: *Form (DB-212.5)* Must be Submitted for Approval [ ]	Excecutive Officer(s) *(DB 212.3)* Must be Submitted for Approval [ ]

17. Employee Classes Covered:	18. Employee Contribution :	19. Employee Contribution (%):
ALL ELIGIBLE UNDER NY DISABILITY BENEFITS LAW:	STATUTORY	NYS MAX 1/2 OF 1%,UP TO $.60 WEEK MAX

20.Eligible Employee:	Number of Lives :				Total Lives:	21. Complete Annual Wages: *(if Covered payroll Rate Only)*	
a) Employees:	Male:	1	Female:	0	1	Male Payroll:	
b) Proprietors / Partners:	Male:	0	Female:	0	0	Female Payroll:	
Combined Covered Lives:	Male:	1	Female:	0	1	Total Payroll:	

22. Underwriting:		23. Type Coverage:	24. Waiting Period:				25. Maximum Duration:		26. Maximum Benefit:	
[x]	Community Rated	(Check One)	Accident		Sickness		Benefit Paid		% of Wages	Wkly Amount
[ ]	Experienced Rated	[x] Statutory	7	Days	7	Days	26	Weeks	50%	$170.00
[ ]	Other	[ ] Enriched		Days		Days		Weeks		

27. Premium Mode:	28.Rates Monthly: Per Capita / Covered Payroll Rate						Quarterly Premium:	Annual Premium:	Minimum Premium :
ANNUAL	Partner Rate	$9.36	Male Rate	$1.50	Female Rate	$3.30	N/A	18.00	$60.00