STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

CERTIFICATE OF PARTICIPATION IN WORKERS' COMPENSATION GROUP SELF-INSURANCE

1a. Legal Name and Address of Business Participating in Group Self-Insurance (Use street address only) Scotia-Glenville CSD 99 Preddice Parkway Scotia NY 12302	1d. Telephone Number of Business referenced in box "1a" (518) 347-3600 1e. NYS Unemployment Insurance Employer Registration Number of Business referenced in box "1a"
1b. Effective date of Membership in the Group 7/1/22 1c. The Proprietor, Partners or Executive Officers are: ☒ included. (Only check box if all partners/officers included) ☐ all excluded or certain partners/officers excluded.	1f. Federal Employer Identification Number of Business referenced in box "1a" 14-6001946
2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)	3. Name and address of Group Self-Insurer Schenectady Area Workers Compensation Plan c/o PMA PO Box 5231 Janesville, WI 53547-5231

This **certifies** that the business referenced above in box "1a" is complying with the mandatory coverage requirements of the New York State Workers' Compensation Law as a participating member of the Group Self-Insurer listed above in box "3" and participation in such group self-insurance is still in force. The Group Self-Insurer's Administrator will send this Certificate of Participation to the entity listed above as the certificate holder in box "2".

The Group Self-Insurer's Administrator will notify the above certificate holder within 10 days IF the membership of the participant listed in box "1a" is terminated. (These notices may be sent by regular mail.) Otherwise, this Certificate is valid for a maximum of one year from the date certified by the group self-insurer.

If this certificate is no longer valid according to the above guidelines and the business referenced in box "1a" continues to be named on a permit, license or contract issued by the certificate holder, the business must provide the certificate holder either with a new certificate or other authorized proof 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 of the Group Self-Insurer referenced above and that the business referenced in box "1a" has the coverage as depicted on this form.

Certified by: Tracy Fraleigh
(Print name of authorized representative of Group Self-Insurer)

Certified by: Tracy L. Fraleigh 2/3/23
(Signature) (Date)

Title: President

Telephone Number: 518-234-4032

GSI-105.2 (2-02)