



CERTIFICATE OF INSURANCE COVERAGE

NYS 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	
<p>1a. Legal Name & Address of Insured (use street address only) LSC COMMUNICATIONS MCL LLC 100 NORTHFIELD ST. GREENWICH, CT 06830</p> <p><i>Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e., Wrap-Up Policy)</i></p>	<p>1b. Business Telephone Number of Insured</p> <p>1c. Federal Employer Identification Number of Insured or Social Security Number 853419080</p>
<p>2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)</p>	<p>3a. Name of Insurance Carrier HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY</p> <p>3b. Policy Number of Entity Listed in Box 1a LNY713468008</p> <p>3c. Policy effective period 01-01-2026 to 12-31-2026</p>
<p>4. Policy provides the following benefits:</p> <p><input checked="" type="checkbox"/> A. Both disability and Paid Family Leave benefits. <input type="checkbox"/> B. Disability benefits only. <input type="checkbox"/> C. Paid Family Leave benefits only.</p> <p>5. Policy covers:</p> <p><input checked="" type="checkbox"/> A. All of the employer's employees eligible under the NYS Disability and Paid Family Leave Benefits Law. <input type="checkbox"/> B. Only the following class or classes of employer's employees:</p> <p>_____</p> <p>_____</p>	
<p>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.</p>	
<p>Date Signed _____</p>	<p style="text-align: center;">By <i>Elizabeth Tello</i></p> <p style="text-align: center; font-size: small;">(Signature of insurance carrier's authorized representative or NYS licensed insurance agent of that insurance carrier)</p>
<p>Telephone Number (212) 553-8074 Name and Title: ELIZABETH TELLO – ASSISTANT DIRECTOR, STATUTORY SERVICES</p>	
<p>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.</p> <p>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.</p>	
<p>PART 2. To be completed by the NYS Workers' Compensation Board (Only if Box 4B, 4C or 5B have been checked)</p>	
<p>State of New York Workers' Compensation Board</p> <p>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.</p>	
<p>Date Signed _____</p>	<p style="text-align: center;">By _____</p> <p style="text-align: center; font-size: small;">(Signature of Authorized NYS Workers' Compensation Board Employee)</p>
<p>Telephone Number _____</p>	<p style="text-align: center;">Name and Title _____</p>

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.**



Additional Instructions for Form DB-120.1

By signing this form, the insurance carrier identified in Box 3 on this form is certifying that it is insuring the business referenced in Box 1a for disability and/or Paid Family Leave benefits under the NYS Disability and Paid Family Leave Benefits Law. The insurance carrier or its licensed agent will send this Certificate of Insurance Coverage (Certificate) to the entity listed 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 cancelled 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 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 NYS disability and/or Paid Family Leave benefits contract of insurance only while the underlying policy is in effect.

Please Note: Upon the cancellation of the disability and/or Paid Family Leave benefits 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 Insurance Coverage for NYS disability and/or Paid Family Leave Benefits or other authorized proof that the business is complying with the mandatory coverage requirements of the NYS Disability and Paid Family Leave Benefits Law.

NYS DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

§220. Subd. 8

(a) The head of a state or municipal department, board, commission or office authorized or required by law to issue any permit for or in connection with any work involving the employment of employees in employment as defined in this article, and notwithstanding any general or special statute requiring or authorizing the issue of such permits, shall not issue such permit unless proof duly subscribed by an insurance carrier is produced in a form satisfactory to the chair, that the payment of disability benefits and after January first, two thousand and twenty-one, the payment of family leave benefits for all employees has been secured as provided by this article. Nothing herein, however, shall be construed as creating any liability on the part of such state or municipal department, board, commission or office to pay any disability benefits to any such employee if so employed.

(b) The head of a state or municipal department, board, commission or office authorized or required by law to enter into any contract for or in connection with any work involving the employment of employees in employment as defined in this article and notwithstanding any general or special statute requiring or authorizing any such contract, shall not enter into any such contract unless proof duly subscribed by an insurance carrier is produced in a form satisfactory to the chair, that the payment of disability benefits and after January first, two thousand eighteen, the payment of family leave benefits for all employees has been secured as provided by this article.