



**VERIFICATION OF  
WORKERS' COMPENSATION/DISABILITY  
INSURANCE COVERAGE**

NEW YORK STATE DEPARTMENT OF LABOR  
Worker Protection Central Processing  
Child Performer Program Room 288C  
State Office Campus Building 12  
Albany NY 12240

To be completed by Payroll Services  
for applicants for Certificates of Eligibility to Employ Child Performers  
and submitted with the application along with  
forms C-105.2 and DB-120.1 from insurance carriers.

The employees of (enter name and address of applicant)

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are covered under the  Workers' Compensation Policy  Disability Insurance Policy of

(enter name and address of the Payroll Service whose policies cover the employees of the applicant listed above)

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I, the undersigned, affirm that I am authorized to submit this verification on behalf of the applicant and Payroll Service shown above.

I certify under penalty of perjury that the information in this verification and all attachments is complete and accurate to the best of my knowledge.

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Authorized Representative Signature

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Date

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Authorized Representative Name *(Please Print)*

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Title