LLOYD S. BERKETT
INSURANCE AGENCY

January 28, 2026

Veratex Inc.
336 East 56th Street
Front A
New York, NY 10022

RE: CNYD 130 - SS29603-000 - QUARTERLY BILLIN
Policy Number: D29603-000
Term: 3/1/2025 to 3/1/2026

Dear Claude Simon:

Please be advised we have processed the following endorsements to Veratex Inc.'s CNYD 130 - SS29603- policy:

change of mailing address

Please review for accuracy. These changes became effective on 01/28/2026 with no change in premium. The balance on your account has been amended to reflect this endorsement.

Please, also, add the enclosed endorsement forms to your policy.

Thank you for your business and the continued opportunity to service your insurance needs.

Sincerely,

Maribel Sosa Ruiz
Account Manager
(310) 566-1448
msosa@berkettinsurance.com

THIS IS A POLICY SUPPLEMENT

attached to and made part of POLICY NUMBER D29603-000

VERATEX INC
INSURED (who will be referred to as "you" or "your")

In consideration of the Continuance of the Policy mentioned above, it is hereby understood and agreed that:

The billing address reads as follows:

VERATEX INC
C/O CLAUDE SIMON
336 EAST 56TH STREET, FRONT A,
NEW YORK, NY 10022

The Policy, as written, is amended as specifically stated above but not otherwise.

This supplement becomes effective January 28, 2026 12:01 A.M., Standard Time, at the place where You reside and terminates with the termination of the Policy to which it is attached.

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

Charles Denaro
Secretary

Scott H. Boutin
President

STATE OF NEW YORK WORKERS' COMPENSATION BOARD
DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW
CERTIFICATE/CANCELLATION OF INSURANCE
Filed on behalf of Employer in compliance with Article 9 of the Workers' Compensation Law

DB-820-829 09-17

☐ Initial ☐ Cancellation ☒ Reinstatement ☐ Supersedes **Transaction Effective Date:** 9/30/2025

A. INSURER

1. INSURER NAME	2. INSURER CODE	3. INSURER PHONE #
STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK	B 150 001	646-509-2100
4. CONTACT NAME	**5. TITLE**	**6. DATE**
CUSTOMER SERVICE DEPARTMENT	CUSTOMER SERVICE REPRESENTATIVE	09/17/2025

B. CURRENT EMPLOYER INFORMATION

7. WCB EMPLOYER NUMBER	8. NYS UIER NUMBER	9. EMPLOYER FEIN
		132804148

10. EMPLOYER'S LEGAL NAME, INCLUDING (DBA/AKA/TA)	13. LEGAL STATUS (SEE BACK OF FORM)
VERATEX INC	3
11. EMPLOYER STREET ADDRESS	**14. NUMBER (#) OF EMPLOYEES**
336 EAST 56TH STREET, GND FLOOR	10
12. EMPLOYER CITY, STATE and ZIP CODE	**15. EMPLOYER PHONE #**
NEW YORK, NY 10022	212-683-9300

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*
D29603-000	03/01/1975	NYDBL-60
19. WCB PLAN NUMBER (Only for Association, Union or Trustee with Form DB-801 on file.)		**20. PREMIUM AMOUNT**

D. REASONS FOR CANCELLATION

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

DATE CANCELLATION OR TERMINATION SENT TO EMPLOYER: _____

E. Complete if SUPERSEDES box is checked at top of form		F. POLICYHOLDER - If different from Employer
21. EMPLOYER'S LEGAL NAME, INCLUDING (DBA/AKA/TA)		**27. POLICYHOLDER NAME**
22. EMPLOYER'S STREET ADDRESS		**28. POLICYHOLDER ADDRESS**
23. CITY, STATE and ZIP CODE		**29. CITY, STATE and ZIP CODE**
24. EMPLOYER FEIN	**25. POLICY EFFECTIVE DATE**	**30. POLICYHOLDER FEIN**
26. POLICY NUMBER		

G. 1. The policy covers Employer's employees as follows:

a. The policy provides coverage for:
☒ Both disability and paid family leave benefits
☐ Disability benefits only
☐ Paid family leave benefits only

b. The policy covers the following class or classes of employees:
☒ All employees
☐ Only the class or classes of employees listed here:
_____
_____

2. The employee contributions required and benefits insured are:
☐ The same in all respects as under Section 204 and not in excess of those authorized under Section 209.
☒ As described in the attached supplement, Form DB820.1.
☐ As described in Employer's Application for Acceptance of a Plan, Form DB800, filed with and accepted by the Chair.
☐ As described in Certificate of Insurance, Form DB820.3, filed on behalf of the Association, Union or Trustees (policyholders) on _____ 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 Chairman. DBL GENERAL AGENCY, AN ALER

S917 S9172011 LLOYD S.

All transactions affecting a statutory disability and paid family leave benefits policy must be submitted to the Board electronically. To file this form electronically or for more information, visit the Board's website at www.wcb.ny.gov.

INSTRUCTIONS

- Check **only one** transaction box at the top of the form.
- All dates should be entered in the MM/DD/YYYY format.
- The transaction effective date is the date that the Initial filing, Cancellation, Reinstatement or Supersedes transaction is to be effective.
- **You must enter a valid Federal Employer Identification Number (FEIN) in box 9 for all transactions.**
- Enter only one complete employer legal entity name in box 10.
- Insurers/Carriers should record employer location information in their own records. **Do not file a form for this purpose.**

SECTIONS A, B, C AND G MUST BE COMPLETED

Initial Filing of Certificate of Insurance: Sections A, B, C and G must be completed.

Cancellations: Sections A, B, C and G must be completed. Check appropriate box next to the reason for cancellation and provide effective date, if required. **All cancellations must be filed strictly in accordance with Section 226, subdivision 5 of the Disability and Paid Family Leave Benefits Law.**

Reinstatements: Section A, B, C and G must be completed.

Supersedes: Sections A, B, C and G must be completed. Provide the new information in Section B or C and give the previously reported information in the appropriate field(s) in Section E.
NOTE: Is there has been a legal entity change, do not file as supersedes. To process legal entity changes, you must file a cancellation for the old legal entity and file an initial filing with a current coverage effective date for the new legal entity.

Section G: Check the appropriate box for the type of coverage under 1 and the class or classes of employes covered under 2. Attached any required forms.

Failure to supply all of the required information will impede processing and could result in rejection of this document.

LEGAL STATUS - INSURED LEGAL STATUS

1 INDIVIDUAL
2 PARTNERSHIP
3 CORPORATION
4 ASSOCIATION, LABOR UNION, RELIGIOUS ORGANIZATION
5 LIMITED PARTNER
6 JOINT VENTURE
10 LIMITED LIABILITY COMPANY (LLC)
11 TRUST OR ESTATE
12 EXECUTOR OR TRUSTEE
13 LIMITED LIABILITY PARTNERSHIP (LLP
99 OTHER