

INCORPORATED VILLAGE OF GARDEN CITY  
DEPARTMENT OF PUBLIC WORKS  
351 STEWART AVENUE  
GARDEN CITY, N.Y. 11530-4528



SEWER SERVICE PERMIT APPLICATION

PERMIT NO. \_\_\_\_\_

**\*\*\*MUST GIVE 48-HOUR NOTICE TO SCHEDULE WORK\*\*\*  
\*\*CALL (516) 465-4005 BETWEEN 8:30 A.M. – 4:30 P.M.\*\***

Applicant: \_\_\_\_\_  
(Business Name)

\_\_\_\_\_ (Business Address) \_\_\_\_\_ (City, State) \_\_\_\_\_ (Zip Code)

\_\_\_\_\_ (Contact Name) \_\_\_\_\_ (Contact Phone) \_\_\_\_\_ (Contact Email)

**The above-named applicant does hereby apply for the issuance of a permit for the following purpose:**

Section: \_\_\_\_\_ Block: \_\_\_\_\_ Lot(s): \_\_\_\_\_

**Work Performed on Private Property:**  Yes (Building Permit Required)  No

**Address (Work Location):** \_\_\_\_\_ **Property Type:**  Residential  Commercial

**Job Type:**  Tap  New Service  Repair  Connect  Disconnect

**Utility Company Reference Number** \_\_\_\_\_

**Description of Work:** \_\_\_\_\_  
\_\_\_\_\_

**SITE DRAWINGS MUST BE ATTACHED TO PERMIT APPLICATION**

I have read and agree to abide by the Rules & Regulations pertaining to Permit work on and within Village Roads.

Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR OFFICIAL USE ONLY**

**THE DURATION OF THE PERMIT HEREBY SOUGHT IS \_\_\_\_\_ DAYS(S) FROM \_\_\_\_\_, 20 \_\_\_\_.**

APPROVED  REJECTED

Check No.: \_\_\_\_\_

Fee: \$ \_\_\_\_\_ Deposit: \$ \_\_\_\_\_

Total: \$ \_\_\_\_\_

By: \_\_\_\_\_ Date: \_\_\_\_\_



## CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERs NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

<b>PRODUCER</b>	CONTACT	
	NAME:	FAX (INC. NO. ER)
<b>INSURED</b>  Fax No.: 516-742-5377	PHONE	
	E-MAIL	
	ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	
	NAIC #	
	INSURER A:	
	INSURER B:	
INSURER C:		
INSURER D:		
INSURER E:		
INSURER F:		

<b>COVERAGEs</b>		<b>CERTIFICATE NUMBER:</b>		<b>REVISION NUMBER:</b>			
<p>THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.</p>							
INSR LTR	TYPE OF INSURANCE	ADDL/BLUR INSR/WD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY END (MM/DD/YYYY)	LIMITS	
A <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <div style="border: 1px solid black; padding: 2px; display: inline-block;"> <input checked="" type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR         </div> <div style="margin-top: 10px;"> <b>GENL AGGREGATE LIMIT APPLIES PER</b>  <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC            OTHER         </div>		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ex. BURGLAR)	\$1,000,000
						MED EXP (Any one person)	\$ 15,000
A <input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <div style="border: 1px solid black; padding: 2px; display: inline-block;"> <input checked="" type="checkbox"/> ANY AUTO  <input checked="" type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS  <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY         </div>		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	PERSONAL & ADV INJURY	\$1,000,000
						GENERAL AGGREGATE PRODUCTS - COMP/PROF AGG	\$2,000,000
B <input checked="" type="checkbox"/> UMBRELLA LIAB <input type="checkbox"/> EXCESS LIAB <div style="border: 1px solid black; padding: 2px; display: inline-block;"> <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS-MADE         </div> <div style="margin-top: 10px;">           DED <input type="checkbox"/> RETENTION <input type="checkbox"/> </div>		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	COMBINED SINGLE LIMIT (Ex. BURGLAR)	\$1,000,000
						BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Ex. BURGLAR)	\$ 15,000
C <input checked="" type="checkbox"/> WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? <small>(Mandatory in NY)</small> <small>If yes, describe under DESCRIPTION OF OPERATIONS BELOW</small>		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N		<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	EACH OCCURRENCE AGGREGATE	\$5,000,000
						E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	\$5,000,000
A <input type="checkbox"/> Professional Liability D <input type="checkbox"/> NYS Disability							
DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101 Additional Remarks Schedule, may be attached if more space is required)							
The Incorporated Village of Garden City is included as Additional Insured.							

<b>CERTIFICATE HOLDER</b>	<b>CANCELLATION</b>
Incorporated Village of Garden City 351 Stewart Avenue Garden City NY 11530	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.
AUTHORIZED REPRESENTATIVE	

© 1988-2015 ACORD CORPORATION. All rights reserved.

# SAMPLE



## Workers' Compensation Board

**CERTIFICATE OF  
NYS WORKERS' COMPENSATION INSURANCE COVERAGE**

This certifies that the insurance carrier indicated above in box '3' insures the business referenced above in box '12' for workers' compensation under the New York State Workers' Compensation Law. (To use this form, New York (NY) must be listed under Item 3A on the INFORMATION PAGE of the workers' compensation insurance policy). The Insurance Carrier or its licensed agent will send this Certificate of Insurance to the entity listed above 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 canceled 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 the 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 Workers' Compensation contract of insurance only while the underlying policy is in effect.

**Please Note: Upon cancellation of the workers' compensation 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 Workers' Compensation Coverage or other authorized proof that 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 or licensed agent of the insurance carrier referenced above and that the named insured has the coverage as depicted on this form.**

Answered by

Approved by

(Signed: *[Signature]*)

18740

TIME

Telephone Number of authorized representative or licensed agent of insurance carrier:

**Please Note: Only insurance carriers and their licensed agents are authorized to issue Form C-105.2. Insurance brokers are NOT authorized to issue this form.**

## SAMPLE



### **New York State Insurance Fund**

199 CHURCH STREET NEW YORK N.Y. 10007-1100

## CERTIFICATE OF WORKERS' COMPENSATION INSURANCE

AKA AKA 111984847

INTOWALKER

POLICYHOLDER 	CERTIFICATE HOLDER INC. VILLAGE GARDEN 351 STEWART GARDEN 		
POLICY NUMBER 	CERTIFICATE NUMBER 	PRICED 	DATE 

THIS IS TO CERTIFY THAT THE POLICYHOLDER NAME IS **W.M. STATE INSURANCE  
FUND** UNDER POLICY NO. **472 001-7**, COVERING THE **EMPLOYEE** ON DUTY  
COMPENSATION UNDER THE NEW YORK WORKERS' COMPENSATION LAW  
STATE OF NEW YORK, EXCEPT AS INDICATED **W.M.**

IF YOU WISH TO RECEIVE NOTIFICATIONS CONCERNING ANY NOTIFICATION OF CANCELLATIONS, OR TO VALIDATE CERTVAL.ASP, THE NEW YORK STATE WEBSITE IS [HTTPS://WWW.NYSIF.COM/CERT/VALIDATE](https://WWW.NYSIF.COM/CERT/VALIDATE). IN THE EVENT OF FAILURE TO GIVE SUCH NOTIFICATIONS,

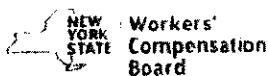
THE POLICY INCLUDES A WAIVER OF SUBROGATION WHICH NYSIF AGREES TO WAIVE ITS RIGHT OF SUBROGATION TO BRING AN ACTION AGAINST THE INSURED OR THE INSUREE IF AN EMPLOYEE OF OUR INSURED IN THE EVENT THAT, PRIOR TO THE COMMENCEMENT OF THE POLICY, THE INSUREE HAS ENTERED INTO A WRITTEN CONTRACT WITH ONE OF THE INSUREES WHICH HIGH FIVE SUBROGATION BE WAIVED.

THIS CERTIFICATE IS ISSUED FOR THE PERIOD OF ONE YEAR FROM THE DATE OF THIS CERTIFICATE. THIS CERTIFICATE CONFERRED NO RIGHTS NOR INSURANCE COVERAGE. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICY.

## NEW YORK STATE INSURANCE FUND

**DIRECTOR, INSURANCE FUND UNDERWRITING**



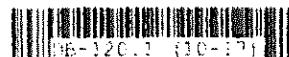


## CERTIFICATE OF INSURANCE COVERAGE DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

### PART 1. To be completed by Disability and Paid Family Leave Benefits Carrier or Licensed Insurance Agent of that Carrier

1a. Legal Name & Address of Insured (use street address only)  [REDACTED]	1b. Business Telephone Number of Insured  [REDACTED]
Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e. Wrap-Up Policy)  [REDACTED]	
2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) <b>Inc. Village of Garden City</b> 351 Stewart Ave. Garden City, NY 11530	3a. Name of Insurance Carrier  [REDACTED]
	3b. Policy Number  [REDACTED]
	3c. Policy Effective Period  [REDACTED]
4. Policy provides the following benefits <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	
5. Policy covers <input checked="" type="checkbox"/> A. All of the employer's employees eligible under the NYS Disability and/or Paid Family Leave Benefits Law <input type="checkbox"/> B. Only the following class or classes of employees  [REDACTED]	
Under penalty of perjury, I certify that I am authorized by the named insured to NYS Disability and/or Paid Family Leave Benefits Law. I am an authorized representative or NYS Licensed Insurance Agent of that insurance carrier referenced above and that the named insured has NYS Disability and/or Paid Family Leave Benefits Law coverage as described above.	
Date Signed [REDACTED] By [REDACTED] [REDACTED] Insurance Carrier's Authorized Representative or NYS Licensed Insurance Agent of that insurance carrier	
Telephone Number [REDACTED] Name [REDACTED]	
IMPORTANT: If Boxes 4 and 5A are checked, this certificate is NOT COMPLETE for purposes of Section 220, Subd. 8 of the NYS Workers' Compensation and Paid Family Leave Benefits Law. It must be mailed for completion to the Workers' Compensation Board, Attention: Acceptance Unit, P.O. Box 5200, Binghamton, NY 13902-5200.	
PART 2. To be completed by the NYS Workers' Compensation Board (Only if Box 4C or 5B of Part 1 has been checked)	
State of New York <b>Workers' Compensation Board</b> I, [REDACTED] the NYS Workers' Compensation Board, the above-named employer has complied with the NYS Paid Family Leave Benefits Law with respect to all of his/her employees	
By [REDACTED] (Signature of Authorized NYS Workers' Compensation Board Employee)	
Telephone Number [REDACTED] Name and Title [REDACTED]	

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-1201. Insurance brokers are NOT authorized to issue this form.



# Village of Garden City Permit Application Sketch

