

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



SIDEWALK, APRON, DROP CURB 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): _____

Was a Violation Issued: ☐ Yes ☐ No Driveway Work Planned: ☐ Yes (Building Permit Required) ☐ No

New Curb Cut: ☐ Yes (Provide Amount _____) ☐ No

Address (Work Location): _____ Property Type: ☐ Residential ☐ Commercial

Total Quantities: Area of Concrete _____ SF Feet of Drop Curb _____ LF Feet of Standard Curb _____ LF

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

By: _____

Date: _____

Check No.: _____

Fee: \$ _____

Deposit: \$ _____

Total: \$ _____

SIDEWALK PERMIT ONLY



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).

PRODUCER

CONTACT

NAME

PHONE

(A/C No. Ext.)

FAX

EMAIL

ADDRESS

FAX

(A/C No.)

INSURER(S) AFFORDING COVERAGE

NAIC #

INSURER A:

INSURER B:

INSURER C:

INSURER D:

INSURER E:

INSURER F:

INSURED

COVERAGES

CERTIFICATE NUMBER:

REVISION NUMBER:

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.

INSR LTR	TYPE OF INSURANCE	ADDITIONAL INSURED	POLICY NUMBER	POLICY EFF. DATE (MM/DD/YYYY)	POLICY EXPIRATION DATE (MM/DD/YYYY)	LIMITS
A	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR GENT. AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input checked="" type="checkbox"/> PROJECT <input type="checkbox"/> LOC <input type="checkbox"/> OTHER	Y Y				EACH OCCURRENCE \$1,000,000 DAMAGE TO RENTED PREMISES (EA OCCURRENCE) \$ 300,000 MED EXP (Any one person) \$ 15,000 PERSONAL & ADV INJURY \$1,000,000 GENERAL AGGREGATE \$2,000,000 PRODUCTS - COMP/OP AGG \$2,000,000
A	AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY	Y Y				COMBINED SINGLE LIMIT (EA OCCURRENCE) \$1,000,000 BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)
B	<input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> EXCESS LIAB <input type="checkbox"/> DED <input type="checkbox"/> RETENTION \$	Y Y				EACH OCCURRENCE \$1,000,000 AGGREGATE \$2,000,000
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N N/A				<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTHER E L EACH ACCIDENT E L DISEASE - EA EMPLOYEE E L DISEASE - POLICY LIMIT
A	Professional Liability					
D	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.

CERTIFICATE HOLDER

CANCELLATION

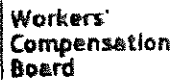
Incorporated Village of Garden City
351 Stewart Avenue
Garden City NY 11530

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

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SAMPLE



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

www.vob.tv.co.uk

SAMPLE



New York State Insurance Fund

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

CERTIFICATE OF WORKERS' COMPENSATION INSURANCE

***** 111984847

POLICYHOLDER [REDACTED]		CERTIFICATE HOLDER INC. VILLAGE GARDEN 351 STEWART GARDEN	
POLICY NUMBER [REDACTED]	CERTIFICATE NUMBER [REDACTED]	PERIOD [REDACTED]	DATE [REDACTED]

THIS IS TO CERTIFY THAT THE POLICYHOLDER NAME IS [REDACTED] INSURED UNDER POLICY NO. 472 001-7, COVERING THE OBLIGATION OF THE NEW YORK STATE INSURANCE FUND UNDER THE NEW YORK WORKERS' COMPENSATION LAW. ALL OPERATIONS IN THE STATE OF NEW YORK, EXCEPT AS INDICATED ABOVE.

IF YOU WISH TO RECEIVE NOTIFICATION OF CANCELLATIONS, OR TO VALIDATE CERTVAL.ASP, THE NEW YORK STATE NOTIFICATIONS.

THE POLICY INCLUDES A WAIVER OF SUBROGATION RIGHTS UNDER WHICH NYSIF AGREES TO WAIVE ITS RIGHT OF SUBROGATION TO BRING ACTION AGAINST THE POLICYHOLDER TO RECOVER AMOUNTS WE PAID IN WORKERS' COMPENSATION BENEFITS FOR AN EMPLOYEE OF OUR INSURED IN THE EVENT THAT, PRIOR TO THE DATE OF THE POLICY, THE POLICYHOLDER HAS ENTERED INTO A WRITTEN CONTRACT WITH OUR INSURED WHICH RIGHT OF SUBROGATION BE WAIVED.

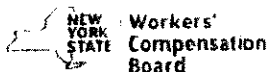
THIS CERTIFICATE IS ISSUED FOR INFORMATION ONLY AND CONFERS NO RIGHTS NOR INSURANCE COVERAGE. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICY.

NEW YORK STATE INSURANCE FUND

[REDACTED]
DIRECTOR, INSURANCE FUND UNDERWRITING



00000000000070760030



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]

Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e. Wrap-Up Policy)

1b. Business Telephone Number of Insured

[Redacted]

1c. Federal Employer Identification Number or Social Security Number

[Redacted]

2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)

Inc. Village of Garden City
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

- ☒ A. Both disability and paid family leave benefits
☐ B. Disability benefits only
☐ C. Paid family leave benefits only

5. Policy covers

- ☒ A. All of the employer's employees eligible under the NYS Disability and Family Leave Benefits Law
☐ B. Only the following class or classes of employees

Under penalty of perjury, I certify that I am an authorized representative of the insurance carrier referenced above and that the named insured has NYS Disability and/or Paid Family Leave Benefits coverage as indicated above.

Date Signed

By

Telephone Number

IMPORTANT

Boxes 4A and 5A must be checked. If this form is signed by the insurance carrier's authorized representative or NYS Licensed Insurance Agent, this certificate is COMPLETE. Mail it directly to the certificate holder.

If Box 4B is checked, this certificate is NOT COMPLETE for purposes of Section 220, Subd. 8 of the NYS Disability and Family Leave Benefits Law. It must be mailed for completion to the Workers' Compensation Board, Box 5200, Binghamton, NY 13902-5200.

PART 2. To be completed by the State of New York Workers' Compensation Board (Only if Box 4C or 5B of Part 1 has been checked)

State of New York
Workers' Compensation Board

To information maintained by the NYS Workers' Compensation Board, the above-named employer has complied with the Disability and Family Leave Benefits Law with respect to all of his/her employees.

By

(Signature of Authorized NYS Workers' Compensation Board Employee)

Telephone Number

Name and Title

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.

