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 (A/C, No):
	E-MAIL ADDRESS:	

INSURED	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A :	
	INSURER B :	
	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

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	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: [X] POLICY [X] PRO-JECT [ ] LOC OTHER	Y	Y				EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$1,000,000 $ 300,000 $ 15,000 $1,000,000 $2,000,000 $2,000,000
A	AUTOMOBILE LIABILITY X ANY AUTO OWNED AUTOS ONLY HIRED AUTOS ONLY SCHEDULED AUTOS NON-OWNED AUTOS ONLY	Y	Y				COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$1,000,000
B	X UMBRELLA LIAB X OCCUR EXCESS LIAB CLAIMS-MADE DED RETENTION $	Y	Y				EACH OCCURRENCE AGGREGATE	$1,000,000 $2,000,000
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) N If yes, describe under DESCRIPTION OF OPERATIONS below	N/A					X PER STATUTE OTH-ER 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

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

CANCELLATION

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

Workers Compensation & Disability

SAMPLE

NEW YORK STATE | Workers' Compensation Board

CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

1 a Legal Name & Address of Insured (use street address only)

[redacted]

1 b Business Telephone Number of Insured

[redacted]

1c NYS Unemployment Insurance Employer Registration Number of Insured

1 d Federal Employer Identification Number of Insured or Social Security Number

Work Location of Insured *(Only required if coverage is specifically limited to*

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

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

3a Name of Insurance Carrier

[redacted]

3b Policy Number of Entity Listed in Box "1 a"

[redacted]

3c Policy effective period to

[redacted]

3d The Proprietor, Partners or Executive Officers are

☐ Included (Only check box if all partners/officers inclu

☒ all excluded or certain partners/officers excluded

This certifies that the insurance carrier indicated above in box "3" insures the business referenced above in box "1a" 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.

Approved by [redacted]
(Print name of authorized representative or licensed agent of insurance carrier)

Approved by [redacted]
(Signature) (Date)

Title [redacted]

Telephone Number of authorized representative or licensed agent of insurance carrier [redacted]

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

C-105.2 (9-17) www.wcb.ny.gov

SAMPLE

NYSIF New York State Insurance Fund
199 CHURCH STREET, NEW YORK, N.Y. 10007-1100

CERTIFICATE OF WORKERS' COMPENSATION INSURANCE

111984847

[redacted]

POLICYHOLDER	CERTIFICATE HOLDER
[redacted]	INC. VILLAGE [redacted] 351 STEWA[redacted] GARDEN [redacted]

POLICY NUMBER	CERTIFICATE NUMBER	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

THIS IS TO CERTIFY THAT THE POLICYHOLDER NAM[redacted]VE IS [redacted] WITH THE STATE INSURANCE FUND UNDER POLICY NO. 472 001-7, COVERING TH[redacted] OBLIG[redacted]ON O[redacted]ER FOR WORKERS' COMPENSATION UNDER THE NEW YORK WORKERS' CO[redacted]ON LAW W[redacted]L OPERATIONS IN THE STATE OF NEW YORK, EXCEPT AS INDICATED BELOW.

IF YOU WISH TO RECEIVE NOTIFIC[redacted]EGARDING THIS POLICY, INCLUDING ANY NOTIFICATION OF CANCELLATIONS, OR TO VALIDATE [redacted]CATE VISIT [redacted]BSITE [redacted] HTTPS://WWW.NYSIF.COM/CERT/CERTVAL.ASP. THE NEW YORK STATE [redacted]ND [redacted]OT LIA[redacted]HE EVENT OF FAILURE TO GIVE SUCH NOTIFICATIONS.

THE POLICY INCLUDES A WAIVER OF SUBRO[redacted]RS[redacted]UNDER WHICH NYSIF AGREES TO WAIVE ITS RIGHT OF SUBROGATION TO BRI[redacted] ACTION AGAIN[redacted]ER [redacted]HOLDER TO RECOVER AMOUNTS WE PAID IN WORKERS' COMPENSATI[redacted] MED[redacted]BENEFI[redacted]OR [redacted]LF OF AN EMPLOYEE OF OUR INSURED IN THE EVENT THAT, PRIOR T[redacted]F TH[redacted]ENT, [redacted]CATE HOLDER HAS ENTERED INTO A WRITTEN CONTRACT WITH O[redacted]QUIR[redacted]ICH RIGH[redacted]F SUBROGATION BE WAIVED.

THIS CERTIFICATE IS IS[redacted]R OF [redacted]N ONLY AND CONFERS NO RIGHTS NOR INSURANCE COVERAGE I[redacted]N TH[redacted]CERTIFI[redacted]HIS C[redacted]ATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED[redacted]E PO[redacted]

NEW YORK STATE INSURANCE FUND

[redacted]

DIRECTOR, INSURANCE FUND UNDERWRITING

[redacted]0000000000070760030

NEW YORK STATE Workers' Compensation Board

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 Car

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 Numb[redacted] Insured 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 Carr[redacted]

3b. Policy Number [redacted]ly Liste[redacted]

[redacted]

3c. Policy effective period [redacted]

4. Policy provides the following benefits
- [x] A. Both disability and paid family leave benefits
- [ ] B. Disability benefits only
- [ ] C. Paid family leave benefits only

5. Policy covers
- [x] A. All of the employer's employees eligible under th[redacted]YS Disabili[redacted]Family L[redacted]
- [ ] B. Only the following class or classes of employe[redacted]oyee[redacted]

[redacted]

Under penalty of perjury, I certify that I am an authorize[redacted]ent of t[redacted]surance carrier referenced above and that the named insured has NYS Disability and/or Paid[redacted]ily Leave Benefits [redacted]over[redacted]e above.

Date Signed [redacted] By [redacted]
(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number [redacted] Name and Title [redacted]

IMPORTANT: [redacted]oxes 4A and 5A[redacted] this fo[redacted]igned by the insurance carrier's authorized representative or NYS [redacted]sed [redacted]nce Agent [redacted] this c[redacted]rtificate is COMPLETE. Mail it directly to the certificate holder.

[redacted]B, 4[redacted]s che[redacted]d, this certificate is NOT COMPLETE for purposes of Section 220, Subd. 8 of the NYS [redacted] and [redacted]Fam[redacted]Benefits Law. It must be mailed for completion to the Workers' Compensation [redacted]ans Accepta[redacted]x 5200, Binghamton, NY 13902-5200.

PART 2. To b[redacted]by th[redacted].s' Compensation Board (Only if Box 4C or 5B of Part 1 has been checked)

State of New York
Workers' Compensation Board

[redacted]to information ma[redacted]d by the NYS Workers' Compensation Board, the above-named employer has complied with the [redacted]Disability[redacted]Fam[redacted]w 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: 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.***

DB-120.1 (10-17)

Village of Garden City Permit Application Sketch