

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

Check No.: _____

Fee: \$ _____

Deposit: \$ _____

Total: \$ _____

By: _____

Date: _____

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:	FAX (AGC No. Ext.)
INSURED	PHONE (AGC No. Ext.)	E-MAIL ADDRESS:
	INSURER(S) AFFORDING COVERAGE	
	AGC #	
	INSURER A:	
	INSURER B:	
	INSURER C:	
INSURER D:		
INSURER E:		
INSURER F:		

COVERS

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	ADOL/SUBR INSR. INVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXPI (MM/DD/YYYY)	LIMITS		
						Y	Y	Y
A	COMMERCIAL GENERAL LIABILITY					EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ex. OCCURRENCE)	\$1,000,000	\$ 300,000
	CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR					MED EXP (Any one person)	\$ 15,000	
	GENL AGGREGATE LIMIT APPLIES PER:					PERSONAL & ADV INJURY	\$1,000,000	
	X POLICY <input checked="" type="checkbox"/> PROJCT <input type="checkbox"/> LOC					GENERAL AGGREGATE	\$2,000,000	
	OTHER					PRODUCTS - COMP/PROP AGG	\$2,000,000	
A	AUTOMOBILE LIABILITY					COMBINED SINGLE LIMIT (Ex. OCCURRENCE)	\$1,000,000	
	X ANY AUTO OWNED AUTOS ONLY	<input checked="" type="checkbox"/> SCHEDULED AUTOS Hired AUTOS ONLY				BODILY INJURY (Per person)		
	EXCESS LIAB	<input checked="" type="checkbox"/> CLAIMS-MADE				BODILY INJURY (Per accident)		
	DED <input type="checkbox"/> RETENTION \$					PROPERTY DAMAGE (Per occurrence)		
B	UMBRELLA LIAB	<input checked="" type="checkbox"/> OCCUR				EACH OCCURRENCE	\$1,000,000	
	EXCESS LIAB	<input checked="" type="checkbox"/> CLAIMS-MADE				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	<input type="checkbox"/> Y/N N/A				X PER STATUTE EL. EACH ACCIDENT		
	DESCRIPTION OF OPERATIONS					EL. DISEASE - EA EMPLOYEE		
	DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101. Additional Remarks Schedule, may be attached if more space is required)					EL. 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 Stewart 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
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SAMPLE

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  *(Please enter name of authorized representative or type in full name of responsible officer)*

Approved by _____
(Signature) _____ (Date) _____

Title: 

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

ANNEXA 111984847

POLICYHOLDER	
[REDACTED]	

CERTIFICATE HOLDER	
INC. VILLAGE GARDEN 351 STEWART GARDEN	

POLICY NUMBER	CERTIFICATE NUMBER	TRIO	DATE
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

THIS IS TO CERTIFY THAT THE POLICYHOLDER NAME IS [REDACTED] FUND UNDER POLICY NO. 472 001-7, COVERING THE STATE INSURANCE FUND FOR WORKERS' COMPENSATION UNDER THE NEW YORK WORKERS' COMPENSATION LAW, WHICH POLICY IS IN FULL FORCE AND EFFECT FOR THE STATE OF NEW YORK, EXCEPT AS INDICATED [REDACTED] IN THE POLICY.

IF YOU WISH TO RECEIVE NOTIFICATIONS OF POLICY CANCELLATIONS, OR TO VALIDATE YOUR POLICY, PLEASE VISIT OUR WEBSITE AT <https://WWW.NYSIF.COM/CERT/VALIDATE.ASP>. THE NEW YORK STATE INSURANCE FUND AGREES TO GIVE SUCH NOTIFICATIONS.

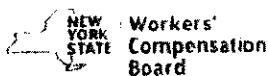
THE POLICY INCLUDES A WAIVER OF SUBROGATION, WHICH NYSIF AGREES TO WAIVE ITS RIGHT OF SUBROGATION TO BRANCHES OF THE INSURANCE POLICYHOLDER TO RECOVER AMOUNTS WE PAID IN WORKERS' COMPENSATION BENEFITS OR MEDICAL BENEFITS, OR IN THE EVENT OF AN EMPLOYEE OF OUR INSURED IN THE CONTRACT WITH ONE OF OUR INSUREDS SUSTAINS A WORKERS' COMPENSATION INJURY, THE POLICYHOLDER HAS ENTERED INTO A WRITTEN CONTRACT WITH ONE OF OUR INSUREDS WHICH WAIVES THE POLICYHOLDER'S RIGHT OF SUBROGATION.

THIS CERTIFICATE IS ISSUED FOR THE PURPOSE OF CONFIRMING THE COVERAGE PROVIDED BY THE POLICYHOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICY.

NEW YORK STATE INSURANCE FUND

DIRECTOR, INSURANCE FUND UNDERWRITING

00000000000070760030

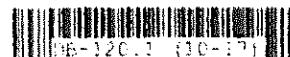


CERTIFICATE OF INSURANCE COVERAGE DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

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]	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) 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 <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	Y.S. Disability Type [REDACTED]
5. Policy covers <input checked="" type="checkbox"/> A. All of the employer's employees eligible under the <input type="checkbox"/> B. Only the following class or classes of employees [REDACTED]	Family [REDACTED]
Under penalty of perjury, I certify that I am authorized insured has NYS Disability and/or Paid Family Leave Benefits over [REDACTED] 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 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 Workers' Compensation Board I, [REDACTED] the NYS Workers' Compensation Board, the above-named employer has complied with the Workers' Compensation 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-120-1. Insurance brokers are NOT authorized to issue this form.



Village of Garden City Permit Application Sketch

