

## ULSTER COUNTY DEPARTMENT OF PUBLIC WORKS

To: Commissioner of Public Works  
Tel: 845-340-3100  
Fax: 845-340-3113

### APPLICATION FOR SPECIAL EVENT PERMIT

Department of Public Works  
317 Shamrock Lane  
Kingston, NY 12401

Permit # \_\_\_\_\_

Date \_\_\_\_\_

TO: Commissioner of Public Works  
County of Ulster

Application is hereby made for a Special Event Permit for access to road(s) on the County Road System.

Applicant \_\_\_\_\_

Address \_\_\_\_\_

Telephone Daytime \_\_\_\_\_ Emergency \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_

Purpose of Event \_\_\_\_\_

Date of Event \_\_\_\_\_

County Road(s) to be Utilized \_\_\_\_\_

If a permit is granted, I hereby agree to conform to all the conditions and restrictions forming a part of this permit and to conform to all local ordinances, if any, and to conform to the provisions as set forth in the Federal and New York State MUTCD (Manual of Uniform Traffic Control Devices).

\_\_\_\_\_  
APPLICANT'S NAME (Please Print)

\_\_\_\_\_  
TITLE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
APPLICANT'S SIGNATURE

-----  
*OFFICIAL USE ONLY*

Permission is hereby granted to applicant.

A Certificate of General Liability (bodily injury/property damage) Insurance, with "Additional Insured" endorsement, shall be on file at the Office of the Commissioner of Public Works and be in compliance with the Department's current insurance directives.

Signature \_\_\_\_\_  
COMMISSIONER OF PUBLIC WORKS

Date \_\_\_\_\_

Signature \_\_\_\_\_  
UCDPW REVIEWER

Date \_\_\_\_\_

**APPLICATION FOR SPECIAL EVENT PERMIT**

**CONDITIONS & RESTRICTIONS**

THE FOREGOING PERMIT IS GRANTED SUBJECT TO THE FOLLOWING CONDITIONS:

1. This permit shall not be assigned or transferred except with the written consent of the County Commissioner.
2. The applicant hereby agrees to indemnify and save harmless the County from all suits, actions or damages of every kind whatsoever, which may arise from or on account of the event under this permit. General Liability Insurance for the protection of the applicant and the County will be maintained in such an amount and in such company and in such case as the County Commissioner may require. The certificate holder shall be named as "County of Ulster, PO Box 1800, Kingston NY, 12402" on the policy provided.
3. A map shall be provided if the event is to take place on multiple roads, highlighting the affected road segments.
4. The County Commissioner reserves the right to revoke or cancel this permit at any time should the applicant fail to comply with the terms and conditions herein prescribed.
5. Applicant's approved copy of this permit shall be in possession of the parties actually involved.
6. The Owner/Applicant is responsible to attain any additional required permits/permissions including, but not limited to, applicable Federal, State and Local permissions.
7. It is mandated that the local fire company(s) as well as the emergency medical service receive prior written notification of the Special Event in order to respond efficiently to non-permit related emergencies as such may occur during the duration of the permit activity. Copies of such notification shall be provided to the Commissioner of Public Works prior to validation of the permit.
8. This permit is subject to any and all constraints, which may be predicated by the Commissioner of Public Works and/or local municipality.
9. Arrangements shall be made by the applicant with local law enforcement agencies to provide, during the period of such Special Event for the handling of pedestrian and motor vehicle traffic, the re-routing of traffic, caring for emergencies and other related needs.
10. The applicant hereby agrees to clean up any debris along the County Highway System in the vicinity of the specified locations arising out of or as a result of the activity under this permit.
11. **No County Road closures will take place during this event and none will be permitted.**

**Refer to Schedule A for Special Conditions if box is checked.**

I HEREBY AGREE TO THE ABOVE CONDITIONS AND RESTRICTIONS.

\_\_\_\_\_  
Authorized Applicant Name (Please Print)

\_\_\_\_\_  
Authorized Applicant Signature

\_\_\_\_\_  
Date

## **Summary of Ulster County Insurance Requirements:**

**Item Numbers 1-3:** See the attached Sample Certificate of Insurance (Accord Form) for the required minimum limits and the language required for the Additional Insured and Certificate Holder Notes.

**Item No. 4:** See the following Part 1 and Part 2 lists of the appropriate acceptable forms for Worker's Compensation and Disability Benefits. ***Please note that the Accord Form is no longer acceptable proof of NYS Workers' Compensation and Disability Benefits Insurance Coverage***

**Part 1:** Acceptable forms for Workers' Compensation: Provide one of the following.

**C-105.2 or U-26.3 or GSI 105.2**

**Part 2:** Acceptable forms for Disability Benefits: Provide one of the following.

**DB 120.1 or DB-155**

**OR**

**Starting December 1, 2008, ONLY** applicants eligible for **exemptions** must file a **new CE-200** for **each** and **every** new or renewed permit, license or contract issued by a government agency. Each CE-200 will specifically list the issuing government agency and the specific type of permit, license or contract requested by the applicant. Applicants for building permits will also need to supply additional information including identifying the specific job location and the estimated cost of the project.

Please ensure that the legal entity name on Form CE-200 exactly matches the legal entity name that is applying for the permit, license or contract. Please also ensure that the applicant signs and dates Form CE-200.

Each CE-200 will have a certificate number printed on it. Form CE-200s may be verified on the Board's web site at [www.wcb.ny.gov](http://www.wcb.ny.gov).

The applicant attests under penalty of perjury that the information contained in the CE-200 is accurate – the Board does not initially verify this information. However, Board staff may investigate applicants filing Form CE-200.

**\*\* Be sure to forward the following pages to your insurance company to ensure the proper insurance coverage is submitted Ulster County.**



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

11/12/2021

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> Insurance Agent Name Insurance Agent Address	<b>CONTACT</b> NAME: PHONE (A/C, No, Ext): E-MAIL ADDRESS: FAX (A/C, No):  <b>INSURER(S) AFFORDING COVERAGE</b>  <b>INSURER A :</b>  <b>INSURER B :</b>  <b>INSURER C :</b>  <b>INSURER D :</b>  <b>INSURER E :</b>  <b>INSURER F :</b>	<b>NAIC #</b>
<b>INSURED</b> Owner/Applicant Name Owner/Applicant Address		

**COVERAGES****CERTIFICATE NUMBER:** Sample Cert**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
<input checked="" type="checkbox"/>	<b>COMMERCIAL GENERAL LIABILITY</b> <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR <b>ITEM 1</b> GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:	Y					EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$
<input checked="" type="checkbox"/>	<b>AUTOMOBILE LIABILITY</b> <input type="checkbox"/> ANY AUTO <input checked="" type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY	Y					COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
<input checked="" type="checkbox"/>	<b>UMBRELLA LIAB</b> <input checked="" type="checkbox"/> OCCUR <b>EXCESS LIAB</b> <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$	Y					EACH OCCURRENCE \$ 2,000,000 AGGREGATE \$ 2,000,000
<input checked="" type="checkbox"/>	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below Y / N <input type="checkbox"/>	N / A					PER STATUTE <input type="checkbox"/> OTH-ER <input type="checkbox"/> E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$

**DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES** (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

County of Ulster is named as an Additional Insured with respects to work performed by the insured.

**ITEM 2****CERTIFICATE HOLDER****CANCELLATION****ITEM 3**County of Ulster  
P.O. Box 1800  
244 Fair Street  
Kingston

NY 12402

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

**NEEDS TO BE SIGNED BY AGENT**

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## **Item No. 4: Workers' Compensation and Disability Benefits**

### **PART 1:**

#### **WORKERS' COMPENSATION REQUIREMENTS UNDER WORKERS' COMPENSATION LAW §57**

To comply with coverage provisions of the Workers' Compensation Law ("WCL"), businesses must:

- A) be legally exempt from obtaining workers' compensation insurance coverage; or
- B) obtain such coverage from insurance carriers; or
- C) be a Board-approved self-insured employer or participate in an authorized group self-insurance plan.

To assist State and municipal entities in enforcing WCL Section 57, businesses requesting permits or seeking to enter into contracts **MUST provide ONE** of the following forms to the government entity issuing the permit or entering into a contract:

- A) **C-105.2** -- Certificate of Workers' Compensation Insurance (the business's insurance carrier will send this form to the government entity upon request) **PLEASE NOTE:** The State Insurance Fund provides its own version of this form, the **U-26.3**; **OR**
- B) **GSI-105.2** -- Certificate of Participation in Worker's Compensation Group Self-Insurance (the business's Group Self-Insurance Administrator will send this form to the government entity upon request), **OR** Certificate of Workers' Compensation Self-Insurance (the business calls the Board's Self-Insurance Office at 518-402-0247). **OR** e-mail Selfinsurance@wcb.ny.gov).

### **PART 2:**

#### **DISABILITY BENEFITS REQUIREMENTS UNDER WORKERS' COMPENSATION LAW §220(8)**

To comply with coverage provisions of the WCL regarding disability benefits, businesses may:

- A) be legally exempt from obtaining disability benefits insurance coverage; or
- B) obtain such coverage from insurance carriers; or
- C) be a Board-approved self-insured employer.

Accordingly, to assist State and municipal entities in enforcing WCL Section 220(8), businesses requesting permits or seeking to enter into contracts **MUST provide ONE** of the following forms to the entity issuing the permit or entering into a contract:

- A) **DB-120.1** -- Certificate of Disability Benefits Insurance (the business's insurance carrier will send this form to the government entity upon request); **OR**
- B) **DB-155** -- Certificate of Disability Benefits Self-Insurance (the business calls the Board's Self-Insurance Office at 518-402-0247). **OR** email selfinsurance@wcb.ny.gov).

## **INSTRUCTIONS FOR OBTAINING FORM CE-200**

The CE-200 is now an on-line application. Please remember that applicants are submitting the CE-200 under penalty of perjury, a felony carrying a penalty of four years jail time. Accordingly, all statements on the CE-200 must be true.

Applicants may access the CE-200 application on the Board's Website: [www.wcb.ny.gov](http://www.wcb.ny.gov)

1. Click on the button entitled "WC/WB Exemption Forms CE-200".
2. Click on the Certificate of Attestation of Exemption (Form CE-200) at the bottom right of the screen.
3. Click the 'Access Web-Based Exemption Application' on the bottom of the screen
4. Applicants should create their own PIN number.
5. Follow the rest of the prompts.

It should take about 5 minutes to fill out the first time. **Applicants are required to print, sign and date Form CE-200 and send it to the Government Agency issuing their permit, license, or contract from. If there are questions during the application process, please contact the NY Business Contact Center at 518-485-5000.**

If the applicant is having difficulty in printing the CE-200, please call the Board's CE-200 Hotline at 866-546-9322, then press 1, and then press 3 and leave a voice message with the certificate number, the name of the business and a contact number. The CE-200 will be sent to the business address on the CE-200 within one business day.





**Workers'  
Compensation  
Board**

**Certificate of Attestation of Exemption  
from New York State Workers' Compensation and/or  
Disability and Paid Family Leave Benefits Insurance Coverage**

**\*\*This form cannot be used to waive the workers' compensation rights or obligations of any party.\*\***

The applicant may use this Certificate of Attestation of Exemption **ONLY** to show a government entity that New York State specific workers' compensation and/or disability and paid family leave benefits insurance is not required. The applicant

may **NOT** use this form to show another business or that business's insurance carrier that such insurance is not required.

Please provide this form to the government entity from which you are requesting a permit, license or contract. This Certificate will not be accepted by government officials one year after the date printed on the form.

<b>In the Application of (Legal Entity Name and Address):</b> Name Address Line 1 Address Line 2 PHONE: FEIN: XXXXX4139	<b>Business Applying For: Contract with Government Agency</b>  From: County of Ulster
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**Workers' Compensation Exemption Statement:**

The above named business is certifying that it is **NOT REQUIRED TO OBTAIN NEW YORK STATE SPECIFIC WORKERS' COMPENSATION INSURANCE COVERAGE** for the following reason:

The business is a one person owned corporation, with that individual owning all of the stock and holding all offices of the corporation. Other than the corporate owner, there are no employees, day labor, leased employees, borrowed employees, part-time employees, other stockholders, unpaid volunteers (including family members) or subcontractors.

**Disability and Paid Family Leave Benefits Exemption Statement:**

The above named business is certifying that it is **NOT REQUIRED TO OBTAIN NEW YORK STATE STATUTORY DISABILITY AND PAID FAMILY LEAVE BENEFITS INSURANCE COVERAGE** for the following reason:

The business **MUST** be either: 1) owned by one individual; OR 2) is a partnership (including LLC, LLP, PLLP, RLLP, or LP) under the laws of New York State and is not a corporation; OR 3) is a one or two person owned corporation, with those individuals owning all of the stock and holding all offices of the corporation (in a two person owned corporation each individual must be an officer and own at least one share of stock); OR 4) is a business with no NYS location. In addition, the business does not require disability and paid family leave benefits coverage at this time since it has not employed one or more individuals on at least 30 days in any calendar year in New York State. (Independent contractors are not considered to be employees under the Disability and Paid Family Leave Benefits Law.)

I, Linda Pierro, am the President with the above-named legal entity. I affirm that due to my position with the above-named business I have the knowledge, information and authority to make this Certificate of Attestation of Exemption. I hereby affirm that the statements made herein are true, that I have not made any materially false statements and I make this Certificate of Attestation of Exemption under the penalties of perjury. I further affirm that I understand that any false statement, representation or concealment will subject me to felony criminal prosecution, including jail and civil liability in accordance with the Workers' Compensation Law and all other New York State laws. By submitting this Certificate of Attestation of Exemption to the government entity listed above I also hereby affirm that if circumstances change so that workers' compensation insurance and/or disability and paid family leave benefits coverage is required, the above-named legal entity will immediately acquire appropriate New York State specific workers' compensation insurance and/or disability and paid family leave benefits coverage and also immediately furnish proof of that coverage on forms approved by the Chair of the Workers' Compensation Board to the government entity listed above.

<b>SIGN HERE</b>	<b>Signature:</b>	<b>Date:</b>
<b>Exemption Certificate Number</b> <b>2021-██████████</b>		<b>Received</b> <b>November 8, 2021</b> <b>NYS Workers' Compensation Board</b>