

ULSTER COUNTY DEPARTMENT OF PUBLIC WORKS

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

APPLICATION FOR SPECIAL HAULING PERMIT

Department of Public Works
317 Shamrock Lane
Kingston, NY 12401

Permit # _____

Date _____

Application is hereby made by the undersigned _____

_____ for a permit to transport over Ulster County roads and bridges the following described vehicles of dimensions which exceed the limitations provided for in Section 385 of the Vehicle & Traffic Law of this State:

<u>DESCRIPTION OF VEHICLES*</u>	<i>DIMENSIONS</i>			
	<u>HEIGHT</u>	<u>LENGTH</u>	<u>WIDTH</u>	<u>WEIGHT</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

ORIGIN: _____

DESTINATION: _____

ROADS TO BE UTILIZED: _____

DESIRED DATE (S) OF TRAVEL: _____

TYPE OF PERMIT: CONDITIONAL ANNUAL

The COMPLETE ROUTE (all State, County, Town, Village, Local, etc. roads being traveled) and a LOAD DIAGRAM showing the AXLE CONFIGURATION is required to be submitted with this permit application.

Applicant Information

Firm Name _____

Authorized Applicant Name (Please Print) _____

Authorized Signature _____

Title _____

Address _____

City _____

State, Zip _____

Phone _____

Fax _____

Email _____

* If additional listing space is required, attach supplemental sheet.

APPLICATION FOR SPECIAL HAULING PERMIT

Permission is hereby granted to _____
_____ to operate, transport or move the vehicles and/or loads referred to on Page 1 of this Application over the County Roads and Bridges and on dates specified pursuant to the following Conditions and Restrictions:

1. This Permit shall not be assigned or transferred.
2. Notice shall be given by said Applicant to the Commissioner of Public Works at least 48 hours in advance of the date(s) when the transport involves a load which will present special problems to the municipality, affect public utility lines, or required specialized escort procedures.
3. 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 transport conducted 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 Commissioner may require.
4. The Commissioner reserves the right to revoke or cancel this Permit at any time should the Applicant fail to comply with the terms and conditions.
5. Applicant's approved copy of the Special Hauling Permit shall be in possession of the transport parties.
6. Transport Criteria:
 - a) No moves shall be made on Sundays or Holidays, including business days before and after Holidays.
 - b) All movements shall be limited to daylight hours, and only when weather and road conditions are favorable.
 - c) Special arrangements or detour routes may be mandated when the County Road has a designated load limit.
 - d) Bridge Load Limits shall be absolutely adhered to. No exceptions shall be made. Violation of this clause shall result in immediate revocation of the Permit and subject the Applicant to legal action as provided by applicable laws.
 - e) The Applicant shall be responsible for the inspection of the transport route to ascertain limiting factors such as bridge clearances, bridge load limits, road gradients and curvature, overhead line clearances and the like, prior to transport.
7. Proper traffic safety procedures, as set forth in the National MUTCD (Manual of Uniform Traffic Control Devices), latest edition, and the NYS Supplement to the MUTCD, shall be adhered to when loading, unloading, transporting or stopping within the public highway corridor.
8. The Owner/Applicant is responsible to attain any additional required permits/permissions including, but not limited to, applicable Federal, State and Local permissions.
9. Arrangements shall be made with local law enforcement agencies to provide, where required, for the handling of motor vehicle traffic, the re-routing of traffic or similar emergencies that may arise out of the exercise of this Permit.

APPLICATION FOR SPECIAL HAULING PERMIT

- 10. The Permit Applicant shall be responsible for arrangements with the public utility corporations to accommodate transport where overhead lines, guy wires and the like may have to be disconnected, elevated or relocated.
- 11. Nothing herein contained shall be deemed to relieve the Applicant or limit its liability for damages to County Roads, public utilities services or municipal services resulting from the exercise of this Permit.

I hereby agree to the above "CONDITIONS AND RESTRICTIONS" as set forth in this SPECIAL HAULING PERMIT.

Authorized Applicant Name (Please Print)

Authorized Applicant Signature

Date

The COMPLETE ROUTE (all State, County, Town, Village, Local, etc. roads being traveled) and a LOAD DIAGRAM showing the AXLE CONFIGURATION is required to be submitted with this permit application.

OFFICIAL USE ONLY

UCDPW Engineering

APPROVED _____
Initials

DISAPPROVED

NOT APPLICABLE

UCDPW Highway Operations

APPROVED _____
Initials

DISAPPROVED

Commissioner, Ulster County Department of Public Works
County Ulster
State of New York

Validated this _____ day of _____ 20_____



**ULSTER COUNTY
DEPARTMENT OF PUBLIC WORKS**

**317 Shamrock Lane
Kingston, NY 12401**
ulstercountyny.gov
TEL (845) 340-3100 FAX (845) 340-3113

Special Hauling Permit Fee Schedule

Oversize

Single Use	\$ 10.00
Annual*	\$ 250.00

Overweight

Single Use	\$ 10.00
Annual*	\$ 250.00
Bridge Review**	\$ 50.00

* The Annual Permit covers oversized and overweight permits on County Roads without Bridges.

** Additional Fees are required for routes that require review from the Ulster County Engineering Department.

All checks are to be made payable to Ulster County Commissioner of Finance.

Submit all payments to: Ulster County Department of Public Works – Highway Department
317 Shamrock Lane
Kingston, NY 12401

Summary of Ulster County Insurance Requirements:

Item Numbers 1-3: See the following 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.state.ny.us.

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 to is submitted Ulster County.**

ACORD CERTIFICATE OF LIABILITY INSURANCE

DATE MM/DD/YY

PRODUCER	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 POLICIES BELOW.
	COMPANIES AFFORDING COVERAGE
INSURED	COMPANY A
	COMPANY B
	COMPANY C
	COMPANY D

COVERAGES
 THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAME 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 HERIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES, LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

ITEM 1

CO LTR	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS
	GENERAL LIABILITY <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS MADE <input checked="" type="checkbox"/> OCCUR <input checked="" type="checkbox"/> OWNER & CONTRACTOR'S PROT <input type="checkbox"/> _____				GENERAL AGGREGATE \$ 1,000,000.00 PRODUCTS-COMP/OP AGG \$ 1,000,000.00 PERSONAL & ADV INJURY \$ 1,000,000.00 EACH OCCURRENCE \$ 1,000,000.00 FIRE DAMAGE Any one fire \$ 50,000.00 MED EXP Any one person \$ 5,000.00
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS <input type="checkbox"/> _____				COMBINED SINGLE LIMIT \$ - BODILY INJURY Per person: \$ - BODILY INJURY Per accident: \$ - PROPERTY DAMAGE \$ -
	GARAGE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> _____				AUTO ONLY-EACH ACCIDENT \$ - OTHER THAN AUTO ONLY \$ - EACH ACCIDENT \$ - AGGREGATE \$ -
	EXCESS LIABILITY <input type="checkbox"/> UMBRELLA FORM <input type="checkbox"/> OTHER THAN UMBRELLA FORM				EACH OCCURRENCE \$ - AGGREGATE \$ - \$ -
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY THE PROPRIETOR PARTNERS/ EXECUTIVE OFFICERS ARE: <input type="checkbox"/> INCL <input type="checkbox"/> EXCL				EL EACH ACCIDENT \$ - EL DISEASE-POLICY LIMIT \$ - EL DISEASE-EA EMPLOYEE \$ -
	OTHER				

ITEM 2

DESCRIPTION OF OPERATIONS; LOCATIONS; VEHICLES; SPECIAL ITEMS
Ulster County, PO Box 1800, 244 Fair Street, Kigston, NY 12402 is named as an additional insured with respect to work performed by the insured.

ITEM 3

CERTIFICATE HOLDER County of Ulster PO Box 1800 244 Fair Street Kingston, NY 12402	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING COMPANY WILL ENDEAVOR TO MAIL 10 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO MAIL SUCH NOTICE SHALL IMPOSE MO OBLIGATION OR LIABILITY OF ANY KIND UPON THE COMPANY ITS AGENTS OR REPRESENTATIVES
---	--

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).

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).

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

1. Click on the button entitled "WC/WB Exemption Forms CE-200" (In bright yellow letters).
2. Click on the Request for WC/WB Exemption (Form CE-200).
3. Click the gray button on the bottom (Select to access web –based Application).
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 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.



**Certificate of Attestation of Exemption
From New York State Workers' Compensation
and/or Disability 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 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.

<p align="center">In the Application of (Legal Entity Name and Address):</p> <p>JOHN SMITH 123 MAIN STREET ALBANY, NY 12207 111-111-1111 Federal ID Number: XXXXX6789</p>	<p align="center">Business Applying For: BUILDING PERMIT</p> <p align="center">From: CITY OF ALBANY, DEPT OF BUILDING AND CODES</p> <p>The location of where work will be performed is 123 ACME AVENUE, ALBANY, NY 12203. Estimated dates necessary to complete work associated with the building permit are from October 14, 2008 to March 31, 2009. The estimated dollar amount of project is \$25,001 - \$50,000</p>
---	---

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 owned by one individual and is not a corporation. Other than the owner, there are no employees, day labor, leased employees, borrowed employees, part-time employees, unpaid volunteers (including family members) or subcontractors.

Disability Benefit Exemption Statement:

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

The business is owned by one individual or is a partnership (LLC, LLP, PLLP or a RLLP) under the laws of New York State and is not a corporation; or 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 is a business with no NYS location. In addition, the business does not require disability 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 Benefits Law.)

I, JOHN SMITH, am the Sole Proprietor 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 benefits coverage is required, the above-named legal entity will immediately acquire appropriate New York State specific workers' compensation insurance and/or disability 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.

SIGN HERE	Signature:	Date:
<p>Exemption Certificate Number 2008-00197</p> 		<p>Received October 2, 2008 NYS Workers' Compensation Board</p> 