



Paula A. Mahan
Town Supervisor

TOWN OF COLONIE

Building and Fire Services Department

Public Operations Center
347 Old Niskayuna Road
Latham, New York 12110

Phone (518) 783-2706 Fax (518) 783-2772
www.colonie.org/building

To all Building and Zoning Permit applicants (Homeowner Regulations are on reverse side):

Section 125 of the General Municipal Law requires that any individual applying for a building permit prove to the building department that he/she is in compliance with the mandatory coverage provisions of the Workers' Compensation Law before the building permit is issued.

The Town of Colonie requires proof of **General Liability Insurance and Workers' Compensation Insurance** before we can issue a building, temporary use, or sign permit.

You must submit a **Certificate of Insurance** showing **General Liability Insurance** with the **Town of Colonie** as certificate holder only. We need not be additional insured.

New York State mandates that we have proof of **Workers' Compensation Insurance** coverage. All applicants who list themselves as the general contractor on the building permit, must prove that they are in compliance with Section 57 of the Workers' Compensation Law (WCL) by producing ONE of the following forms:

- A.) submit form C-105.2(9/07) as proof of Workers' Compensation Insurance; or
- B.) if you are covered by the State Insurance Fund, submit U-26.3; or
- C.) if you participate in Workers' Compensation Self-Insurance, submit form SI-12 or form GSI-105.2 ; or
- D.) For entities with NO Employees - form CE-200 is required to be submitted for **each** specific application. (WC/DB-100 is no longer acceptable.)

Town of Colonie must be listed as certificate holder on the applicable Workers' Compensation Insurance coverage submitted.

ACORD FORMS ARE NOT ACCEPTABLE PROOF OF WORKERS' COMPENSATION COVERAGE

For general questions regarding Workers' Compensation Insurance, please call the Bureau of Compliance at (518) 486-6307 or visit www.wcb.ny.gov .

HOMEOWNER APPLICANTS

Affidavit of Exemption to Show Specific Proof of Workers' Compensation Insurance Coverage for a 1,2,3 or 4 Family, Owner –occupied Residence.

If the homeowner qualifies for an **Affidavit of Exemption**, the homeowner must complete **Form BP-1 (9-07)** and file it with the local building department.

A HOMEOWNER QUALIFIES FOR AN EXEMPTION IF THEY ARE OWNER OCCUPIED AND THE HOMEOWNER IS LISTED AS THE GENERAL CONTRACTOR ON THE PERMIT AND IS:

- performing all the work, for which the building permit was issued, him/herself.
- is not hiring, paying or compensating in any way, the individual(s) that is (are) performing all the work for which the building permit was issued or helping the homeowner perform such work, or
- has a homeowner's insurance policy that is currently in effect and covers the property for which the building permit was issued AND homeowner is hiring or paying individuals a total of less than 40 hours per week (aggregate hours for all paid individuals on the jobsite) for the work which the building permit was issued.

A HOMEOWNER DOES NOT QUALIFY FOR AN EXEMPTION IF:

The homeowner of a 1,2,3, or 4 family, Owner-occupied Residence is hiring or paying individuals a total of 40 hours or MORE in any week (aggregate hours for all paid individuals on the jobsite) for the work for which the building permit was issued, then the homeowner **may not** file the "Affidavit of Exemption" form BP-1 (9-07) but must either:

- acquire appropriate workers' compensation coverage and provide, the government entity issuing the building permit, appropriate proof of that coverage on forms C-105.2(9-07) or U-26.3 OR
- have the general contractor performing the work provide appropriate proof of workers' compensation coverage, under the mandatory coverage provision of the Workers' Compensation Law, or proof of exemption from that coverage, to the government entity issuing the building permit.

Any residence NOT a 1,2,3, or 4 Family Owner-occupied is considered a business (income or potential income property) and must prove Workers' Compensation Insurance compliance by filing one of the acceptable forms as outlined on the reverse side.

SAMPLE HOME OWNER APPLICANTS BP-1 Affidavit of Exemption

SAMPLE ACCORD FORM

Affidavit of Exemption to Show Specific Proof of Workers' Compensation Insurance Coverage for a 1, 2, 3 or 4 Family, Owner-occupied Residence

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

Under penalty of perjury, I certify that I am the owner of the 1, 2, 3 or 4 family, owner-occupied residence (including condominiums) listed on the building permit that I am applying for, and I am not required to show specific proof of workers' compensation insurance coverage for such residence because (please check the appropriate box):

- I am performing all the work for which the building permit was issued.
- I am not hiring, paying or compensating in any way, the individual(s) that is(are) performing all the work for which the building permit was issued or helping me perform such work.
- I have a homeowner's insurance policy that is currently in effect and covers the property listed on the attached building permit AND am hiring or paying individuals of less than 40 hours per week (aggregate hours for all paid individuals on the jobsite) for which the building permit was issued.

I do not agree to either:
 acquire appropriate workers' compensation insurance coverage or provide appropriate proof of that coverage on forms approved by the Chair of the NYS Workers' Compensation Board to the government entity issuing the building permit if I need to hire or pay or compensate individuals for 40 hours or more per week (aggregate hours for all paid individuals on the jobsite) for which the building permit was issued, or if appropriate, file a WC/DB-100 exemption.

I do not have the general contract for the work on the 1, 2, 3 or 4 family, owner-occupied residence (including condominiums) listed on the building permit that I am applying for, provide appropriate proof of workers' compensation insurance coverage or proof of exemption from that coverage on forms approved by the Chair of the NYS Workers' Compensation Board to the government entity issuing the building permit if the project takes a total of 40 hours or more per week (aggregate hours for all paid individuals on the jobsite) for work indicated on the building permit.

(Signature of Homeowner)

(Date Signed)

(Homeowner's Name Printed)

Home Telephone Number

County Address that requires the building permit:

Sworn to before me this _____ day of _____, 20____.

(County Clerk or Notary Public)

Notarized, this Form BP-1 serves as an exemption for both workers' compensation and disability benefits insurance coverage.

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CERTIFICATE HOLDER Town of Colonie Public Operations Center 347 Old Niskayuna Road Latham, New York 12110		CANCELLATION STATEMENT OF THE ABOVE DESCRIBED POLICIES IS CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE HOMEOWNER WILL BE RESPONSIBLE FOR ALL POLICY DUES AND FEES PAID TO THE INSURANCE COMPANY UP TO THE DATE OF CANCELLATION. THE POLICY HOLDER SHALL BE RESPONSIBLE FOR THE CANCELLATION OF ANY POLICY UPON THE INSURANCE COMPANY OR REPRESENTATIVE.																																																																																																																																																																																																												

SAMPLE FORM C-105.2

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

<p>a. Legal Name and address of Insured (Use street address only)</p> <p>Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e. a Wrap-Up Policy)</p>	<p>b. Business Telephone Number of Insured</p> <p>1c. NYS Unemployment Insurance Employer Registration Number of Insured</p> <p>1d. Federal Employer Identification Number of Insured or Social Security Number</p>
<p>1. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)</p> <p>Town of Colonie Public Operations Center 347 Old Niskayuna Road Latham, New York 12110</p>	<p>3a. Name of Insurance Carrier</p> <p>3b. Policy Number of entity listed in box "1"</p> <p>3c. Policy effective period:</p> <p>3d. The Proprietor, Partners or Executive Officers are:</p> <p><input type="checkbox"/> included. (Only check box if all persons/officers included and not excluded or certain partners/officers excluded.)</p> <p>3e. Demolition is: (Definition of Demolition on Reverse)</p> <p><input type="checkbox"/> included.</p> <p><input type="checkbox"/> excluded.</p>

The insured 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 box 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 will also notify the certificate holder within 10 days if a policy is renewed due to nonpayment of premium, or within 30 days if there are no renewals due to nonpayment of premium that causes the policy to terminate the insured from the coverage indicated on this Certificate. (These notices may be sent by regular mail.) Otherwise, this Certificate is valid for a minimum of one year and this form is approved by the insurance carrier or its licensed agent.

Upon the expiration of the workers' compensation policy indicated on this form, if the business continues to be named on a permit issued by the State of New York, the business must provide that certificate holder with a new Certificate of Workers' Compensation Insurance. The certificate holder must provide proof that the business is complying with the mandatory coverage requirements of the New York State Workers' Compensation Law.

In order to receive this Certificate, I certify that I am an authorized representative or licensed agent of the insurance carrier referenced above and that the insured has the coverage as depicted on this form.

Approved by: _____
(Print name of authorized representative or licensed agent of insurance carrier)

Approved by: _____
(Signature) (Date)

Title: _____

Telephone Number of authorized representative or licensed agent of insurance carrier: _____

NOTE: Only insurance carriers and their licensed agents are authorized to issue this C-105.2 form. Insurance brokers are NOT authorized to issue it.

SAMPLE FORM CE-200



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 specific workers' compensation and/or disability benefits insurance is not required. This 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 cannot be accepted by government officials one year after the date printed on the form.

<p>In the Application of (Legal Entity Name and Address):</p> <p>JOHN SMITH 123 MAIN STREET ALBANY, NY 12207 913-313-1111 Federal ID Number: XXXXX0789</p>	<p>Business Applying For: BUILDING PERMIT</p> <p>From: CITY OF ALBANY, DEPT OF BUILDING AND CO</p> <p>The location of where work will be performed is: 123 ACME AVENUE, ALBANY, NY 12208.</p> <p>Estimated dates necessary to complete work associated with the build permit are from October 14, 2008 to March 31, 2009.</p> <p>The estimated dollar amount of project is \$25,001 - \$50,000</p>
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Workers' Compensation Exemption Statement:
The above named business is certifying that it is **NOT** REQUIRED TO OBTAIN NEW YORK STATE STATUTORY 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, lease employees, borrowed employees, part-time employees, unpaid volunteers (including family members) or subcontractors.

Disability Benefits 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 by a partnership (LLC, LLP, LLLP 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 a 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 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, as the Sole Proprietor with the above named legal entity. I affirm that due to my position with the above named business I have knowledge, information and authority to make this Certificate of Attestation of Exemption. I hereby affirm that the statements made herein are true and correct to the best of my knowledge and I make this Certificate of Attestation of Exemption under the penalty of perjury. I further affirm 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 a 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 update appropriate New York State specific workers' compensation insurance and 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.

SEVEN EIGHTY Signature: _____ Date: _____
