



PGL1: Project Specific General
Liability Insurance Summary
and Affirmation

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DEPT BLDGS Job No. 220546586
Scan Code ESHS6240922

This document must be submitted with an ACORD Certificate summarizing the General Liability Insurance coverage for this project.

1 Location Information Required for all applications.

House No(s) 126 Street Name East 169 Street
Borough Bronx Block 2466 Lot 22 BIN 2002860 CB No. 204

2 Project Specific Insurance Requirement The required insurance is calculated based on information provided by the applicant.

Yes No

☐ ☒ 1 or 2 family home?

Height of proposed construction 30 ft

☒ ☐ Depth of Excavation < 12'?

Number of stories of proposed construction 2

☒ ☐ Proposed Height < 35'?

Height of tallest adjacent building 60 ft

☒ ☐ Proposed construction on lot line with an existing structure?

Number of stories of tallest adjacent building 5

☐ ☒ Is a Tower Crane to be used?

Permit Type NB/Major Alt

Calculated Project Specific GL Insurance Required 5M

3 Applicant Statement and Signatures Required for all applications.

The information in this application is correct and complete to the best of my knowledge and I assume responsibility for all statements on this form. I understand that if I am found after hearing to have knowingly or negligently made a false statement on this or any other document submitted to the Department, I may be subject to fine, imprisonment, and/or barred from filing further documents with the Department. I also understand it is unlawful to give to a city employee, or for a city employee to accept, any benefit, monetary or otherwise, either as a gratuity for properly performing the job or in exchange for special consideration.

Name Universal Design and Construction M

Notarization (required if not licensee)
State of New York, County of:

Licensee Seal or Notary Seal

Registration/Tracking Number 0608057

Sworn to or affirmed under penalty of perjury

Signature *[Signature]*

12 day of Sep 2018

Sam Hillyard Holiday
Commissioner of Deeds
City of NY. #211459
Certificate on file in NY County
Commission Expires 6-1-2020

Date 9/14/18

Notary Signature *[Signature]*

4 Brokers Certification Required for all applications.

The undersigned insurance broker or agent represents to the City of New York that the attached Certificate of Insurance is accurate in all material respects. With regard to the commercial general liability insurance (including primary, excess, umbrella, or wrap-up policies) described in the Certificate of Insurance, the undersigned further represents that:

- The total per occurrence limit is \$ 2 million and the total general aggregate limit, which applies per project, is \$ 7 Agg. Limits
- The City of New York, together with its officials and employees, is an additional insured with coverage at least as broad as set forth in the most recent edition of ISO Forms CG 2012 or CG 2026.

Name of broker or agent ATLANTIC Agency HUNTINGTON INC.

Notarization (required)
State of NY, County of: Suffolk

Notary Seal

Address of broker or agent 1469 DEC PARK AVE, N. BABY LN, NY, 11705

Sworn to or affirmed before me this

Email address of broker or agent ERIC@atlanticagency.com

30 day of JULY 2018

Signature of authorized official, broker or agent *[Signature]*

Notary Signature TONI LEIBOWITZ

Name and title of authorized official, broker, or agent Eric Leibowitz, Broker

Notary Public for the State of NY

TONI LEIBOWITZ
Notary Public, State of New York
Reg. No. 01LA6068041
Qualified in Suffolk County
Commission Expires 02/11/20 22



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

06/28/2018

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	Atlantic Agency Huntington, Inc 1152 E Jericho Turnpike Huntington, NY 11743	CONTACT NAME: Stacey Johnson PHONE (A/C, No, Ext): 631.244.7784 x2 E-MAIL ADDRESS: StaceyJ@atlanticagency.com FAX (A/C, No): 631.709.5014
INSURED	UNIVERSAL DESIGN & CONSTR MGMT LLC 1914 GRAND AVE BALDWIN, NY 11510	INSURER(S) AFFORDING COVERAGE INSURER A: Atlantic Casualty Ins Co NAIC # 42846 INSURER B: National Union INSURER C: SHELTERPOINT LIFE INS CO 81434 INSURER D: INSURER E: INSURER F:

COVERAGES

CERTIFICATE NUMBER: 00000000-264451

REVISION NUMBER: 4

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 SUBR INSD Y/N	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	☒ COMMERCIAL GENERAL LIABILITY ☐ CLAIMS-MADE ☒ OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: ☐ POLICY ☒ PROJECT ☐ LOC OTHER:		BINDER # 1706969	03/28/2018	03/28/2019	EACH OCCURRENCE \$ 2,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000 MED EXP (Any one person) \$ 5,000 PERSONAL & ADV INJURY \$ 2,000,000 GENERAL AGGREGATE \$ 4,000,000 PRODUCTS - COM/OP AGG \$ 4,000,000
	AUTOMOBILE LIABILITY ☐ ANY AUTO ☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS ☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY					COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
B	☐ UMBRELLA LIAB ☒ EXCESS LIAB ☐ DED ☐ RETENTION \$		BE 014229296	03/28/2018	03/28/2019	EACH OCCURRENCE \$ 3,000,000 AGGREGATE \$ 3,000,000
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ Y/N ☐ N/A If yes, describe under DESCRIPTION OF OPERATIONS below					PER STATUTE ☐ OTH-ER ☐ E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
C	Disability		D367094	10/20/2017	10/20/2018	Statutory Limits

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

REMODELING - INCLUDING ONLY THOSE CLASSES SHOWN ON REQUIRED FORM AGL-REM0117 - The certificate of insurance is issued subject to all policy terms, conditions, limitations and exclusions of the policy.

Job-126 East 169 Street, Bronx NY 10007

CERTIFICATE HOLDER

CANCELLATION

NEW YORK CITY DEPARTMENT OF BUILDINGS
Attn: Licensing Unit
280 BROADWAY, 6TH FLOOR
NEW YORK, NY 10007

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

(SAJ)

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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)
UNIVERSAL DESIGN AND CONSTRUCTION MANAGEMENT LLC
ATTN: JOHN BROWN
1914 GRAND AVENUE
BALDWIN, NY 11510

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
516-693-0112

1c. Federal Employer Identification Number of Insured
or Social Security Number
264281700

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

NYC DEPARTMENT OF BUILDINGS
280 BROADWAY, 6TH FLOOR
NEWYORK, NY 10007

3a. Name of Insurance Carrier

ShelterPoint Life Insurance Company

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

DBL367094

3c. Policy effective period

10/20/2017

to

10/19/2019

4. Policy provides the following benefits:

- ☒ A. Both disability and paid family leave benefits.
☐ B. Disability benefits only.
☐ C. Paid family leave benefits only.

5. Policy covers:

- ☒ A. All of the employer's employees eligible under the NYS Disability and Paid Family Leave Benefits Law.
☐ B. Only the following class or classes of employer's employees:

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 NYS Disability and/or Paid Family Leave Benefits insurance coverage as described above.

Date Signed 7/23/2018 By Richard White

(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number 516-829-8100

Name and Title Richard White, Chief Executive Officer

IMPORTANT: If Boxes 4A and 5A are checked, and this form is signed by the insurance carrier's authorized representative or NYS Licensed Insurance Agent of that carrier, this certificate is COMPLETE. Mail it directly to the certificate holder.

If Box 4B, 4C or 5B is checked, this certificate is NOT COMPLETE for purposes of Section 220, Subd. 8 of the NYS Disability and Paid Family Leave Benefits Law. It must be mailed for completion to the Workers' Compensation Board, Plans Acceptance Unit, PO 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

According to information maintained by the NYS Workers' Compensation Board, the above-named employer has complied with the NYS Disability and Paid Family Leave Benefits Law with respect to all of his/her employees.

Date Signed _____ By _____

(Signature of Authorized NYS Workers' Compensation Board Employee)

Telephone Number _____

Name and Title _____

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.





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 Carrier

1a Legal Name & Address of Insured (use street address only)
UNIVERSAL DESIGN AND CONSTRUCTION MANAGEMENT LLC
ATTN: JOHN BROWN
1914 GRAND AVENUE
BALDWIN, NY 11510

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
516-693-0112

1c. Federal Employer Identification Number of Insured
or Social Security Number
264281700

2 Name and Address of Entity Requesting Proof of Coverage
(Entity Being Listed as the Certificate Holder)
NEW YORK CITY DEPARTMENT OF BUILDINGS
280 BROADWAY
NEW YORK, NY 10007

3a Name of Insurance Carrier
ShelterPoint Life Insurance Company

3b Policy Number of Entity Listed in Box "1a"
DBL367094

3c Policy effective period
10/20/2017 to 10/19/2019

4 Policy provides the following benefits:

- ☒ A Both disability and paid family leave benefits
☐ B Disability benefits only
☐ C Paid family leave benefits only.

5. Policy covers:

- ☒ A. All of the employer's employees eligible under the NYS Disability and Paid Family Leave Benefits Law
☐ B Only the following class or classes of employer's employees.

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 NYS Disability and/or Paid Family Leave Benefits insurance coverage as described above.

Date Signed 7/31/2018 By 
(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number 516-829-8100 Name and Title Richard White, Chief Executive Officer

IMPORTANT. If Boxes 4A and 5A are checked, and this form is signed by the insurance carrier's authorized representative or NYS Licensed Insurance Agent of that carrier, this certificate is COMPLETE. Mail it directly to the certificate holder.

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Date Signed _____ By _____
(Signature of Authorized NYS Workers' Compensation Board Employee)

Telephone Number _____ Name and Title _____

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