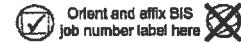




# PW2: Work Permit Application Must be typewritten.



BIS Document No., required:

## 1 Reason For Filing Required for all applications.

- ☒ Initial Permit Complete all sections. Expected work start date: \_\_\_\_\_ ☐ Renewal Permit with changes Complete all sections.  
☐ No Work Permit ☐ Renewal Permit without changes 1, 3, 4, 7 - 12

## 2 Location Information Required for all applications.

House No(s) 135-25 Street Name 217TH STREET  
 Borough 4 Block 13015 Lot 9 BIN 4280006 C.B. No. 413  
 Work on Floor(s) ROOF Apt. / Condo No(s)  
 Total number of dwelling units at location ROOF Number of dwelling units occupied during construction 2

## 3 Type of Permit Choose one and complete any appropriate sub-choices or other information.

- ☒ Alteration ☐ Curb Cut ☐ Fuel Burning ☐ Plumbing 3C 3A Electrical application no. for shed lighting:  
☐ Filed as NB (28-101.4-5) ☐ Demolition and Removal ☐ Gas ☐ Sign  
☐ Boiler ☐ Fire Alarm ☐ Oil ☐ Sprinkler 3C 3B Related fence job no.  
☐ Construction Equipment ☐ Fire Suppression System ☐ Fuel Storage ☐ Standpipe 3C 3C Secondary permit description (if applies):  
☐ Chute ☐ Fence ☐ Foundation / Earthwork ☐ Mechanical / HVAC  
☐ Sidewalk Shed 3A Area of site (sq. ft):  
☐ Supported Scaffold ☐ New Building 3B  
☐ Other: ☐ Earthwork Only

- 3D ☐ Yes ☒ No Are you adding more than three stories? ☐ Yes ☒ No Are you removing one or more stories? If yes, 8  
☐ Yes ☒ No Are you performing work in 50% or more of the area of the building? ☐ Yes ☒ No Are you demolishing 50% or more of the area of the building? If yes, 8  
☐ Yes ☒ No Are you performing a vertical or horizontal enlargement adding more than 25% of the area of the building? ☐ Yes ☒ No Does your approved work include concrete? If yes, is your concrete work completed?  
☐ Yes ☐ No complete section 9  
☐ Yes ☒ No Are mechanical means to be used? ☐ Yes ☒ No Are you altering 10% or more of the existing floor surface area of the building?

## 4 Applicant / Contractor Required for all applications. (\* Indicates optional.)

Last Name Christensen First Name Cameron Middle Initial  
 Business Name Pro Custom Solar LLC dba Momentum Solar Business Telephone 732-902-6224  
 Business Address 3096B Hamilton Boulevard \*Business Fax 732-902-6223  
 City South Plainfield State NJ Zip 07080 \*Mobile Telephone  
 \*E-Mail permits@momentumsolar.com Taxpayer ID 27-1242539

- ☒ General Contractor 4A, 4B 4A Provide registration or tracking number: 616847  
☐ Fire Suppression Contractor 4C, 4D 4B Does work require a HIC license? ☐ Yes ☐ No If yes, HIC  
☐ Master Plumber 4C, 4D 4C License Number:  
☐ Oil Burner Installer 4C, 4D 4D Is applicant responsible for all work on this application? ☐ Yes  
☐ Sign Hanger 4D If no, describe work responsibility:  
☐ Professional Engineer 4C, 6  
☐ Registered Architect 4C, 6  
☐ Homeowner  
 DOB approval required. 4E



Mechanical equipment other than handheld devices to be used for demolition or removal of debris (BC §3306.4).

PW2

**5 Filing Representative** Complete if different from applicant specified in section 3. (\* Indicates optional.)

|                  |                           |            |        |                     |              |
|------------------|---------------------------|------------|--------|---------------------|--------------|
| Last Name        | Dunzik                    | First Name | Daniel | Middle Initial      |              |
| Business Name    | N/A                       |            |        | Business Telephone  | 908-872-3664 |
| Business Address | 370 Burnt Hill Rd         |            |        | *Business Fax       |              |
| City             | Skillman                  | State      | NJ     | Zip                 | 08558        |
| *E-Mail          | studiogdesign@comcast.net |            |        | *Mobile Telephone   |              |
|                  |                           |            |        | Registration Number | 039534       |

**6 Insurance P.E. / R.A. only** (\* indicates required for all permits)

☐ Liability Insurance (NB permits only) ☐ Workers' Compensation Insurance\* ☐ Disability Insurance \*

**7 Construction Superintendent, Site Safety Coordinator, Site Safety Manager** Required if applicable. (\* Indicates optional.)

I, the applicant / contractor, hereby declare the scope of work filed under this permit application requires: (choose one)

|                                                      |                                                  |                                              |
|------------------------------------------------------|--------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Construction Superintendent | <input type="checkbox"/> Site Safety Coordinator | <input type="checkbox"/> Site Safety Manager |
| Last Name                                            | First Name                                       | Middle Initial                               |
| Business Name                                        | Telephone                                        |                                              |
| Address                                              | *Fax                                             |                                              |
| City                                                 | State                                            | Zip                                          |
| *E-Mail                                              | *Mobile Telephone                                |                                              |
|                                                      |                                                  | Registration Number                          |

I, the undersigned, will perform, on behalf of the Contractor, all of the functions required of a Construction Superintendent, or Site Safety Coordinator, or Site Safety Manager (identified above) as set forth in the Department of Buildings rules and regulations.

|              |                                                            |             |
|--------------|------------------------------------------------------------|-------------|
| Name (print) | Notarization<br>State of New York, County of:              | Notary Seal |
| Signature    | Sworn to or affirmed under penalty of perjury<br>day of 20 |             |
| Date         | Notary Signature                                           |             |

**8 Demolition Subcontractor** Required if applicable. (\* Indicates optional.)

☐ Yes ☐ No Is the applicant/contractor named in section four performing the demolition work for this permit? If no, complete this section.

|               |                   |                     |
|---------------|-------------------|---------------------|
| Last Name     | First Name        | Middle Initial      |
| Business Name | Telephone         |                     |
| Address       | *Fax              |                     |
| City          | State             | Zip                 |
| *E-Mail       | *Mobile Telephone |                     |
|               |                   | Registration Number |

I, the undersigned, will perform, on behalf of the Contractor, all of the functions required of a Demolition Subcontractor as set forth in the Department of Buildings rules and regulations.

|              |                                                            |             |
|--------------|------------------------------------------------------------|-------------|
| Name (print) | Notarization<br>State of New York, County of:              | Notary Seal |
| Signature    | Sworn to or affirmed under penalty of perjury<br>day of 20 |             |
| Date         | Notary Signature                                           |             |

PW2

|          |                                                                              |
|----------|------------------------------------------------------------------------------|
| <b>9</b> | <b>Concrete Information</b> Choose and complete any appropriate sub-choices. |
|----------|------------------------------------------------------------------------------|

9A ☐ Yes ☐ No Are you requesting to exclude concrete work at this time from this permit? If no, 9B

9B ☐ Yes ☐ No Does your approved work include 2,000 cubic yards or more of concrete? If yes, 10 and 11

|           |                                                                               |
|-----------|-------------------------------------------------------------------------------|
| <b>10</b> | <b>Concrete Subcontractor Required if applicable. (* Indicates optional.)</b> |
|-----------|-------------------------------------------------------------------------------|

☐ Yes ☐ No Is the applicant/contractor named in section four performing the concrete work for this permit? If no, complete this section.

|               |                     |                |
|---------------|---------------------|----------------|
| Last Name     | First Name          | Middle Initial |
| Business Name | Telephone           |                |
| Address       | *Fax                |                |
| City          | State               | Zip            |
| *E-Mail       | *Mobile Telephone   |                |
|               | Registration Number |                |

I, the undersigned, will perform, on behalf of the Contractor, all of the functions required of a Concrete Subcontractor as set forth in the Department of Buildings rules and regulations.

|              |                                                            |             |
|--------------|------------------------------------------------------------|-------------|
| Name (print) | Notarization<br>State of New York, County of:              | Notary Seal |
| Signature    | Sworn to or affirmed under penalty of perjury<br>day of 20 |             |
| Date         | Notary Signature                                           |             |

|           |                                                                                |
|-----------|--------------------------------------------------------------------------------|
| <b>11</b> | <b>Concrete Safety Manager Required if applicable. (* Indicates optional.)</b> |
|-----------|--------------------------------------------------------------------------------|

|               |                     |                |
|---------------|---------------------|----------------|
| Last Name     | First Name          | Middle Initial |
| Business Name | Telephone           |                |
| Address       | *Fax                |                |
| City          | State               | Zip            |
| *E-Mail       | *Mobile Telephone   |                |
|               | Registration Number |                |

I, the undersigned, will perform, on behalf of the Contractor, all of the functions required of a Concrete Safety Manager (identified above) as set forth in the Department of Buildings rules and regulations.

|              |                                                            |             |
|--------------|------------------------------------------------------------|-------------|
| Name (print) | Notarization<br>State of New York, County of:              | Notary Seal |
| Signature    | Sworn to or affirmed under penalty of perjury<br>day of 20 |             |
| Date         | Notary Signature                                           |             |

|           |                                                                                        |
|-----------|----------------------------------------------------------------------------------------|
| <b>12</b> | <b>Applicant / Contractor Statements and Signatures Required for all applications.</b> |
|-----------|----------------------------------------------------------------------------------------|

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.

I will comply with all applicable laws, rules and regulations including all insurance requirements, and, in addition,

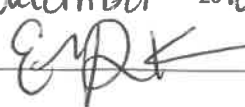
\*I hereby state if a Construction Superintendent, Site Safety Coordinator, Site Safety Manager, Demolition Subcontractor, Concrete Subcontractor, or Concrete Safety Manager is required for this application I have hereby advised the individual listed herein he or she is designated as such and hereby certify he or she is registered and in good standing with the NYC Department of Buildings.

\*I hereby state this renewal application with no change to Applicant, Filing Representative, Construction Superintendent, Site Safety Coordinator, Site Safety Manager, Subcontractors, Concrete Safety Manager or insurance is for the work as originally filed or as officially amended.

\*In accordance with §28-104.8 of the Administrative Code, I hereby declare I am authorized by the owner of the above-referenced premises to make this application for a permit to perform the work described herein. In accordance with Rule 101-18, I will post the permit in a conspicuous and visible location.

\*I hereby state that all construction and demolition workers employed or otherwise engaged at the site and working under this permit have received site safety training in accordance with BC 3321.

☒ Check here if the work authorized by this permit does NOT require adjacent property insurance. (moved from section 13)

|                                                                                                  |                                                                                                          |                                                                                                      |
|--------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|
| Name (print)<br>Cameron Christensen                                                              | Notarization (required if not licensee)<br>State of New York, County of:                                 | Licensee Seal or Notary Seal                                                                         |
| Signature<br> | Sworn to or affirmed under penalty of perjury<br>14th day of December 2018                               | <b>ERICA S. DRAKE</b><br><b>NOTARY PUBLIC OF NEW JERSEY</b><br><b>My Commission Expires 9/4/2023</b> |
| Date 12/14/18                                                                                    | Notary Signature<br> |                                                                                                      |



## CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
12/12/2018

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 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><br>Brown & Brown Insurance<br>2000 Midlantic Dr. - Suite 440<br>Mount Laurel, NJ 08054<br>Brian DiLuigi | <b>CONTACT NAME:</b> Lisa MacDonald                                                       |                                    |
|                                                                                                                         | <b>PHONE (A/C, No, Ext):</b> 732-504-2001                                                 | <b>FAX (A/C, No):</b> 732-504-2011 |
|                                                                                                                         | <b>E-MAIL ADDRESS:</b> <a href="mailto:lmacdonald@bbdvins.com">lmacdonald@bbdvins.com</a> |                                    |
|                                                                                                                         | <b>INSURER(S) AFFORDING COVERAGE</b>                                                      |                                    |
|                                                                                                                         | <b>NAIC #</b>                                                                             |                                    |
| <b>INSURED</b><br>Pro Custom Solar LLC dba<br>Momentum Solar<br>3096 Hamilton Boulevard<br>South Plainfield, NJ 07080   | <b>INSURER A :</b> Southwest Marine & General Ins                                         |                                    |
|                                                                                                                         | <b>INSURER B :</b> Gotham Insurance Company                                               |                                    |
|                                                                                                                         | <b>INSURER C :</b> Lloyd's                                                                |                                    |
|                                                                                                                         | <b>INSURER D :</b> United States Fire Ins Co                                              |                                    |
|                                                                                                                         | <b>INSURER E :</b>                                                                        |                                    |
| <b>INSURER F :</b>                                                                                                      |                                                                                           |                                    |

## COVERAGES

## 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                                                                                                                                                                                                                                                                                        | ADDL INSD | SUBR WVD | POLICY NUMBER                | POLICY EFF (MM/DD/YYYY) | POLICY EXP (MM/DD/YYYY) | LIMITS                                                               |
|----------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|----------|------------------------------|-------------------------|-------------------------|----------------------------------------------------------------------|
| A        | <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY<br><input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR<br><br>GEN'L AGGREGATE LIMIT APPLIES PER:<br><input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC<br>OTHER: |           |          | GL201800010727               | 12/12/2018              | 12/12/2019              | EACH OCCURRENCE \$ 1,000,000                                         |
|          |                                                                                                                                                                                                                                                                                                          |           |          |                              |                         |                         | DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000                 |
|          |                                                                                                                                                                                                                                                                                                          |           |          |                              |                         |                         | MED EXP (Any one person) \$ 5,000                                    |
|          |                                                                                                                                                                                                                                                                                                          |           |          |                              |                         |                         | PERSONAL & ADV INJURY \$ 1,000,000                                   |
|          |                                                                                                                                                                                                                                                                                                          |           |          |                              |                         |                         | GENERAL AGGREGATE \$ 2,000,000                                       |
|          |                                                                                                                                                                                                                                                                                                          |           |          |                              |                         |                         | PRODUCTS - COMP/OP AGG \$ 2,000,000                                  |
|          |                                                                                                                                                                                                                                                                                                          |           |          |                              |                         |                         |                                                                      |
| D        | <input checked="" type="checkbox"/> AUTOMOBILE LIABILITY<br><input type="checkbox"/> ANY AUTO<br><input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS<br><input checked="" type="checkbox"/> HIRED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS                |           |          | 133-743613-5                 | 04/21/2018              | 04/21/2019              | COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000                     |
|          |                                                                                                                                                                                                                                                                                                          |           |          |                              |                         |                         | BODILY INJURY (Per person) \$                                        |
|          |                                                                                                                                                                                                                                                                                                          |           |          |                              |                         |                         | BODILY INJURY (Per accident) \$                                      |
|          |                                                                                                                                                                                                                                                                                                          |           |          |                              |                         |                         | PROPERTY DAMAGE (Per accident) \$                                    |
|          |                                                                                                                                                                                                                                                                                                          |           |          |                              |                         |                         |                                                                      |
| B        | <input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR<br><input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE<br>DED <input checked="" type="checkbox"/> RETENTION \$ 10000                                                                   |           |          | UM201800004884               | 12/12/2018              | 12/12/2019              | EACH OCCURRENCE \$ 5,000,000                                         |
|          |                                                                                                                                                                                                                                                                                                          |           |          |                              |                         |                         | AGGREGATE \$ 5,000,000                                               |
|          |                                                                                                                                                                                                                                                                                                          |           |          |                              |                         |                         |                                                                      |
|          |                                                                                                                                                                                                                                                                                                          |           |          |                              |                         |                         |                                                                      |
|          | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY<br>ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)<br>If yes, describe under DESCRIPTION OF OPERATIONS below                                                                                                                   |           |          |                              |                         |                         | PER STATUTE <input type="checkbox"/> OTH-ER <input type="checkbox"/> |
|          |                                                                                                                                                                                                                                                                                                          |           |          |                              |                         |                         | E.L. EACH ACCIDENT \$                                                |
|          |                                                                                                                                                                                                                                                                                                          |           |          |                              |                         |                         | E.L. DISEASE - EA EMPLOYEE \$                                        |
|          |                                                                                                                                                                                                                                                                                                          |           |          |                              |                         |                         | E.L. DISEASE - POLICY LIMIT \$                                       |
| C        | Professional Liab                                                                                                                                                                                                                                                                                        |           |          | ANE1860007.18<br>CLAIMS MADE | 12/12/2018              | 12/12/2019              | Limit 1,000,000                                                      |

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

## CERTIFICATE HOLDER

## CANCELLATION

|                                                                                                                                              |                                                                                                                                                                |
|----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>NEWYORK</b><br><br>New York City Department of Buildings<br>Attn: Licensing & Exams Unit<br>280 Broadway, 6th Floor<br>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<br>                                                                                                                                  |



**Workers'  
Compensation  
Board**

**CERTIFICATE OF  
NYS WORKERS' COMPENSATION INSURANCE COVERAGE**

|                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>1a. Legal Name Address of Insured (use street address only)</b><br>CoAdvantage Resources 51, Inc. Labor Contractor, for leased workers to:<br><br>Pro Custom Solar, LLC dba: Momentum Solar<br><br>45 Fairchild Ave Ste B<br>Plainview, NY 11803<br><br>Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e., a Wrap-Up Policy) | <b>1b. Business Telephone Number of Insured</b><br>(813) 935-2000<br><br><b>1c. NYS Unemployment Insurance Employer Registration Number of insured</b><br><br><b>1d. Federal Employer Identification Number of Insured or Social Security Number</b><br>27-1242539                                                                                                                                                                                                         |
| <b>2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)</b><br>Rockland County Consumer Protection<br><br>50 Sanatorium Road, Building A, 8th FL<br><br>Pomona, NY 10970                                                                                                                                                                         | <b>3a. Name of Insurance Carrier</b><br>American Zurich Insurance Company<br><b>3b. Policy Number of Entity Listed in Box "1a"</b><br>WC 11-25-632-00<br><b>3c. Policy effective period</b><br>12/8/2018 to 4/1/2019<br><b>3d. The Proprietor, Partners, or Executive Officers are</b><br><input type="checkbox"/> included. (Only check box if all partners/officers included)<br><input checked="" type="checkbox"/> all excluded or certain partners/officers excluded. |

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: Douglas Jones  
(Print name of authorized representative or licensed agent of insurance carrier)  
Approved by:  12/14/2018  
(Signature) (Date)  
Title: Vice President

Telephone number of authorized representative or licensed agent of insurance carrier: (480)951-4177

**Please Note: Only insurance carriers and their licensed agents are authorized to issue Form C-105.2. Insurance brokers are NOT authorized to issue it.**



# 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)

PRO CUSTOM SOLAR LLC  
DBA MOMENTUM SOLAR  
3096 Hamilton Boulevard  
South Plainfield, NJ 07080

1b. Business Telephone Number of Insured  
(732) 902-6224

Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e., a Wrap-Up Policy)

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

271-24-2539

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

NEW YORK CITY DEPARTMENT OF BUILDINGS  
ATTN: LICENSING AND EXAMS UNIT  
280 BROADWAY, 6TH FL  
NEW YORK, NY 10007

3a. Name of Insurance Carrier

**New York State Insurance Fund (NYSIF)**

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

DBL 3152 68 - 4

3c. Policy effective period

10/15/1998 to 07/01/2019

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 12/12/2018

By

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

Telephone Number (866) 697-4332

Name and Title **Melissa Jensen, Acting Head of Disability Insurance Unit**

**IMPORTANT:** If Box 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, DB 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.**

## Additional Instructions for Form DB-120.1

By signing this form, the insurance carrier identified in box "3" on this form is certifying that it is insuring the business referenced in box "1a" for disability and/or paid family leave benefits under the New York State Disability and Paid Family Leave Benefits Law. The Insurance Carrier or its licensed agent will send this Certificate of Insurance to the entity listed as the certificate holder in box "2".

The insurance carrier must notify the above certificate holder and the Worker's Compensation Board within 10 days IF a policy is cancelled 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 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 Disability and/or Paid Family Leave Benefits contract of insurance only while the underlying policy is in effect.

**Please Note: Upon the cancellation of the disability and/or paid family leave benefits 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 NYS Disability and/or Paid Family Leave Benefits Coverage or other authorized proof that the business is complying with the mandatory coverage requirements of the New York State Disability and Paid Family Leave Benefits Law.**

### DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

#### §220. Subd. 8

(a) The head of a state or municipal department, board, commission or office authorized or required by law to issue any permit for or in connection with any work involving the employment of employees in employment as defined in this article, and not withstanding any general or special statute requiring or authorizing the issue of such permits, shall not issue such permit unless proof duly subscribed by an insurance carrier is produced in a form satisfactory to the chair, that the payment of disability benefits and after January first, two thousand and twenty-one, the payment of family leave benefits for all employees has been secured as provided by this article. Nothing herein, however, shall be construed as creating any liability on the part of such state or municipal department, board, commission or office to pay any disability benefits to any such employee if so employed.

(b) The head of a state or municipal department, board, commission or office authorized or required by law to enter into any contract for or in connection with any work involving the employment of employees in employment as defined in this article and notwithstanding any general or special statute requiring or authorizing any such contract, shall not enter into any such contract unless proof duly subscribed by an insurance carrier is produced in a form satisfactory to the chair, that the payment of disability benefits, and after January first, two thousand eighteen, the payment of family leave benefits for all employees has been secured as provided by this article.