## Westbury Terrace Condominium Major Alteration Agreement

Unit No:	Name:
Telephone Home:-	
Email:	_
An alteration agreement must be compalteration.	pleted and submitted for approval for any
Please fill out the following information	n:
Contractor:	
Electrician:	
Plumber:	<del></del>
Start Date:	

Please include with a signed copy of this agreement:

- A detailed description of the work to be performed.
- The General Contractor/Plumber/Electrician requirements are enclosed in this packet.
- A check for \$500 as an alteration deposit payable to "Westbury Terrace Condominium. Upon completion of this alteration and final inspection by Kaled Management, these funds will be refunded, less the cost to repair any damages made in connection with this alteration.

By signing this agreement, the unit owner acknowledges and agrees to the following:

- All paperwork must be submitted by the unit owner not the contractor. Work limited between hours of 8:00 AM and 4:00 PM, Monday through Friday only. Any work which can produce unusual noises, which might be disturbing to building occupants, shall not be done before 9:00 AM. Any contractor found on the premises or any work performed after 5PM will first be warned, but could result in a fine of \$50.00 per half hour if not resolved.
- I agree to reimburse for any reasonable fees incurred.
- All contractors and deliveries must use the rear service entrance.
- All contractors must provide floor protection from the service entrance to the Unit Owners apartment.
- All contractors MUST use the padded elevator.
- No debris or any other materials may be stored or left at any time in the common areas of the building or grounds.

- Kaled Management/Westbury Terrace Condominium shall have the right to inspect my apartment on as many occasions as it may deem necessary prior to, during and upon completion of the alteration.
- It is the Unit Owner's responsibility to notify their neighbors (Owners on your floor, and the floors above and below) of any renovations before work proceeds. A notification form is enclosed as well and must be filled out by the owner and given to the Superintendent for distribution.

Unit Owner Signature/Date
Contractor Signature/Date

## **Westbury Terrace Condominium**

### **Requirements for General Contractors**

(General Contractor defined as any vendor doing work outside the limits of a Plumber or Electrician)

-	Nassau County General Contractor License
-	Mandatory copy of Contractor's EPA Certificate for Lead Paint Removal.
-	Certificate of Liability Insurance (Accord Form) with a minimum One Million (\$1,000,000) for general liability. Workers Compensation (Form U-26.3), Disability (Form DB120.1), and/or Kaled's requirement for Automobile Liability. (Sample of Accord and Insurance forms attached.)
	<ul> <li>Please follow certificate holder information, and information for additionally insured. In the additionally insured section please make sure to include your name, address, and unit number, along with Kaled Management Corp. and Westbury Terrace Condominiums.</li> </ul>
-	Signed and Dated Indemnification Agreement
-	If the application results in the requirement of a permit from the Incorporated Village of Westbury you will be directed to do so

Failure to submit all requirements will result in denial for this application.

## Westbury Terrace Condominium Requirements for Electricians

-	Town of North Hempstead Electrical License
-	Licensed by Incorporated Village of Westbury.
-	Certificate of Liability Insurance (Accord Form) with a minimum One Million (\$1,000,000 for general liability. Workers Compensation (Form U-26.3), Disability (Form DB120.1), and/or Kaled's requirement for Automobile Liability. (Sample of Accord and Insurance forms attached.)
	<ul> <li>Please follow certificate holder information, and information for additionally insured. In the additionally insured section please make sure to include your name, address, and unit number, along with Kaled Management Corp. and Westbury Terrace Condominiums.</li> </ul>
-	Signed and Dated Indemnification Agreement
-	If the application results in the requirement of a permit from the Incorporated Village of Westbury you will be directed to do so
	Failure to submit all requirements will result in denial for this application.

## Westbury Terrace Condominium Requirements for Plumbers

-	Town of North Hempstead Plumbing License
-	Licensed by Incorporated Village of Westbury.
-	Certificate of Liability Insurance (Accord Form) with a minimum One Million (\$1,000,000 for general liability. Workers Compensation (Form U-26.3), Disability (Form DB120.1), and/or Kaled's requirement for Automobile Liability. (Sample of Accord and Insurance forms attached.)
	<ul> <li>Please follow certificate holder information, and information for additionally insured. In the additionally insured section please make sure to include your name, address, and unit number, along with Kaled Management Corp. and Westbury Terrace Condominiums.</li> </ul>
-	Signed and Dated Indemnification Agreement
-	If the application results in the requirement of a permit from the Incorporated Village of Westbury you will be directed to do so
	Failure to submit all requirements will result in denial for this application.

# Insurance Samples For Contractors Electricians Plumbers



#### CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

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	CONTACT NAME:	
	PHONE FAX	_
	(A/C, No, Ext): (A/C, No):	
Name and Address of Producer	E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE NAIC #	
	INSURER A: Liability Insurance Carrier	
INSURED	INSURER B: Auto Insurance Carrier	
	INSURER C: Umbrella Carrier	
Contractor's Full Name and Address	INSURER D: Workers Comp Carrier	
	INSURER E:	
	INSURER F:	
COVERAGES OFFICIAL ATTAILMENT.	DEVICION NUMBER.	

COVERAGES	CERTIFICATE NUMBER:	REVISION NUMBER:
COVERAGES	CENTIFICATE NUMBER.	KEVISION 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.

NSR LTR	SR TYPE OF INSURANCE		SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMIT	S
Α	X COMMERCIAL GENERAL LIABILITY  CLAIMS-MADE X OCCUR  CONTRACTUAL LIABILITY	Y		Policy Number	01/01/2024	01/01/2025	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person)	\$ 1,000,000 \$ 100,000 \$ 5,000 \$ 1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER: POLICY X PRO- OTHER:	,	•	r olicy Number	01/01/2024	01/01/2020	PERSONAL & ADV INJURY  GENERAL AGGREGATE  PRODUCTS - COMP/OP AGG	\$ 1,000,000 \$ 2,000,000 \$ 2,000,000 \$
В	AUTOMOBILE LIABILITY  X ANY AUTO OWNED AUTOS ONLY HIRED AUTOS ONLY AUTOS ONLY AUTOS ONLY AUTOS ONLY	Y	Y	include for deliveries	01/01/2024	01/01/2025	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	\$ 500,000 \$ \$ \$ \$
С	Y   UMBRELLA LIAB   X   OCCUR	Y	Y	Policy Number	01/01/2024	01/01/2025	EACH OCCURRENCE AGGREGATE	\$ 4,000,000 \$ 4,000,000 \$
D	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory In NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A	Y	Policy Number	01/01/2024	01/01/2025	E.L. DISEASE - POLICY LIMIT	\$ 1,000,000 \$ 1,000,000 \$ 1,000,000

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

[Please Include: Kaled Management Corp. (7001 Brush Hollow Rd.), The Westbury Terrace Condiminium (135 Post Avenue), Tenant Name & Unit #] The contractor hereby agrees to indemnify and save harmless Westbury Terrace Condo, and Kaled Management Corp., their officers, directors, agents and employees, from and against all liability claims and demands on account of injury to persons including death resulting there from and damage to property arising out of the performance of this Contract by the Contractor, employees, & agents of the Contractor and Contractor's property, except from & against such claims, loss, damage or liabilities and demands that may arise out of the sole negligence of the Owner or its agents. The Contractor shall, as his or its own expense, defend any and all claims or suit brought against the Owner, or its officers, directors or agents, based thereon and shall pay all attorney fees and all other expense and promptly discharge any judgement arising there from. These conditions also shal apply to any of the Contractor's subcontracted operations.

CERTIFICATE HOLDER	CANCELLATION
Westbury Terrace Condo	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.
c/o Kaled Management Corp 7001 Brush Hollow Rd, Suite 200 Westbury, NY 11590	AUTHORIZED REPRESENTATIVE



## 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  10. Legal Name & Address of Insured (use street address only)  Work Location of Insured (Only Insurance (use street address only)  10. Federal Employer Identification Number of Insured or Social Security Number  11. Federal Employer Identification Number of Insured or Social Security Number  12. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)  13. Policy Number of Entity Listed in Box "1a"  13. Policy Insurance Carrier  14. Policy provides the following benefits:  15. Policy effective period  16. Policy Number of Entity Listed in Box "1a"  17. Policy effective period  18. Disability and paid family leave benefits.  19. Disability benefits only.  19. Policy covers:  10. Policy ocvers:  10. Policy ocvers:  10. Policy Insurance Carrier referenced above and that the named insured bas NYS Disability and/or Paid Family Leave Benefits insurance coverage as described above.  19. Determined the Symbol Disability and/or Paid Family Leave Benefits insurance coverage as described above.  19. Determined the Insurance Agent of that insurance coverage as described above.  19. Determined the Insurance Agent of that insurance coverage as described above.  19. Determined the Insurance Agent of that insurance coverage as described above.  19. Determined the Insurance Agent of that insurance coverage as described above.  20. Determined the Insurance Agent of that insurance coverage as described above.  20. Determined the Insurance Agent of that insurance coverage as described above.  20. Determined the Insurance Agent of that insurance coverage as described above.  20. Determined the Insurance Agent of that insurance coverage as described above.  20. Determined the Insurance Agent of that insurance coverage as described above.  20. Determined the Insurance Agent of that insurance coverage as described above.  20. Determined the Insurance Agent of that insu					
Work Location of Insured (Only required if coverage is specifically limited to certain focations in New York State, i.e., Wap-up Policy)  2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)  3a. Name of Insurance Carrier  3b. Policy Number of Entity Listed in Box "1a"  3c. Policy provides the following benefits:  A. Both disability and paid family leave benefits only.  C. Paid family leave benefits only.  S. 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 name insured has NYS Disability and/or Paid Family Leave Benefits insurance coverage as described above.  Date Signed  By  (Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier's authorized representative or NYS Licensed Insurance Agent 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 58 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.	PART 1. To be	completed by Disability an	d Paid Family Leave	Benefits Carrier or Licensed Insurance Agent of that Carrier	
or Social Security Number  2. Name and Address of Entity Requesting Proof of Coverage (Entity Beling Listed as the Certificate Holder)  3a. Name of Insurance Carrier  3b. Policy Number of Entity Listed in Box "1a"  3c. Policy provides the following benefits:  A. Both disability and paid family leave benefits.  B. Disability and paid family leave benefits only.  C. Paid family leave benefits only.  B. Disability and policy covers:  A. Both office only.  B. Only the following class or classes of employer's employees:  D. Policy covers:  B. Only the following class or classes of employer's employees:  D. All off the employer's employees eligible under the NYS Disability and Paid Family Leave Benefits 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 NYS Disability and/or Paid Family Leave Benefits insurance coverage as described above.  Date Signed  By  (Signature of insurance carrier's authorized representative or NYS licensed insurance Agent of that insurance carrier's many and Title  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 (only if Box 4C or 5B of Part 1 has been checked)  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 (only if Box 4C or 5B of Part 1 has been checked)	1a. Legal Name	& Address of Insured (use street a	address only)	1b. Business Telephone Number of Insured	
(Entity Being Listed as the Certificate Holder)  3b. Policy Number of Entity Listed in Box "1a"  3c. Policy effective period  to  4. Policy provides the following benefits:    A. Both disability and paid family leave benefits.   B. Disability benefits only.   C. Paid tamily leave benefits only.   S. 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 By   Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)  Telephone Number   Name and Title  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.			specifically limited to	Federal Employer Identification Number of Insured or Social Security Number	
4. Policy provides the following benefits:  A. Both disability and paid family leave benefits.  B. Disability benefits only.  C. Paid family leave benefits only.  P. Policy covers:  A. All of the employer's employees eligible under the NYS Disability and Paid Family Leave Benefits Law.  D. Policy covers:  A. All of the employer's employees eligible under the NYS Disability and Paid Family Leave Benefits 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 NYS Disability and/or Paid Family Leave Benefits insurance coverage as described above.  Date Signed  By  Gignature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)  Telephone Number  Name and Title  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.			f Coverage	3a. Name of Insurance Carrier	
4. Policy provides the following benefits:    A. Both disability and paid family leave benefits.   B. Disability and paid family leave benefits.   B. Disability and paid family leave benefits only.   C. Paid family leave benefits only.   S. 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				3b. Policy Number of Entity Listed in Box "1a"	
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  By  (Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)  Telephone Number  Name and Title  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.					
A. Both disability and paid family leave benefits.  B. Disability 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  By  (Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier')  Telephone Number  Name and Title  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.					
Telephone Number	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				
Telephone Number	Date Signed		Rv		
Telephone Number	Date eighed		(Signature of insurance	carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)	
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 Numb	er			
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)	IMPORTANT:	IMPORTANT: If Boxes 4A and 5A are checked, and this form is signed by the insurance carrier's authorized representative or NYS			
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 SignedBy	Disability and Paid Family Leave Benefits Law. It must be mailed for completion to the Workers' Compensation				
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	PART 2. To be completed by the NYS Workers' Compensation Board (Only if Box 4C or 5B of Part 1 has been checked)				
(Signature of Authorized NYS Workers' Compensation Board Employee)	Workers' Compensation Board According to information maintained by the NYS Workers' Compensation Board, the above-named employer has complied with the				
	Date Signed	E		Signature of Authorized NYS Workers' Compensation Board Employee)	
	Telephone Numb	er		,,	

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.



#### Form U-26.3



199 CHURCH STREET, NEW YORK, N.Y. 10007-1100 Phone: (212) 312-9000

## CERTIFICATE OF WORKERS' COMPENSATION INSURANCE

^^^^^ 146013200 STATE INSURANCE FUND PRODUCTION CONTROL POLICY #1 199 CHURCH ST USWS-7TH FLOOR **NEW YORK** NY 10007

POLICYHOLDER

STATE INSURANCE FUND PRODUCTION CONTROL POLICY #1 199 CHURCH ST USWS-7TH FLOOR **NEW YORK** 

NY 10007

CERTIFICATE HOLDER SAMPLE CERTIFICATE 123 NEW YORK ROAD K NY 10001

**POLICY NUMBER** L 1265 328-3

CERTIFICATE NUMBER 929707

DATE 6/17/2010

THIS IS TO CERTIFY THAT THE POLICYHOLDER NAME ABOVE TO THE NEW YORK STATE INSURANCE FUND UNDER POLICY NO. 1265 328-3 UNTIL 12/26/200 OVERING ENTIRE OBLIGATION OF THIS POLICYHOLDER FOR WORKERS' COMPENSATION UNDER THE NEW WORKER COMPENSATION LAW WITH RESPECT TO ALL OPERATIONS IN THE STATE OF NEW YORK, EXCEPT

PRIOR TO 12 6/200 SUCH MANNER AS TO AFFECT THIS CERTIFICATE, LATION WILL FAIVEN TO THE CERTIFICATE HOLDER ABOVE.

STATE SUFFICIENT COMPLIANCE WITH THIS PROVISION. THE NEW SOME A BILLITY IN THE EVENT OF FAILURE TO GIVE SUCH NOTICE. IF SAID POLICY IS CANCELLED, OR CHANG 10 DAYS WRITTEN NOTICE OF SUCH NOTICE BY REGULAR MAIL SO ADDRESSE YORK STATE INSURANCE FUND DOES NOT AS

THIS CERTIFICATE DOES NO PAPPLY TO THOS JOB SITES WHICH ARE COVERED BY OTHER INSURANCE AND ARE SPECIFICALLY EXCLUDED BY EN WENT.

THIS POLICY DOES NOT COVER T TOR, PARTNERS AND/OR MEMBERS OF A LIMITED LIMITED COMPANY:

MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS NOR INSURANCE THIS CERTIFIC SSUED AS COVERAGE THE CERTIFIC HOLDER THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERA

> NEW YORK STATE INSURANCE FUND ohn Manetti

DIRECTOR, INSURANCE FUND UNDERWRITING

This certificate can be validated on our web site at https://www.nysif.com/cert/certval.asp or by calling (888) 875-5790 VALIDATION NUMBER: 591780737

U-26.3



CORPORATE OFFICE 7001 BRUSH HOLLOW ROAD SUITE 200 WESTBURY, NY 11590 TEL: (516) 876-4800 FAX: (516) 876-6812

EMAIL: INFO@KALED.COM

Whereas	("Contractor/Elec	trician/Plumber") is and will
be performing certain work for _	The Westbury Terrace Condominium	("Owner") pursuant to
oral and/or written agreement and	d/or Purchase Orders. As to all such work,	Owner and Contractor agree
as follows:		_

#### INDEMNIFICATION AGREEMENT

To the fullest extent permitted by law, Contractor agrees to indemnify, defend and hold harmless Property Owner, The Westbury Terrace Condominium and their Property Manager, Kaled Management Corp., its employees, owners and directors, building owner, Board of Managers, and Owners from any and all claims, suits, damages, liabilities, professional fees, including attorney's fees, costs, court costs, expenses and disbursements related to death, personal injuries or property damage (including loss of use thereof) arising out of or in connection with the performance of the work of the Contractor, its agents, servants, subcontractors or employees, of the work premises. This agreement to indemnify specifically contemplates full indemnity in the event of liability imposed against the Property Owner without negligence and solely by reason of statute, operation of law or otherwise and partial indemnity in the event of any actual negligence on the part of Property Owner causing or contributing to the underlying claim. In that event, indemnification will be limited to any liability imposed over and above that percentage attributable to actual fault, whether by statute, by operation of law or otherwise.

#### INSURANCE PROCUREMENT

Contractor shall obtain and maintain at all times during the term of this agreement, at its sole cost and expense, the following insurance (a) worker's compensation insurance with statutory limits and employer's liability coverage of not less than \$500,000.00; (b) commercial general liability insurance with a minimum limit of \$1,000,000.00 per occurrence and \$2,000,000.00 in the aggregate, which insurance shall cover the following: premises and operations liability, products/completed operations. broad form property damage, broad form contractual liability, personal injury and independent contractor's liability; (c) automobile liability insurance covering owned, hired and non-owned vehicles, with a minimum limit of liability of \$1,000,000.00. Contractor shall, by specific endorsements to its primary and umbrella/excess liability policy, cause the Property Owner, property manager and building/property owner to be named as the additional insured. Contractor shall, by specific endorsements to its primary liability policy, cause the coverage afforded to the additional insured thereunder to be primary to and not concurrent with other valid and collectible insurance available to the Property Owner. Contractor shall, by specific endorsement to its umbrella/excess liability policy, cause the coverage afforded to the Property Owner, property manager, building/property owner thereunder to be first tier umbrella/excess coverage above the primary coverage afforded to the Property Owner, property manager, building/property owner and not concurrent with or excess to other valid and collectible insurance available to the Property Owner, property manager, building/property owner.

Dated:	
Owner	Contractor/Electrician/Plumber
By:	By:

## Westbury Terrace Condominium Renovation Notification

Hello neighbors,

My name is	and there will be
renovations occurring in U	nit Renovations
will begin on, a	nd if you have any
questions or concerns you	can reach out to Kaled
Management Corp, at 516-876-4800.	

Thank you for your understanding.