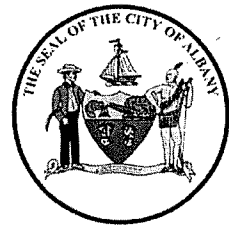


10/27/20 * Hold for: PICS
 Plot Plan
 Pymt
 Swo Resolution



CITY OF ALBANY
 DEPARTMENT OF BUILDINGS & REGULATORY COMPLIANCE
 200 Henry Johnson Boulevard
 Albany, NY 12210
 Phone (518) 434-5995
 codes@albanyny.gov

GENERAL BUILDING PERMIT APPLICATION

A building permit is needed before any general construction, repair, rehab, gutting, or other work may be done. Project-specific building permit applications may be available. Additional permits are required for specialized work such as electric or plumbing work which requires a license. Please refer to our website or ask our staff if you have any questions about what permits your project requires.

JOB SITE ADDRESS: 82 Euclid Ave ZIP: 12208 1
PROPERTY ACCT #: _____ **ZONE:** R-12 **OVERLAYS:** —
THIS INFORMATION IS AVAILABLE AT [HTTPS://ALBANYNY.MAPGEO.IO](https://albanyny.mapgeo.io)

APPLICANT: J.R.N. Construction, LLC 2
ADDRESS: 531 Third St Albany NY 12206 ZIP: 12206
EMAIL: JRNcompanies@outlook.com **PHONE:** (518) 858-0784

HOW WOULD YOU LIKE TO RECEIVE YOUR PERMIT? (PLEASE CHOOSE ONE): PICK-UP MAIL OR EMAIL 3
THE APPLICANT WILL BE NOTIFIED BY EMAIL ONLY WHEN THE PERMIT IS READY FOR PICK-UP. WHERE "PICK-UP" IS SELECTED, PERMITS THAT ARE NOT PICKED UP AT OUR OFFICE WITHIN 6 MONTHS OF ISSUANCE WILL BE MARKED "VOID". IF YOU WOULD LIKE TO RECEIVE YOU PERMIT BY MAIL, PLEASE INCLUDE A STAMPED, SELF-ADDRESSED ENVELOPE WITH THIS APPLICATION.

OWNER (IF DIFFERENT): Jeff Zimring 4
ADDRESS: 82 Euclid Ave Albany NY 12208 ZIP: 12208
EMAIL: Jeff@Zimringlaw.com **PHONE:** (518) 396-9800

PROPOSED PROJECT: (PLEASE PROVIDE A DETAILED DESCRIPTION OF THE WORK TO BE DONE): 5
Add A Basement Door to Left Front corner of Home
Need to Excavate front lawn from sidewalk to Home Foundation,
build a Retaining wall and pour a walkway from city sidewalk to New basement
door, cut hole in foundation for new door

DETAILED SITE PLANS OR OTHER DOCUMENTS DETAILING THE PROJECT ARE ATTACHED (RECOMMENDED): YES NO 6

CURRENT USE OF THE PROPERTY: Residence 7

CHANGE OF USE: DOES THIS PROJECT INVOLVE A CHANGE OF USE OR TENANCY AT THE PROPERTY? YES NO 8
IF "YES", PLEASE COMPLETE OUR "CHANGE OF USE OR TENANT" APPLICATION (BRC FORM 033) AND ATTACH IT TO THIS PERMIT APPLICATION.

DEVELOPMENT PERMIT: IS THIS PROJECT THE SUBJECT OF A PLANNING DEP'T ISSUED DEVELOPMENT PERMIT. YES NO 9

TOTAL COST OF WORK: \$12,000.00 10 **PERMIT FEE:** \$ 156.00 11
INCLUDING LABOR & MATERIALS. BRC STAFF RESERVE THE RIGHT TO CONDITION CLOSURE OF A PERMIT, INCLUDING ISSUANCE OF A CERT. OF OCCUPANCY ON PROOF OF TOTAL WORK COST. FEES DEPEND ON THE PROJECT TYPE. SEE OUR WEBSITE FOR OUR FEE SCHEDULE OR CALL OUR OFFICE AT (518) 434-5995 TO SPEAK WITH OUR STAFF ABOUT FEE CALCULATION.

- APPLICATIONS MUST BE ACCOMPANIED BY PROOF OF WORKER'S COMP INSURANCE OR A FORM BP-1 "AFFIDAVIT OF EXEMPTION" AND FOR PROJECTS WHERE THE TOTAL COST OF WORK IS MORE THAN \$10,000 PROOF OF LIABILITY INSURANCE NAMING THE CITY OF ALBANY AS ADDITIONALLY INSURED.
- WORK THAT WILL OBSTRUCT A PUBLIC RIGHT OF WAY WILL REQUIRE A SIDEWALK & BARRICADE PERMIT.
- AN ADDITIONAL INSPECTION FEE OF \$100 MAY BE CHARGED WHERE PREVIOUSLY CITED CORRECTIONS HAVE NOT BEEN MADE, NO ONE IS AVAILABLE TO MEET OUR INSPECTOR OR THE WORK IS NOT READY FOR INSPECTION AT A SCHEDULED INSPECTION, AND WHERE THE INSPECTION IS REQUESTED TO ISSUE A TCO.
- NEW STRUCTURES AND SUBSTANTIAL ADDITIONS OR ALTERATIONS, INCLUDING TWO-STORY DECKS AND ALTERATIONS TO OR REMOVAL OF LOAD-BEARING BUILDING COMPONENTS, MUST BE ACCOMPANIED BY PLANS STAMPED BY A LICENSED ENGINEER OR ARCHITECT.

PERMIT No.: 21817 **DATE REC'D:** 10/27/20 **REC'D BY:** LFM **S&B PENDING** **SCANNED & SAVED**

JOB SITE ADDRESS: _____

12

ADDITIONAL CONTRACTOR/CONTACT INFORMATION (WHERE APPLICABLE)

CONTRACTOR: _____

TYPE: ELECTRIC PLUMBING HVAC ELEVATOR SPRINKLER OTHER COST: \$ _____

ADDRESS _____ ZIP: _____

EMAIL: _____ PHONE: (____) _____

CONTRACTOR: _____

TYPE: ELECTRIC PLUMBING HVAC ELEVATOR SPRINKLER OTHER COST: \$ _____

ADDRESS _____ ZIP: _____

EMAIL: _____ PHONE: (____) _____

CONTRACTOR: _____

TYPE: ELECTRIC PLUMBING HVAC ELEVATOR SPRINKLER OTHER COST: \$ _____

ADDRESS _____ ZIP: _____

EMAIL: _____ PHONE: (____) _____

CONTRACTOR: _____

TYPE: ELECTRIC PLUMBING HVAC ELEVATOR SPRINKLER OTHER COST: \$ _____

ADDRESS _____ ZIP: _____

EMAIL: _____ PHONE: (____) _____

Certification: I hereby certify that I have examined this application and know the information contained therein to be correct. I understand that the granting of a permit does not grant authority to violate or ignore any law, that this permit authorizes only the work described herein and will expire, unless otherwise noted, in one year from the date of issuance.

Applicant Signature: *[Handwritten Signature]*

Date: 10-14-20

APPLICATION VALIDATION (STAFF USE ONLY)

APPLICATION ACCEPTED (ALL REQUIRED INSURANCE, WORKER'S COMPENSATION, AND PLANS HAVE BEEN SUBMITTED).

APPLICATION REJECTED. WE ARE UNABLE TO ACCEPT YOUR APPLICATION BECAUSE IT IS MISSING THE FOLLOWING:

- INSURANCE INFORMATION
- WORKER'S COMP INFORMATION
- DETAILED PLANS
- PLANS STAMPED BY A LICENSED ARCHITECT OR ENGINEER
- APPLICATION ILLEGIBLE

ADDITIONAL INFORMATION: _____

APPLICATION PROCESSING (STAFF USE ONLY)

OTHER PERMITS/APPROVALS PENDING: PLUMBING ELECTRIC SITE PLAN HVAC

OTHER: _____

ASSIGNED TO: _____ DATE ASSIGNED: _____

APPROVED BY (SUBJECT TO CONDITIONS): _____ DATE: _____



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
10/15/2020

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 Eastern Shore Associates An ISU Network Member P.O. Box 408, 3720 Main Street Walworth NY 14568	CONTACT NAME: Chelsea Rosato PHONE (A/C, No, Ext): (315) 986-7017 FAX (A/C, No): (315) 986-1783 E-MAIL ADDRESS: crosato@esainsurance.com																				
	<table border="1"> <tr> <th colspan="2">INSURER(S) AFFORDING COVERAGE</th> <th>NAIC #</th> </tr> <tr> <td>INSURER A:</td> <td>Main Street America Assurance</td> <td>29939</td> </tr> <tr> <td>INSURER B:</td> <td>NGM Insurance Company</td> <td>14788</td> </tr> <tr> <td>INSURER C:</td> <td></td> <td></td> </tr> <tr> <td>INSURER D:</td> <td></td> <td></td> </tr> <tr> <td>INSURER E:</td> <td></td> <td></td> </tr> <tr> <td>INSURER F:</td> <td></td> <td></td> </tr> </table>	INSURER(S) AFFORDING COVERAGE		NAIC #	INSURER A:	Main Street America Assurance	29939	INSURER B:	NGM Insurance Company	14788	INSURER C:			INSURER D:			INSURER E:			INSURER F:	
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INSURER F:																					
INSURED J.R.N. Construction LLC 531 Third St Albany NY 12206																					

COVERAGES **CERTIFICATE NUMBER:** 20-21 Master **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 <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR BP0451 0106, BPM3142 0215 <input checked="" type="checkbox"/> BP0497 0106 GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PRO-JECT <input checked="" type="checkbox"/> LOC OTHER:			MPZ7158C	04/29/2020	04/29/2021	EACH OCCURRENCE	\$ 500,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	\$ 50,000
							MED EXP (Any one person)	\$ 10,000
							PERSONAL & ADV INJURY	\$ 500,000
A	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY <input checked="" type="checkbox"/> 642910518			B1Z7160C	04/29/2020	04/29/2021	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 <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> DED <input checked="" type="checkbox"/> RETENTION \$ 10,000			CUZ7166C	04/29/2020	04/29/2021	EACH OCCURRENCE	\$ 1,000,000
							AGGREGATE	\$ 1,000,000
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below						PER STATUTE	
							OTH-ER	
							E.L. EACH ACCIDENT	\$
							E.L. DISEASE - EA EMPLOYEE	\$
A	Leased/Rented Equipment			MPZ7158C	04/29/2020	04/29/2021	Special Form	100,000
							Max 30 Days	250 Ded

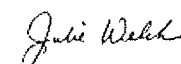
DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

City Of Albany Dept Of Buildings & Regulatory Compliance
 200 Henry Johnson Blvd
 Albany NY 12210

CANCELLATION

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


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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

<p>1a. Legal Name & Address of Insured (use street address only) JRN CONSTRUCTION LLC</p> <p>531 THIRD STREET ALBANY, NY 12206</p> <p>Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e., Wrap-Up Policy)</p>	<p>1b. Business Telephone Number of Insured 518-858-0787</p> <p>1c. Federal Employer Identification Number of Insured or Social Security Number 825206125</p>
<p>2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) City Of Albany Dept Of Buildings & Regulatory Compliance 200 Henry Johnson Blvd Albany, NY 12210</p>	<p>3a. Name of Insurance Carrier ShelterPoint Life Insurance Company</p> <p>3b. Policy Number of Entity Listed in Box "1a" DBL615169</p> <p>3c. Policy effective period 04/24/2020 to 04/23/2021</p>

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 10/14/2020 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.

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)

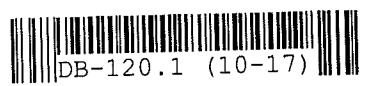
**State of New York
Workers' Compensation Board**

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.



CERTIFICATE OF WORKERS' COMPENSATION INSURANCE



SCAN TO VALIDATE
AND SUBSCRIBE

***** 825206125
EASTERN SHORE ASSOCIATES
PO BOX 408
3720 MAIN ST
WALWORTH NY 14568

POLICYHOLDER J.R.N. CONSTRUCTION LLC 531 THIRD ST ALBANY NY 12206		CERTIFICATE HOLDER CITY OF ALBANY,DEPT OF BLDGS®ULATORY COMPLIANCE 200 HENRY JOHNSON BLVD ALBANY NY 12210	
POLICY NUMBER A2512 032-0	CERTIFICATE NUMBER 675164	POLICY PERIOD 04/24/2020 TO 04/24/2021	DATE 10/14/2020

THIS IS TO CERTIFY THAT THE POLICYHOLDER NAMED ABOVE IS INSURED WITH THE NEW YORK STATE INSURANCE FUND UNDER POLICY NO. 2512 032-0, COVERING THE ENTIRE OBLIGATION OF THIS POLICYHOLDER FOR WORKERS' COMPENSATION UNDER THE NEW YORK WORKERS' COMPENSATION LAW WITH RESPECT TO ALL OPERATIONS IN THE STATE OF NEW YORK, EXCEPT AS INDICATED BELOW, AND, WITH RESPECT TO OPERATIONS OUTSIDE OF NEW YORK, TO THE POLICYHOLDER'S REGULAR NEW YORK STATE EMPLOYEES ONLY.

IF YOU WISH TO RECEIVE NOTIFICATIONS REGARDING SAID POLICY, INCLUDING ANY NOTIFICATION OF CANCELLATIONS, OR TO VALIDATE THIS CERTIFICATE, VISIT OUR WEBSITE AT [HTTPS://WWW.NYSIF.COM/CERT/CERTVAL.ASP](https://www.nysif.com/cert/certval.asp). THE NEW YORK STATE INSURANCE FUND IS NOT LIABLE IN THE EVENT OF FAILURE TO GIVE SUCH NOTIFICATIONS.

THIS POLICY DOES NOT COVER THE SOLE PROPRIETOR, PARTNERS AND/OR MEMBERS OF A LIMITED LIABILITY COMPANY.

THE POLICY INCLUDES A WAIVER OF SUBROGATION ENDORSEMENT UNDER WHICH NYSIF AGREES TO WAIVE ITS RIGHT OF SUBROGATION TO BRING AN ACTION AGAINST THE CERTIFICATE HOLDER TO RECOVER AMOUNTS WE PAID IN WORKERS' COMPENSATION AND/OR MEDICAL BENEFITS TO OR ON BEHALF OF AN EMPLOYEE OF OUR INSURED IN THE EVENT THAT, PRIOR TO THE DATE OF THE ACCIDENT, THE CERTIFICATE HOLDER HAS ENTERED INTO A WRITTEN CONTRACT WITH OUR INSURED THAT REQUIRES THAT SUCH RIGHT OF SUBROGATION BE WAIVED.

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS NOR INSURANCE COVERAGE UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICY.

NEW YORK STATE INSURANCE FUND

DIRECTOR, INSURANCE FUND UNDERWRITING