AFFIDAVIT THAT WORKER'S COMPENSATION AND DISABILITY BENEFITS COVERAGE ARE NOT REQUIRED

STATE OF NEW YORK)

COUNTY OF _____) SS:

_____, being duly sworn, deposes and says:

(Applicant's Name)

1. I reside at _____

(CHECK BOX OPPOSITE EITHER 2 0R 3 AND COMPLETE THAT PARAGRAPH)

☐ 2. I have engaged _____ with offices at

(Name of contractor)

_____ to construct a _____

(Address) (Type of building addition or other work)

at _____ which activity requires the issuance of a

(Site address)

building permit pursuant to the New York State Uniform Fire Prevention and Building Code. Said contractor has advised me that no Worker's Compensation Insurance of Disability benefits Insurance is required because he/she is an individual owner or partner with no employees and is not a corporation.

OR

☐ 3. I have not engaged an employer or any employees as those terms are defined in Section 2 of the Worker's Compensation Law to perform the work relating to the requested Building Permit as,

a. I will be doing the work personally without employing any employees, or

b. The work will be performed for me by _____ who will not receive any compensation from me for performing this work.

4. I make this Affidavit knowing that it will be relied upon by the Building Inspector in insuring compliance with Section 125 of the General Municipal Law of the State of New York. I understand that making a false statement under oath is perjury for which I may be prosecuted.

_____

(Applicant's signature)

Sworn to before me this

_____ day of _____, _____

_____

(Notary Public) My commission expires: _____ (Date)

STATE OF NEW YORK

WORKERS' COMPENSATION BOARD

STATEMENT FOR A GOVERNMENT ENTITY THAT A BUSINESS DOES NOT REQUIRE WORKERS' COMPENSATION AND/OR DISABILITY BENEFITS COVERAGE

Applicant's Name	Business or Trade Name, If Different
Applicant's Home Address	Business Address (Physical Location), If Different
Home Telephone Number	Business Telephone Number, If Different
Type of Business	Federal Employer Identification Number

Under penalty of perjury, I certify that the above business does not require ☐Workers Compensation ☐Disability Benefits Coverage Because:

A. Check one:

- ☐ The business is owned by one individual with no employees and is not a corporation.
- ☐ The business is a partnership under the laws of New York State, and there are no employees.
- ☐ The business is a one or two person owned corporation, with those individuals owning all of the stock and holding all offices of the corporation, and there are no employees.
- ☐ The business does not require disability benefits coverage at this time since it has not employed one or more individuals on each of at least 30 days in any calendar year.
- ☐ (Please specify other reason)

AND

B. I hereby agree not to engage an employer or any employees, as those terms are defined in Section Two of the Workers' Compensation Law, to perform work relating to the permit being sought by this certification.

I also agree to acquire appropriate worker's compensation and disability benefits coverage for the above business, if circumstances change so that such coverage is required.

Date Signed:_____

By:_____ (Signature of Business Owner, Partner or Corporate Officer)

Title:_____

Requested Effective Dates: From _____ to _____ (One Year Maximum)

(Business Owners: Please Send Completed Application to nearest WCB Enforcement Unit.)

ANY FALSE STATEMENT, REPRESENTATION, OR CONCEALMENT WILL SUBJECT YOU TO FELONY FRIMINAL PROSECUTION, INCLUDING JAIL AND CIVIL LIABILITY IN ACCORDANCE WITH THE WORKERS' COMPENSATION LAW

In conformance with Sections 57 and 220 Subd. 8 of the Workers' Compensation Law, based on the foregoing certification made by the above business, the Workers' Compensation board has no objections, at this time, to the issuance of requested permits or contracts.

Date Signed:_____

By:_____ (Signature of WCB Employee)

Telephone Number:_____

Title:_____

Please Note: This Statement is valid only from _____ to _____ (one year maximum). At the expiration of this term, if the business continues to be named on a permit or contract issued by a government entity, the business must provide that government entity with a new Statement. The business must provide a Certificate of Workers' Compensation and Disability benefits coverage to the government entity if circumstances change so that such coverage is required during this period. Further, it is understood that the board reserves the right to request revocation of the permit or contract if, after incestigation, it is found that the above business is required to have workers' comensation and/or disability benefits coverage.

****This form cannot be used to waive the workers compensation rights or obligations of a subcontractor****