

**OGS Contract No.**  
**OGS Project Number:**  
**Work Order Number:**

**Date: September 21, 2020**

## **DECOMMISSIONING AND DEMOLITION OF COMPRESSED NATURAL GAS (CNG) STATION**

22422 State Route 342  
Watertown, NY 13601

**Directions:** Interstate 81N to exit 48. Take a left off the ramp. Facility is a mile down the road. Driveway is on the left.



### **SCOPE OF WORK**

Remove and dispose of High Pressure Natural Gas storage cylinder assembly, all associated piping including the priority valve assembly. Remove and dispose of the CNG Dispenser. Remove and dispose of the CNG Compressor/housing assembly, its associated piping and electrical. Remove and dispose of the Filter/Dryer equipment and all associated piping. Remove any protruding anchor bolt hazards on the concrete pad once equipment is removed.

Note: Not included in sale are the concrete pads and bollards.



## **CNG Equipment Removal**

### **I. Equipment Information**

- (1) ANGI Compressor station
- (6) CNG Storage Tanks.
- (1) CNG Dispenser, serial # 2041
- (1) CNG Dryer Assembly
- (1) Priority Valve and Miscellaneous Piping
- (2) Fuel Makers, Serial # 1A040601 & Serial # 1G042102R

Note: The card reader is not included in the sale. The Estimated weight of the tank assembly is 30,000 lbs. The system has had the gas service removed. The Natural gas meter and piping have all been removed by the utility company. The system may have residual amounts of natural gas and proper precautions should be taken to ensure safety during the removal.

II. Location: 22422 State Route 342, Watertown NY 13601

**Directions:** Interstate 81N to exit 48. Take a left off the ramp. Facility is a mile down the road. Driveway is on the left.

### **III. Current Condition**

- a. Was operable when last used but it is sold in as-is condition
- b. Gas Utility supply line is disconnected and capped.
- c. Electricity is disconnected some conduit and wiring remains.
- d. Residual gas may remain in cylinders and system
- e. Bolted to concrete slab

#### IV. Scope of Work

- a. Furnish your own electricity
- b. Furnish your own crane and truck
- c. Verify electric is off, lock-out/tag-out disconnects prior to work
- d. Cut off electrical and data conduits as necessary
- e. Leave concrete pads and bollards in place.
- f. Bleed residual gas off as necessary. Advise the local fire department that a controlled release of natural gas will occur.
- g. Remove CNG Equipment from the premises.
- h. Remove debris and waste material and dispose of in accordance with applicable Federal, State, and local environmental regulations.

#### V. Permitting, Fees & Insurance Requirements

- a. Form ACORD 25, Certificate of Liability Insurance
- b. Form C-105.2, Certificate of NYS Workers Compensation Insurance Coverage
- c. Form DB-120.1, Certificate of Insurance Coverage under the NYS Disability Benefits Law.
- d. Furnish proof of coverage for general liability, automobile Insurance and workers compensation insurance.

Note: Samples of all insurance documents are attached. The insurance documents are usually obtained from your insurance company. The insurance limits table is attached. Typically, we expect bidders on this equipment will fall into the "Business" category.

#### VI. Exhibits

- a. Form ACORD 25, Certificate of Liability Insurance
- b. Form C-105.2, Certificate of NYS Workers Compensation Insurance Coverage
- c. Form DB-120.1, Certificate of Insurance Coverage under the NYS Disability Benefits Law.

# ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

PRODUCER

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 POLICIES BELOW.

INSURED

INSURERS AFFORDING COVERAGE

NAIC #

INSURER A:

INSURER B:

INSURER C:

INSURER D:

INSURER E:

## COVERAGES

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. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR ADD'L LTR	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS
	GENERAL LIABILITY				EACH OCCURRENCE \$
	COMMERCIAL GENERAL LIABILITY				DAMAGE TO RENTED PREMISES (Ea occurrence) \$
	<input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> OCCUR				MED EXP (Any one person) \$
					PERSONAL & ADV INJURY \$
	GEN'L AGGREGATE LIMIT APPLIES PER:				GENERAL AGGREGATE \$
	<input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC				PRODUCTS - COMP/OP AGG \$
	AUTOMOBILE LIABILITY				COMBINED SINGLE LIMIT (Ea accident) \$
	ANY AUTO				BODILY INJURY (Per person) \$
	ALL OWNED AUTOS				BODILY INJURY (Per accident) \$
	SCHEDULED AUTOS				PROPERTY DAMAGE (Per accident) \$
	HIRED AUTOS				
	NON-OWNED AUTOS				
	GARAGE LIABILITY				AUTO ONLY - EA ACCIDENT \$
	ANY AUTO				OTHER THAN EA ACC \$
					AUTO ONLY: AGG \$
	EXCESS/UMBRELLA LIABILITY				EACH OCCURRENCE \$
	<input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE				AGGREGATE \$
					\$
	DEDUCTIBLE				\$
	RETENTION \$				\$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY				WC STATU-TORY LIMITS <input type="checkbox"/> OTH-ER <input type="checkbox"/>
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED?				E.L. EACH ACCIDENT \$
	If yes, describe under SPECIAL PROVISIONS below				E.L. DISEASE - EA EMPLOYEE \$
	OTHER				E.L. DISEASE - POLICY LIMIT \$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS / DEDUCTIBLES / SPECIAL PROVISIONS

## CERTIFICATE HOLDER

## CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL \_\_\_\_\_ DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE

This is a double-sided form, to be printed head to head

STATE OF NEW YORK  
WORKERS' COMPENSATION BOARD

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

<b>1a. Legal Name and address of Insured (Use street address only)</b>     <i>Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e. a Wrap-Up Policy)</i>	<b>1b. Business Telephone Number of Insured</b>  <b>1c. NYS Unemployment Insurance Employer Registration Number of Insured</b>  <b>1d. Federal Employer Identification Number of Insured or Social Security Number</b>  
<b>2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)</b>          	<b>3a. Name of Insurance Carrier</b>  <b>3b. Policy Number of entity listed in box "1a":</b>  <b>3c. Policy effective period:</b> _____ to _____ <b>3d. The Proprietor, Partners or Executive Officers are:</b> <input type="checkbox"/> included. (Only check box if all partners/officers included) <input type="checkbox"/> all excluded or certain partners/officers excluded. <b>3e. Demolition is: (Definition of Demolition on Reverse)</b> <input type="checkbox"/> included. <input type="checkbox"/> 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 will also notify the above certificate holder 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 a maximum of one year after this form is approved by the insurance carrier or its licensed agent.*

**Please Note:** Upon the 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: \_\_\_\_\_  
(Print name of authorized representative or licensed agent of insurance carrier)

Approved by: \_\_\_\_\_  
(Signature) (Date)

Title: \_\_\_\_\_

Telephone Number of authorized representative or licensed agent of insurance carrier: \_\_\_\_\_

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



## Workers' Compensation Law

### Section 57. Restriction on issue of permits and the entering into contracts unless compensation is secured.

1. 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 a hazardous employment defined by this chapter, and notwithstanding 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 compensation for all employees has been secured as provided by this chapter. 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 compensation to any such employee if so employed.
2. 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 a hazardous employment defined by this chapter, 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 compensation for all employees has been secured as provided by this chapter.

### Definition of Demolition (Box "3e," on the reverse side of this form)

A building wrecking or demolition is one where a building, chimney or steeple is razed, or where a floor, exterior wall or roof is removed. If the contract involves only the removal of interior walls, partitions or the facing only of any exterior wall, it is not considered demolition.

### Out-of-State Companies Working in NYS – NYS Workers' Compensation and Disability Benefits Requirements for Permits, Licenses or Contracts issued by NYS Government Entities

Generally, employers must have a workers' compensation policy or a combination of policies that cover each state in which they employ permanent employees to cover on-the-job accidents and disabilities. As you are probably aware, certain insurance carriers write policies that cover multiple states. "Riders" found under sections 3A and 3C on the Information Page of the policy specify the states of coverage. In addition, the operations covered in each state are identified in attachments to the policy.

In addition to any other state's workers' compensation coverages, an out-of-state employer needs to be specifically covered for NYS workers' compensation insurance when there are "sufficient contacts" between that employer and the state. While there is no single determinative factor, any of the following criteria could be the basis for finding "sufficient contacts" requiring New York coverage:

- a physician location within New York State;
- \$50,000 in payroll during a calendar year in New York State;
- one or more employees (including subcontractors) with a primary work location or hired within New York State; or
- employees (including subcontractors) working in New York State for more than 90 days during a calendar year.

If an out-of-state employer meets **any** of the above criteria, it is required to carry a New York State workers' compensation policy. When New York is listed in **Item 3A** on the Information Page of an employer's workers' compensation insurance policy, the employer is fully covered under the NYS Workers' Compensation Law. If insured through a private insurance carrier, the out-of-state employer must file a C-105.2 – Certificate of Workers' Compensation Insurance (the business' insurance carrier will send this form to the government entity upon request) **PLEASE NOTE:** The New York State Insurance Fund provides its own version of this form, the U-26.3. If the out-of-state employer is legally, fully self-insured in New York State, the out-of-state employer must file a SI-12 – Certificate of Workers' Compensation Self-Insurance (the business calls the Board's Self-Insurance Office at 518-402-0247). If the out-of-state employer is participating in group self-insurance, the out-of-state employer must file a GSI-105.2 – Certificate of Participation in Worker's Compensation Group Self-Insurance (the business' Group Self-Insurance Administrator will send this form to the government entity upon request).

If an out-of-state employer **does not** meet **any** of the above criteria and has New York (NY) listed in **Item 3C** on the Information Page of its workers' compensation insurance policy (the Other States Insurance section), NYS specific coverage is not required and the employer may be able to use its own state's workers' compensation coverage by filing a WC/DB-101 form. [The out-of-state employer's employees will be covered under NY benefits when working in New York by having NY listed in **Item 3C** on the Information Page of the workers' compensation insurance policy (the Other States Insurance section).]

STATE OF NEW YORK  
WORKERS' COMPENSATION BOARD

**CERTIFICATE OF INSURANCE COVERAGE UNDER THE NYS DISABILITY BENEFITS LAW**

**PART 1. To be completed by Disability Benefits Carrier or Licensed Insurance Agent of that Carrier**

1a. Legal Name and Address of Insured (Use street address only) \_\_\_\_\_  
1b. Business Telephone Number of Insured \_\_\_\_\_  
NYS Employer Insurance Employer Registration  
Number of Insured \_\_\_\_\_

1d. Actual Employer Identification Number of Insured or  
Social Security Number \_\_\_\_\_

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

3a. Name of Insurance Carrier \_\_\_\_\_

3b. Policy Number of Insurance Carrier listed in "1a": \_\_\_\_\_

3c. Policy effective period: \_\_\_\_\_  
to \_\_\_\_\_

4. Policy coverage of the employee is eligible under the New York Disability Benefits Law  
for the following classification of the employer's employee: \_\_\_\_\_

Under penalty of perjury, I certify that I am an authorized representative of the insurance carrier referenced above and  
that the named insured has NYS Disability Benefits Law coverage as described above.

Date Signed \_\_\_\_\_ By \_\_\_\_\_  
(Signature of insurance carrier authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number \_\_\_\_\_ Title \_\_\_\_\_  
**IMPORTANT:** If box "4a" is checked, and this form is signed by an insurance carrier authorized representative or NYS Licensed Insurance Agent of that  
carrier, this certificate is COMPLETE and is subject to the Disability Benefits Law.  
If box "4b" is checked, this certificate is NOT COMPLETE for purposes of Section 220, Subd. 8 of the Disability Benefits Law. It must be mailed  
for completion to the Workers' Compensation Board, Planning and Policy Unit, 20 Park Street, Albany, New York 12207.

**PART 2. To be completed by NYS Workers' Compensation Board (Only if box "4b" 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 Benefits Law with respect to all of his/her employees.

Date Signed \_\_\_\_\_ By \_\_\_\_\_  
(Signature of NYS Workers' Compensation Board Employee)

Telephone Number \_\_\_\_\_ Title \_\_\_\_\_

*Please Note: Only insurance carriers licensed to write NYS disability 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.*

**GENERAL NOTES**

- All removals and associated waste disposal shall be performed in accordance with applicable Federal, State, and local environmental regulations.
- Preservation of all existing utilities not to be removed/abandoned is the responsibility of the Contractor.