

SCA SUBCONTRACTOR APPROVAL FORM (SAF)

SECTION "A" (PRIME INFORMATION)

- 1 PRIME CONTRACTOR'S NAME: _____
- 2 PRIME'S FEDERAL TAX I.D. NO: _____ TEL. NO: _____
- 3 PRIME'S PROJECT OFFICER: _____
- 4 SCA CONTRACT NO.C00000: _____ SOLICITATION NO: _____
- 5 SCA PROJECT OFFICER: _____
- 6 SCA PROJECT SCHOOL(S): _____ BORO: _____
- 7 SCA PROJECT DESCRIPTION: _____

SECTION "B" (SUBCONTRACTOR INFORMATION)

- 1 PRIMARY SUBCONTRACTOR'S NAME: _____
PRIMARY SUBCONTRACTOR'S FEDERAL TAX I.D. NO: _____
- 2 SECONDARY SUBCONTRACTOR'S NAME: _____
SECONDARY SUBCONTRACTOR'S FEDERAL TAX I.D. NO: _____
- 3 ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
- 4 TELEPHONE NO.: () _____ FAX NO.: () _____
- 5 OWNER'S NAME: _____ SS #: _____
- 6 LICENSE TYPE: _____ LICENSE NO: _____ EXP. DATE: _____
- 7 EST. VALUE OF FIRM'S SUBCONTRACT WORK (IN DOLLARS) : \$ _____
- 8 DESCRIPTION OF WORK TO BE DONE WITH FIRM'S WORKFORCE ONLY (BE TRADE SPECIFIC): _____

- 9 WORK START DATE : _____ FINISH DATE: _____ AWARD DATE: _____
- 10 IS FIRM A: MBE?: No () Yes () WBE?: No () Yes () LBE?: No () Yes ()
- 11 IDENTIFY THE SUBCONTRACTOR APPRENTICESHIP PROGRAM(S) THAT YOUR FIRM PARTICPATES IN THAT SUPPORT THE DESCRIPTION OF WORK BEING DONE ON THIS JOB BY YOUR FIRM: _____

MANAGER, PREQUALIFICATION

APPROVED: NO: () YES: () DATE: _____

New York City School
Construction Authority

**CONTRACTOR REQUEST
FOR INSURANCE FORM**

FOR OFFICIAL USE ONLY

Project Manger:
SCA Contract #: C00000
Project No.:
Prime Contractor:

**THIS FORM MUST BE COMPLETED BY ALL CONTRACTORS AND SUBCONTRACTORS
WHO WILL PERFORM WORK AT THE CONSTRUCTION JOB-SITE**

PROJECT SCHOOL: _____ BORO: _____

SCHOOL ADDRESS: _____

CONTRACTOR/SUBCONTRACTOR'S FIRM NAME: _____

CONTRACTOR/SUBCONTRACTOR'S ADDRESS: _____

CITY: _____ STATE: _____

FIRM'S TELEPHONE NO.: () _____ FAX NO.: () _____

FIRM'S FEDERAL TAX I.D. #: _____

WORKER'S COMPENSATION BUREAU NO. _____

PROJECT REPRESENTATIVE

INSURANCE RISK MANAGER

NAME: _____

ADDRESS: _____

TELEPHONE NO.: _____

BRIEF DESCRIPTION OF JOB-SITE ACTIVITIES TO BE DONE WITH FIRM'S WORKFORCE ONLY:

(Be trade specific) _____

FIRM'S ESTIMATED JOB-SITE START DATE: _____

FIRM'S ESTIMATED JOB-SITE FINISH DATE: _____

**CONTRACTOR REQUEST FOR
INSURANCE FORM - Page 2**

Contractor's Firm Name: _____

Firm's Tax I.D. #: _____

WORKERS COMPENSATION DATA

CLASSIFICATION	CODE	PAYROLL

W.C. Exp. Mod.: _____ Rating Date: _____

Worker's Compensation Bureau Risk No.: _____

Location of Payroll Records: _____

Contact: _____

Estimated Contract Amount: \$ _____

PRESENT INSURANCE COVERAGE

	WORKER'S COMPENSATION	GENERAL LIABILITY
INSURER:		
POLICY NO:		
EFFECTIVE DATE:		
AGENT/BROKER:		
ADDRESS:		
City/State:		
ACCOUNT EXEC.:		
TELEPHONE NO.:		

Contractor's Firm Name: _____
 Firm's Tax ID#: _____

ADDITIONAL MISCELLANEOUS INFORMATION

- 1. The SCA Contract No. for this job is: C00000 _____
- 2. Is your firm the prime contractor for this job? Yes _____ No _____
- 3. If your firm is a subcontractor on this job, name your prime contractor for this job: _____

- 4. Will your firm need a building permit for this job? Yes _____ No _____
- 5. Is this a Capital Improvement job? Yes _____ No _____
- 6. Does your firm anticipate that some of the work to be done on this job under this contract will be subcontracted out to other firms? Yes _____ No _____

If the answer is **YES**, please indicate the names and addresses of the firms which will act your subcontractor. **(IMPORTANT: All firms your firm will be subcontracting work to will have to submit a Subcontractor Approval Form with three (3) pages of Request for Insurance forms for approval to work on the jobsite.)**

FIRM'S NAME	FIRM'S ADDRESS

- 7. Is your firm a subsidiary and/or a division of another company? YES _____ NO _____
Note: If you are a subsidiary and/or a division of another company or if you are participating as a Joint Venture partner you must complete the Form ERM-14.

CERTIFICATION

I certify that the statements in the Request for Insurance are true to the best of my knowledge. I understand that my firm's Workers' Compensation loss experience incurred on this project is reported annually to the Workers' Compensation Bureau and will be used to promulate my firm's experience modification factor.

 Officer of Firm's Signature

 Print Officer's Name

 Date Signed

 Officer's Title