



VILLAGE OF DOBBS FERRY

Building Department
112 Main Street, Dobbs Ferry, NY 10522
Phone: (914) 231-8509 | Fax: (914) 693-3470

Ed Manley
Building Inspector



Permit Application

Application Number AT2021-0138

Date 09/20/2021

Job Location 25 CHESTNUT RIDGEWAY

Lot # 3.140-126-39

Owner: ROOS TRUST LLOYD I
25 CHESTNUT RIDGEWAY
DOBBS FERRY, NY 10522

Applicant: Roberta Roos
25 Chestnut Ridge Way
Dobbs Ferry, NY 10522
(914)715-1509 RMRoos@aol.com

Application Type: Tree Removal Estimated Cost of Construction: \$

Description of Work: tree in imminent danger of falling - hollowed

Form Questions:

Application Parcel Owner Contact:

Parcel Owner Email	rmroos@aol.com
Parcel Owner Phone	9147151509

No marking or ribbon / Continued

Job Location: 25 CHESTNUT RIDGE WAY

Parcel Id: 3.140-126-39

AFFIDAVIT OF APPLICANT

I Robert M. Roos being duly sworn, depose and says: That s/he does business as: _____ with offices at: _____ and that s/he is:

X The owner of the property described herein.

The _____ of the New York Corporation _____ with offices at: _____ duly authorized by resolution of the Board of Directors, and that said corporation is duly authorized by the owner to make this application.

_____ A general partner of _____ with offices _____ and that said Partnership is duly authorized by the Owner to make this application.

_____ The Lessee of the premises, duly authorized by the owner to make this application.

_____ The Architect of Engineer duly authorized by the owner to make this application.

_____ The contractor authorized by the owner to make this application.

That the information contained in this application and on the accompanying drawings is true to the best of his knowledge and belief. The undersigned hereby agrees to comply with all the requirements of the New York State Uniform Fire Prevention and Building Code, the Village of Dobbs Ferry Building Code, Zoning Ordinance and all other laws pertaining to same, in the construction applied for, whether or not shown on plans or specify in this application.

Sworn to before me this _____ day of _____ of _____

Notary Public/ Commission of Deeds

Applicant's Signature

OWNER'S AUTHORIZATION

I Robert M. Roos ^{beneficial} as the owner of the subject premises and have authorized the contractor named above to perform the work under the subject application.

Owner phone number 9147151509. Owner email address rmroos@aol.com

_____ I hereby acknowledge that it is my responsibility as the property owner to ensure that if the permit (if issued) receives a Final Certificate of Approval from the Building Department and further that if a Final Certificate of Approval is not obtained upon completion of the construction, a property violation may be placed on the property for which this permit is being requested.

Sworn to before me this 20th day of Sept. of 2021

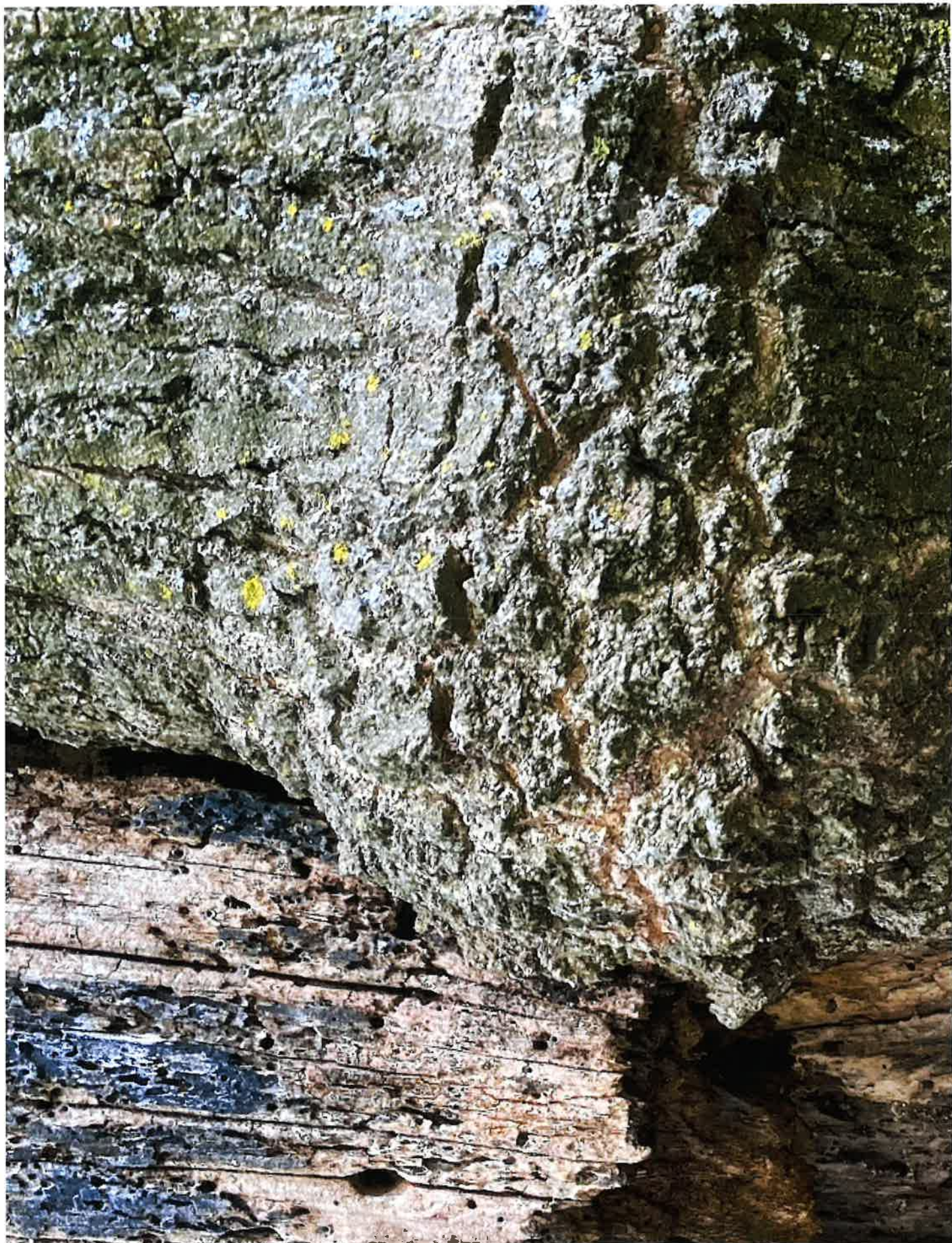
Edward Canora

Notary Public/ Commission of Deeds



Robert M. Roos

Applicant's Signature



George Latimer
Westchester County Executive

Westchester
gov.com

James Maisano
Director, Consumer Protection

Department of Consumer Protection Home Improvement License

RAMOS & V. TREE SERVICES INC.

PO BOX 80

HAWTHORNE, NY-10532

This license is issued in accordance with Article XVI of the Westchester County Consumer Protection Code and is valid only upon presence of the official department seal. Proof of citizenship or immigration status is not required for issuance of this license.
NOT FOR FEDERAL PURPOSES

License Number

WC-20245-H08



Date of Expiration

03/13/2022



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

09/20/2021

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 CHRISTOPHER TARR 500 Route 32 PO Box 1014 Highland Mills NY 10930		CONTACT NAME: CHRISTOPHER TARR PHONE (A/C, No, Ext): 845-738-8801 FAX (A/C, No): 845-395-0011 E-MAIL ADDRESS: Highlandmillsoffice@american-national.com	
INSURED Ramos & V Tree Services Inc PO Box 80 Hawthorne NY 10532		INSURER(S) AFFORDING COVERAGE INSURER A: Farm Family Casualty Ins Co INSURER B: United Farm Family Ins Co INSURER C: INSURER D: INSURER E: INSURER F:	
		NAIC # 13803 29963	

COVERAGES**CERTIFICATE NUMBER:****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	X	X	3102X0326	9/24/20	9/24/22	EACH OCCURRENCE	\$ 2,000,000
	<input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	\$ 100,000
	<input checked="" type="checkbox"/> SELECT BUSINESS PCKG						MED EXP (Any one person)	\$ 5,000
	<input checked="" type="checkbox"/> INLAND MARINE						PERSONAL & ADV INJURY	\$ 2,000,000
GEN'L AGGREGATE LIMIT APPLIES PER:							GENERAL AGGREGATE	\$ 4,000,000
	<input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC						PRODUCTS - COMP/OP AGG	\$ 4,000,000
	<input checked="" type="checkbox"/> OTHER DEDUCTIBLE \$500							\$
B	AUTOMOBILE LIABILITY			3101C4702	5/16/21	5/16/22	COMBINED SINGLE LIMIT (Ea accident)	\$ 1,000,000
	ANY AUTO		BODILY INJURY (Per person)				\$	
	OWNED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS NON-OWNED AUTOS ONLY		BODILY INJURY (Per accident)				\$	
	HIRED AUTOS ONLY <input checked="" type="checkbox"/>		PROPERTY DAMAGE (Per accident)				\$	
								\$
	UMBRELLA LIAB						EACH OCCURRENCE	\$
	EXCESS LIAB						AGGREGATE	\$
	DED	RETENTION \$						\$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY						PER STATUTE	OTH-ER
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	Y/N	N/A				E.L. EACH ACCIDENT	\$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	\$
							E.L. DISEASE - POLICY LIMIT	\$

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

Village of Dobbs Ferry is listed as additional insured

CERTIFICATE HOLDER**CANCELLATION**

VILLAGE OF DOBBS FERRY
112 MAIN ST
DOBBS FERRY, NY 10522-4622

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 LIABILITY INSURANCE

DATE (MM/DD/YYYY)

09/10/2020

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	CONTACT NAME: CHRISTOPHER TARR
CHRISTOPHER TARR	PHONE (A/C, No, Ext): 845-738-8801 FAX (A/C, No): 845-395-0011
500 ROUTE 32	E-MAIL ADDRESS: HIGHLANDMILLSOFFICE@AMERICAN-NATIONAL.COM
PO BOX 1014	INSURER(S) AFFORDING COVERAGE
HIGHLAND MILLS, NY 10930	INSURER A: FARM FAMILY CASUALTY INS CO NAIC # 13803
INSURED	INSURER B: UNITED FARM FAMILY INS CO 29963
RAMOS & V TREE SERVICES INC	INSURER C:
PO BOX 80	INSURER D:
HAWTHORNE, NY 10532	INSURER E:
	INSURER F:

COVERAGES

CERTIFICATE NUMBER:

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	ADOL 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 <input checked="" type="checkbox"/> BOP GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:	X	X	3102X0326	9/24/19	9/24/21	EACH OCCURRENCE \$ 2,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000 MED EXP (Any one person) \$ 5,000 PERSONAL & ADV INJURY \$ 2,000,000 GENERAL AGGREGATE \$ 4,000,000 PRODUCTS - COMP/OP AGG \$ 4,000,000
B	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			3101C4702	5/16/20	5/16/21	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
	UMBRELLA LIAB EXCESS LIAB DED RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N	N/A				PER STATUTE OTH-ER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$

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

LANDSCAPING/TREE REMOVAL

VILLAGE OF DOBBS FERRY IS LISTED AS ADDITIONAL INSURED

CERTIFICATE HOLDER

CANCELLATION

VILLAGE OF DOBBS FERRY
112 MAIN ST
DOBBS FERRY, NY 10522-4622

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



**Workers'
Compensation
Board**

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

1a. Legal Name & Address of Insured (use street address only) Ramos & V. Tree Services, Inc. dba Ramos & V. Tree Services, Inc. PO Box 80 Hawthorne, NY 10532-0080 <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>	1b. Business Telephone Number of Insured (914)391-4293 1c. NYS Unemployment Insurance Employer Registration Number of Insured 1d. Federal Employer Identification Number of Insured or Social Security Number 208107376
2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) Village of Dobbs Ferry 112 Mainstreet Dobbs Ferry, NY 10522	3a. Name of Insurance Carrier Continental Indemnity Co. 3b. Policy Number of Entity Listed in Box "1a" 46-853973-01-11 3c. Policy effective period 08/05/21 to 08/05/22 3d. The Proprietor, Partners or Executive Officers are <input checked="" type="checkbox"/> included. (Only check box if all partners/officers included) <input type="checkbox"/> all excluded or certain partners/officers 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 must notify the above certificate holder and the Workers' Compensation Board 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 one year after this form is approved by the insurance carrier or its licensed agent, or until the policy expiration date listed in box "3c", whichever is earlier.**

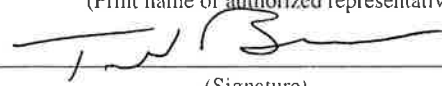
This certificate is issued as a matter of information only and confers no rights upon the certificate holder. This certificate does not amend, extend or alter the coverage afforded by the policy listed, nor does it confer any rights or responsibilities beyond those contained in the referenced policy.

This certificate may be used as evidence of a Workers' Compensation contract of insurance only while the underlying policy is in effect.

Please Note: Upon 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: Todd Brown
(Print name of authorized representative or licensed agent of insurance carrier)

Approved by:  09/20/2021
(Signature) (Date)

Title: Authorized Representative

Telephone Number of authorized representative or licensed agent of insurance carrier: (877) 234-4424

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



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) RAMOS & V. TREE SERVICES INC. P.O. BOX 80 HAWTHORNE, NY 10532</p> <p><small>Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e., Wrap-Up Policy)</small></p>	<p>1b. Business Telephone Number of Insured 914-391-4293</p> <p>1c. Federal Employer Identification Number of Insured or Social Security Number 208107376</p>
<p>2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)</p> <p>Village of Dobbs Ferry 112 Main Street, Dobbs Ferry, NY 10522</p>	<p>3a. Name of Insurance Carrier ShelterPoint Life Insurance Company</p> <p>3b. Policy Number of Entity Listed in Box "1a" DBL256964</p> <p>3c. Policy effective period 07/10/2021 to 07/09/2022</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 9/20/2021 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.

