VILLAGE OF DOBBS FERRY

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

Daniel Roemer
Building Inspector

Permit Application

Application Number AT2023-0129 **Date** 11/08/2023

Job Location 9 BRACE TER **Lot #** 3.120-110-21

Owner: MOUSSAPOUR, AMIR
9 BRACE TER
DOBBS FERRY, NY 10522

Applicant: Amir Moussapour
9 Brace Ter
Dobbs ferry, NY 10522
(914)960-2744
amirmoussapour@gmail.com

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

Description of Work: Dead Ash Tree to be removed

Form Questions:

Application Parcel Owner Contact:

Parcel Owner Email	amirmoussapour@gmai.com
Parcel Owner Phone	9149602744

Job Location: **9 BRACE TER** Parcel Id: **3.120-110-21**

AFFIDAVIT OF APPLICANT

I Amir Moussapour being duly sworn, depose and says: That s/he does business as: _____ with offices at: 9 Brace Ter, Dobbs Ferry and that s/he is:

✓ 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

PROPERTY OWNER'S AUTHORIZATION

I Amir Moussapour 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 9149602744.Owner email address amirmoussapour@gmail.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 8 day of November of 2023

Notary Public / Commission of Deeds

PROPERTY OWNER's SIGNATURE

DAE GON KIM
Notary Public, State of New York
License Number: 01KI6396277
Expiration Date: 08/19/2027
Qualified in Westchester County

George Latimer
Westchester County Executive

Westchester gov.com

James Maisano
Director, Consumer Protection

Department of Consumer Protection
Home Improvement License

BETHEL HG TREE SERVICE & LANDSCAPING LLC

411 KELSEY AVENUE

WEST HAVEN,CT-06516

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-31675-H19

Department of Consumer Protection
Westchester County, NY

Date of Expiration

04/05/2025

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 11-03-2023

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 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: VALDEZ AGENCY	
TAPCO KL P O BOX 286 BURLINGTON NC 27216	PHONE (A/C, No, Ext): 475-331-6377	FAX (A/C, No):
	E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A: WESTERN WORLD INSURANCE	
INSURED BETHEL HG TREE SERVICE & LANDSCAPING 413 KELSEY AVE WEST HAVEN CT 06516	INSURER B:	
	INSURER C:	
	INSURER D:	
	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	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	GENERAL LIABILITY						EACH OCCURRENCE	$ 1,000,000
	[X] COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 100.000
	[ ] CLAIMS-MADE [X] OCCUR						MED EXP (Any one person)	$ 5,000
				NPP1608083	11/01/2023	11/01/2024	PERSONAL & ADV INJURY	$ 1,000,000
							GENERAL AGGREGATE	$ 2,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						PRODUCTS - COMP/OP AGG	$ 2,000,000
	[ ] POLICY [ ] PRO-JECT [ ] LOC							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	[ ] ANY AUTO						BODILY INJURY (Per person)	$
	[ ] ALL OWNED AUTOS [ ] SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	[ ] HIRED AUTOS [ ] NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
	[ ] UMBRELLA LIAB [ ] OCCUR						EACH OCCURRENCE	$
	[ ] EXCESS LIAB [ ] CLAIMS-MADE						AGGREGATE	$
	[ ] DED [ ] RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N						[ ] WC STATU-TORY LIMITS [ ] OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [ ] N/A (Mandatory in NH)						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 (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

For information

CERTIFICATE HOLDER

Village of Dobbs Ferry
112 Mai st. Dobbs Ferry, NY 10522

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

NEW YORK STATE | Workers' Compensation Board

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

1a. Legal Name & Address of Insured (use street address only)
BETHEL HG TREE SERVICE & LANDSCAPING LLC
411 KELSEY AVE
WEST HAVEN, CT 06516

1b. Business Telephone Number of Insured
(914) 879-3477

1c. Federal Employer Identification Number of Insured or Social Security Number
832778917

Work Location of Insured *(Only required if coverage is specifically limited to certain locations in New York State, i.e., a Wrap-Up Policy)*

2. Name and Address of Entity Requesting Proof of Coverage
(Entity Being Listed as the Certificate Holder)
VILLAGE OF DOBBS FERRY
112 MAIN ST
DOBBS FERRY, NY 10522

3a. Name of Insurance Carrier
New York State Insurance Fund (NYSIF)

3b. Policy Number of Entity Listed in Box "1a"
DBL 7502 53 - 8

3c. Policy effective period
05/11/2023 to 05/11/2024

4. Policy provides the following benefits
- [X] A. Both disability and paid family leave benefits
- [ ] B. Disability benefits only
- [ ] C. Paid family leave benefits only

5. Policy covers
- [X] 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 11/2/2023 By Kristin Markwica
(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number (866) 697-4332 Name and Title **Kristin Markwica, Head of Disability Insurance Unit**

IMPORTANT: If Box 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, DB 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.

DB-120.1 (10-17) **Certificate Number 762261**

Additional Instructions for Form DB-120.1

By signing this form, the insurance carrier identified in box "3" on this form is certifying that it is insuring the business referenced in box "1a" for disability and/or paid family leave benefits under the New York State Disability and Paid Family Leave Benefits Law. The Insurance Carrier or its licensed agent will send this Certificate of Insurance to the entity listed as the certificate holder in box "2"

The insurance carrier must notify the above certificate holder and the Worker's Compensation Board within 10 days IF a policy is cancelled 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 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 Disability and/or Paid Family Leave Benefits contract of insurance only while the underlying policy is in effect.

Please Note: Upon the cancellation of the disability and/or paid family leave benefits 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 NYS Disability and/or Paid Family Leave Benefits Coverage or other authorized proof that the business is complying with the mandatory coverage requirements of the New York State Disability and Paid Family Leave Benefits Law.

NYSIF
New York State Insurance Fund

PO Box 66699, Albany, NY 12206
| nysif.com

CERTIFICATE OF WORKERS' COMPENSATION INSURANCE

^^^^^^ 832778917
BETHEL HG TREE SERVICE &
LANDSCAPING LLC
411 KELSEY AVE
WEST HAVEN CT 06516

SCAN TO VALIDATE
AND SUBSCRIBE

POLICYHOLDER	CERTIFICATE HOLDER
BETHEL HG TREE SERVICE & LANDSCAPING LLC 411 KELSEY AVE WEST HAVEN CT 06516	VILLAGE OF DOBBS FERRY 112 MAIN ST DOBBS FERRY NY 10522

POLICY NUMBER	CERTIFICATE NUMBER	POLICY PERIOD	DATE
W2466 739-6	857104	03/08/2023 TO 03/08/2024	11/2/2023

THIS IS TO CERTIFY THAT THE POLICYHOLDER NAMED ABOVE IS INSURED WITH THE NEW YORK STATE INSURANCE FUND UNDER POLICY NO. 2466 739-6, 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. 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.

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

VALIDATION NUMBER: 173832651

U-26.3