Ed Manley Building Inspector



Parcel Owner Phone 914-772-5172

VILLAGE OF DOBBS FERRY

RECEIVED

NOV -1 2021

VILLAGE OF DOBBS FERRY BUILDING DEPARTMENT

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

Permit Application

Application Number AT2021-0167	10/29/2021				
Date					
29 SUMMIT TER Job Location	3.60-27-5				
Owner: LORETODERUBEIS 29 SUMMIT TER DOBBS FERRY, NY 10522	Loreto & Marilyn DeRubeis 29 Summit Terrace Dobbs Ferry, NY 10522 (914)772-5172 marilyn.derubeis@gmail.co				
	m				
Tree Removal Application Type: Estimated Co	st of Construction: \$				
Remove large oak tree located 2' from house. Several tree experts inspected it and determined it is a threat to both persons and property. It's roots have lifted and					
buckled driveway and w Form Questions: conditions. The roots ha Application Parcel Owner Contact: Parcel Owner Email marilyn.derubeis@gmail.com	valkway, creating hazardous ve the potential to, if not the home's foundation.				

Locato Sefections

Job Location: 29 SUMMIT TER Parcel Id: 3.60-27-5

AFFIDAVIT OF APPLICANT
I Loreto Declubers being duly sworn, depose and says: That s/he does business as: with offices at: 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 not shown on plans or specify in this application.
Sworn to before me this 28 day of Oct of 2021 CYNTHIA B. MCINTOSH Notary Public, State of New York No. 01MC5060403 Qualified in Kings County Commission Expires May 2022 Notary Public / Commission of Deeds Applicant's Signature Contractor: All American Tree Can Applicant's Signature
PROPERTY OWNER'S AUTHORIZATION I Locato De Rubastine owner of the subject premises and have authorized the contractor named above to perform the work under the subject application.
Owner phone number 9147725172 .Owner email address marilyn.derubeis@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 28 day of Oct of 2021 CYNTHIA B. MCINTOSH Notary Public, State of New York No. 01MC5060403 Qualified in Kings County Commission Expires May 20, 2000—lighthuafth

Notary Public / Commission of Deeds

PROPERTY OWNER'S SIGNATURE



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 08/20/2021

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.

Scavone fisurance Center 470 Mamariance kay Suite 205 White Plains, NY 10805 MISURED All American Tree Care, Inc. 87 Bolton Avenue White Plains, NY 10805 MISURER 6: MISURER 6	PRODUCER		does not confer rights to the certificate holder in lieu of suc			CONTACT Linda Scavene				
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AUTHORIZED REPRESENTATIVE	112 Main Street			AUTHORIZED REPRESENTATIVE						

Joseph Scaro

Dobbs Ferry, NY 10522



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					
	Address of Insured (use street addre		1b. Business Telephone Number of Insured 914-447-8917		
87 BOLTON AVENUE WHITE PLAINS, NY 10605 Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e., Wrap-Up Policy)			1c. Federal Employer Identification Number of Insured or Social Security Number 208545208		
Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) Village of Dobbs Ferry 112 Main Street Dobbs Ferry, NY 10522			3a. Name of Insurance Carrier ShelterPoint Life Insurance Company 3b. Policy Number of Entity Listed in Box "1a" DBL315657 3c. Policy effective period 03/11/2021 to 03/10/2022		
 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 Date Signed	8/20/2021 By		coverage as described above. Licensed Insurance Agent of that insurance carrier)		
Tolophono Numbe	F16 920 9100		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	Ву		(Signature of Authorized NYS Workers' Compensation Board Employee)		
Telephone Number	ır				

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.





CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

1a. Legal Name & Address of Insured (use street address only)	1b. Business Telephone Number of Insured			
All American Tree Care, Inc. dba All American Tree Care, Inc. 87 Bolton Ave White Plains, NY 10605-2526	(914)490-5464 1c. NYS Unemployment Insurance Employer Registration Number of Insured			
Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e. a Wrap-Up Policy)	1d. Federal Employer Identification Number of Insured or Social Security Number 208545208			
2. Name and Address of Entity Requesting Proof of Coverage (Entity	3a. Name of Insurance Carrier Continental Indemnity Co.			
Being Listed as the Certificate Holder)				
Village of Dobbs Ferry 112 Main Street Dobbs Ferry, NY 10522	3b. Policy Number of Entity Listed in Box "1a" 46-691022-01-06			
	3c. Policy effective period			
	01/13/21 to 01/13/22			
	3d. The Proprietor, Partners or Executive Officers are included. (Only check box if all partners/officers included) [X] 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 licenced agent	of insurance carrier)
Approved by:	1313	08/20/2021
	(Signature)	(Date)
Title:	Authorized Representative	
Telephone Number of au	thorized 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 <u>NOT</u> authorized to issue it.











