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 AT2024-0041 **Date** 04/17/2024

Job Location 24-82 BEACON HILL DR| **Lot #** 3.90-58-2

Owner: Meagan Batchelder
200 Beacon Hill Apartments LLC
Dobbs Ferry, NY 10522-1610
9149379300

Applicant: Meagan Baizan
200 Beacon Hill Drive Apt 8J1
Dobbs Ferry, NY 10522
(914)937-9300 mbaizan@rosepmg.com

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

Description of Work: Remove 2 dead trees on border of 82 Beacon & 2 Castle Drive overlooking private home at 2 Castle Drive.

Form Questions:

Diameter of Tree to be Removed	**37 & 54**

Application Parcel Owner Contact:

Parcel Owner Email	mbaizan@rosepmg.com
Parcel Owner Phone	9147604890

MARTIGNETTI
TREE CARE

Serving Westchester since 1953
Licensed and Fully Insured
914 • 632 • 3616

April 19,2024

To Whom it May Concern,

My name is Fred Martignetti and I am the Certified Arborist for Martignetti Tree Care inc. I was contacted by Luis Ceja (Ceja Bros. Inc.) regarding 2 hazardous trees on the property of 82 Beacon Hill Dobbs Ferry NY. The sugar maple tree has a large cavity on the trunk and I am recommending the removal of the tree in a timely manner. The second tree, a oak tree has basal decay and excessive dead in the canopy. I am recommending the removal of this tree as well.

Please feel free to give me a call (914-755-0457) with any questions or concerns.

Sincerely,

Fred Martignetti
Certified Arborist NY-5892A
Martignetti Tree Care Inc.
30 Sharot Street New Rochelle NY 10801
914-632-3616

Job Location: **24-82 BEACON HILL DR** Parcel Id: **3.90-58-2**

AFFIDAVIT OF APPLICANT

I Meagan Baiz being duly sworn, depose and says: That s/he does business as: 200 Beacon Hill Dr LLC with offices at: 200 Beacon Hill Dr, Dobbs Ferry NY 10522 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 Meagan Baiz 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 9147604890.Owner email address mbaizan@rosepmg.com

Meagan Baiz 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 18 day of April of 2024

Notary Public / Commission of Deeds PROPERTY OWNER's SIGNATURE

Cynthia B McIntosh
NOTARY PUBLIC, STATE OF NEW YORK
Registration No. 01MC5060403
Qualified in Westchester County
My Commission Expires 07/07/2026

George Latimer
Westchester County Executive

Westchester gov.com

James Maisano
Director, Consumer Protection

Department of Consumer Protection
Home Improvement License

CEJA BROTHERS LANDSCAPING INC.

25 CONGRESS STREET - 2ND FLOOR

NEW ROCHELLE,NY-10801

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

Department of Consumer Protection
Westchester County-NY

License Number

WC-20832-H08

Date of Expiration

06/19/2024

CEJABRO-01 FHOLZHAY

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 4/15/2024

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
Acrisure Insurance Partners Services of NY, LLC
90 S. Ridge Street
Rye Brook, NY 10573

CONTACT NAME: Ellen Greig
PHONE (A/C, No, Ext): (914) 937-1230 FAX (A/C, No):
E-MAIL ADDRESS: egreig@acrisure.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Merchants Preferred Insurance Company	12901
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Ceja Brothers Landscaping Inc.
25 Congress Street
New Rochelle, NY 10801

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	X COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$ 2,000,000
	CLAIMS-MADE X OCCUR	X		CTRI006104	8/9/2023	8/9/2024	DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 500,000
							MED EXP (Any one person)	$ 10,000
							PERSONAL & ADV INJURY	$ 2,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 4,000,000
	POLICY X PRO-JECT LOC						PRODUCTS - COMP/OP AGG	$ 4,000,000
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	OWNED AUTOS ONLY / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS ONLY / NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	$
	DED RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N						PER STATUTE / OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	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 included as an additional insured when required by written contract or agreement.

CERTIFICATE HOLDER

Village of Dobbs Ferry
112 Main Street
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)
CEJA BROTHERS LANDSCAPING INC

25 CONGRESS STREET 2ND FLOOR
NEW ROCHELLE NY 10801
Work Location of Insured *(Only required if coverage is specifically limited to certain locations in New York State, i.e., Wrap-Up Policy)*

1b. Business Telephone Number of Insured
(914) 469-5998

1c. Federal Employer Identification Number of Insured or Social Security Number
27-1506358

2. 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"
D480347

3c. Policy effective period
1/7/2024 to 1/6/2025

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 4/15/2024 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.

DB-120.1 (10-17)

NEW YORK STATE | Workers' Compensation Board

CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

1a. Legal Name & Address of Insured (use street address only) Ceja Brothers Landscaping Inc. 25 Congress Street New Rochelle, NY 10801 Work Location of Insured *(Only required if coverage is specifically limited to certain locations in New York State, i.e., a Wrap-Up Policy)*	1b. Business Telephone Number of Insured 914-469-5998 1c. NYS Unemployment Insurance Employer Registration Number of Insured 1d. Federal Employer Identification Number of Insured or Social Security Number 271506358
2. 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 Merchants Mutual Insurance Company 3b. Policy Number of Entity Listed in Box "1a" WCAI038722 3c. Policy effective period 8/9/2023 to 8/9/2024 3d. The Proprietor, Partners or Executive Officers are ☒ included. (Only check box if all partners/officers included) ☐ 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: Paul Sohigian
(Print name of authorized representative or licensed agent of insurance carrier)

Approved by: _____ 04/15/2024
(Signature) (Date)

Title: Principal

Telephone Number of authorized representative or licensed agent of insurance carrier: 914-937-1230

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.