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

RECEIVED
APR 30 2024
VILLAGE OF DOBBS FERRY
BUILDING DEPARTMENT

Permit Application

Application Number AT2024-0048 **Date** 04/24/2024

Job Location DANFORTH AVE| **Lot #** 3.180-154-3

Owner: LINCOLN DOBBS FERRY LLC
221 CRESCENT ST - STE. 102A
WALTHAM, MA 02453

Applicant: Jason Fabbri
P.O. Box 401
New City, NY 10956
(845)639-6801
jasoncmlandscape@gmail.com

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

Description of Work: Remove 6 large dead and or leaning trees

Form Questions:

Diameter of Tree to be Removed	**14' - 30"**

Application Parcel Owner Contact:

Parcel Owner Email	vmilmore@willowbridgepc.com
Parcel Owner Phone	Victoria Milmore Regional Property Manager 914-584-2677

Job Location: **DANFORTH AVE** Parcel Id: **3.180-154-3**

AFFIDAVIT OF APPLICANT

I _____ 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 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 Garner Giles 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 Victoria Milmore Regional Property Manager 914-584-2677 .Owner email address vmilmore@willowbridgepc.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 25th day of April of 2024

Margaret Parr

Notary Public / Commission of Deeds

PROPERTY OWNER's SIGNATURE

MARGARET PARR
Notary Public, State of New York
Reg. No. 01PA6342478
Qualified in Putnam County
Commission Expires 8/18/2024


STO
BIKE LANE

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 04/26/2024

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
THOMAS R LETIZIA & ASSOCIATES, INC
500 ROUTE 32
PO BOX 1014
HIGHLAND MILLS NY 10930

CONTACT NAME: THOMAS R LETIZIA
PHONE (A/C, No, Ext): 845-738-8801 **FAX (A/C, No):** 845-395-0011
E-MAIL ADDRESS: Highlandmillsoffice@american-national.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : UNITED FARM FAMILY INSURANCE CO	29963
INSURER B : FARM FAMILY CASUALTY INSURANCE CO	13803
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
CM LAWN SERVICE INC.
PO Box 401
NEW CITY, NY 10956

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 [ ] CLAIMS-MADE [X] OCCUR [X] SELECT BUSINESS PACKAGE [X] INLAND MARINE GEN'L AGGREGATE LIMIT APPLIES PER: [X] POLICY [ ] PRO-JECT [ ] LOC [X] OTHER: DEDUCTIBLE $500	X	X	3102X3952	9/29/23	9/29/24	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 100,000 $ 5,000 $ 1,000,000 $ 2,000,000 $ 2,000,000
A	AUTOMOBILE LIABILITY [ ] ANY AUTO [ ] OWNED AUTOS ONLY [X] SCHEDULED AUTOS [X] HIRED AUTOS ONLY [X] NON-OWNED AUTOS ONLY	X	X	3101C7448	9/29/23	9/29/24	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
B	[X] UMBRELLA LIAB [X] OCCUR EXCESS LIAB [ ] CLAIMS-MADE [ ] DED [X] RETENTION $ 10,000	X	X	3101E4827	9/29/23	9/29/24	EACH OCCURRENCE AGGREGATE	$ 5,000,000 $ 5,000,000
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N: Y If yes, describe under DESCRIPTION OF OPERATIONS below	N/A	X	3103W9816	9/29/23	9/29/24	[X] PER STATUTE [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 1,000,000 $ 1,000,000 $ 1,000,000

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

CERTIFICATE HOLDER
The 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
Thomas R Letizia

NEW YORK STATE | Workers' Compensation Board

CERTIFICATE OF INSURANCE COVERAGE

NYS DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

PART 1. To be completed by NYS disability and Paid Family Leave benefits carrier or licensed insurance agent of that carrier

1a. Legal Name & Address of Insured (use street address only)
C M LAWN SERVICE INC.
ATTN: JASON FABBRI
P.O BOX 401
NEW CITY, NY 10956

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
914-447-3054

1c. Federal Employer Identification Number of Insured or Social Security Number
133456493

2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)
The 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"
DBL515907

3c. Policy effective period
10/25/2023 to 10/24/2024

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 4/26/2024 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 emailed to PAU@wcb.ny.gov or it can 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 4B, 4C or 5B have 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(Article 9 of the Workers' Compensation Law) with respect to all of their 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.***

NEW YORK STATE | Workers' Compensation Board

CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

1a. Legal Name & Address of Insured (use street address only) CM LAWN SERVICE INC. PO Box 401 NEW CITY, NY 10956 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 (845) 639-6801 1c. NYS Unemployment Insurance Employer Registration Number of Insured 1d. Federal Employer Identification Number of Insured or Social Security Number 133456493
2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) The Village of Dobbs Ferry 112 Main Street Dobbs Ferry, NY 10522	3a. Name of Insurance Carrier UNITED FARM FAMILY INSURANCE CO 3b. Policy Number of Entity Listed in Box "1a" 3103W9816 3c. Policy effective period 9/29/23 to 9/29/24 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: THOMAS R. LETIZIA
(Print name of authorized representative or licensed agent of insurance carrier)

Approved by: Thomas R Letizia 04 26 24
(Signature) (Date)

Title: AGENT

Telephone Number of authorized representative or licensed agent of insurance carrier: 845-738-8801

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.