



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 AT2022-0053

Date 05/29/2022

Job Location 79 OGDEN AVE Lot # 3.140-125-5

Owner: MARY D. ARTHUR
79 OGDEN AVE
DOBBS FERRY, NY 10522

Applicant: Rosaura Bollengier
61 Hickory Hill Drive
Dobbs Ferry, NY 10522
9142177737
rosaurabusnello@hotmail.com

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

Description of Work: Remove 2 Norway Maple - left side, backyard closer to the house - 12" and 11"
Remove 3 Norway Maple - Left side, backyard closer to the street - 9", 12", 14"
Remove 1 Norway Maple - Right side, backyard - 13" Remove 3 Norway Maple - Right
side yard - 12", 14", 9" All trees growing over/leaning over the home. Trunk decay.

Form Questions:

Application Parcel Owner Contact:

Parcel Owner Email	bollengierproperty@gmail.com
Parcel Owner Phone	9142177737

Continued until planting plan submitted

X

X

X

Job Location: 79 OGDEN AVE

Parcel Id: 3.140-125-5

AFFIDAVIT OF APPLICANT

I EMERSON OLIVEIRA being duly sworn, depose and says: That s/he does business as: GENESIS TIME with offices at 41 LINCOLN AVENUE, WHITE PLAINS, NY 10606 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 7th day of June of 2022


Notary Public/ Commission of Deeds

ALEIDY CEPEDA
NOTARY PUBLIC, STATE OF NEW YORK
Registration No. 01CE6191224
Qualified in Westchester County
My Commission Expires October 16, 2024

PROPERTY OWNER'S AUTHORIZATION

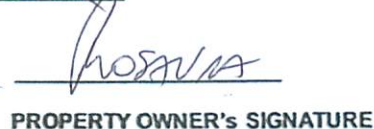
I _____ as the owner of the subject premises and have authorized the contractor named above to perform the work under the subject application.

Owner phone number 9142177737. Owner email address bollengierproperty@gmail.com

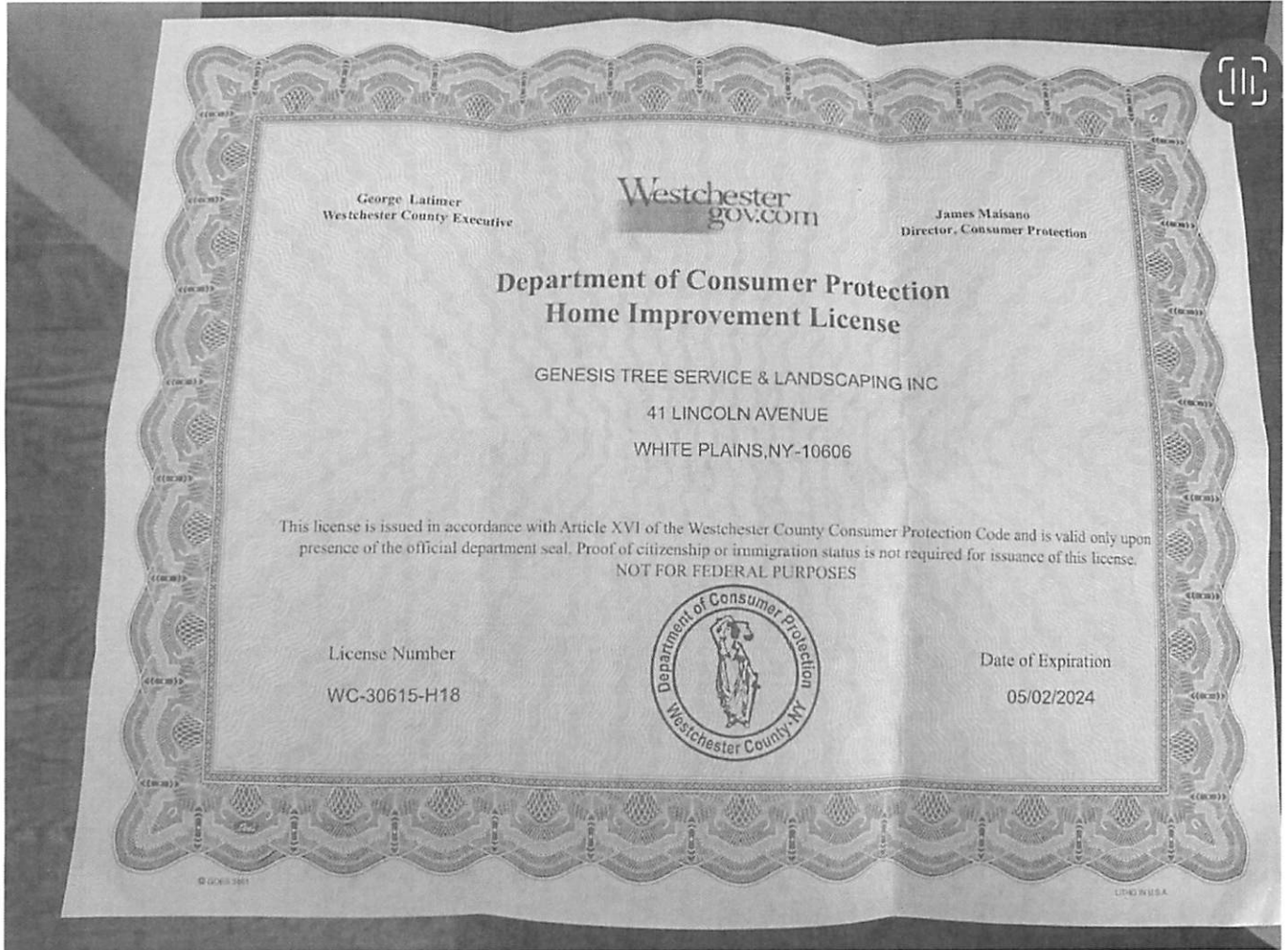
I hereby acknowledge that it is my responsibility as the property owner to ensure that if the permit (if issued) receives a Final Certificate of Approval from the Building Department and further that if a Final Certificate of Approval is not obtained upon completion of the construction, a property violation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

Sworn to before me this 2nd day of June of 2022


Notary Public/ Commission of Deeds


PROPERTY OWNER's SIGNATURE

ELIZABETH A. DREAPER
Notary Public, State of New York
No: 01DR6177050
Qualified In Westchester County
Commission Expires November 5, 2023





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

<p>1a. Legal Name & Address of Insured (use street address only) GENESIS TREE SERVICE & LANDSCAPING INC. 41 LINCOLN AVENUE WHITE PLAINS, NY 10606</p> <p>Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e., Wrap-Up Policy)</p>	<p>1b. Business Telephone Number of Insured 914-830-1675</p> <p>1c. Federal Employer Identification Number of Insured or Social Security Number 262087997</p>
<p>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</p>	<p>3a. Name of Insurance Carrier ShelterPoint Life Insurance Company</p> <p>3b. Policy Number of Entity Listed in Box "1a" DBL634254</p> <p>3c. Policy effective period 03/01/2022 to 02/28/2023</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 5/18/2022 By Richard White
(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.

DB-120.1 (12-21)



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 NYS Disability and Paid Family Leave Benefits Law. The insurance carrier or its licensed agent will send this Certificate of Insurance Coverage (Certificate) to the entity listed 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 cancelled due to nonpayment of premiums or within 30 days if there are reasons other than nonpayment of premiums that caused the notice or eliminate the insured from insurance indicated on this Certificate. (These notices may

3:22



Genesis WC.pdf



Workers' Compensation Board		CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE	
1a. Legal Name & Address of Insured (use street address only) GENESIS TREE SERVICE & LANDSCAPING INC. 41 LINCOLN AVE. WHITE PLAINS, NY 10606 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) 830-1675 1c. NYS Unemployment Insurance Employer Registration Number of Insured 1d. Federal Employer Identification Number of Insured or Social Security Number 242087997	
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 Farm Family Casualty Ins Co 3b. Policy Number of Entity Listed in Box "1a" 7103099145 3c. Policy effective period 06/17/22 to 06/17/23 3d. The Proprietor, Partners or Executive Officers are <input type="checkbox"/> included (Only check box if all partners/officers are included) <input checked="" 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 box 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 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 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: CHRISTOPHER TARR
(Print name of authorized representative or licensed agent of insurance carrier)

Approved by: *Christopher Tarr* 05/18/22
Signature Date

For: AGENT

Telephone Number of authorized representative or licensed agent of insurance carrier: 845-738-6801

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.

C-105.2 (8-17) www.wcb.ny.gov

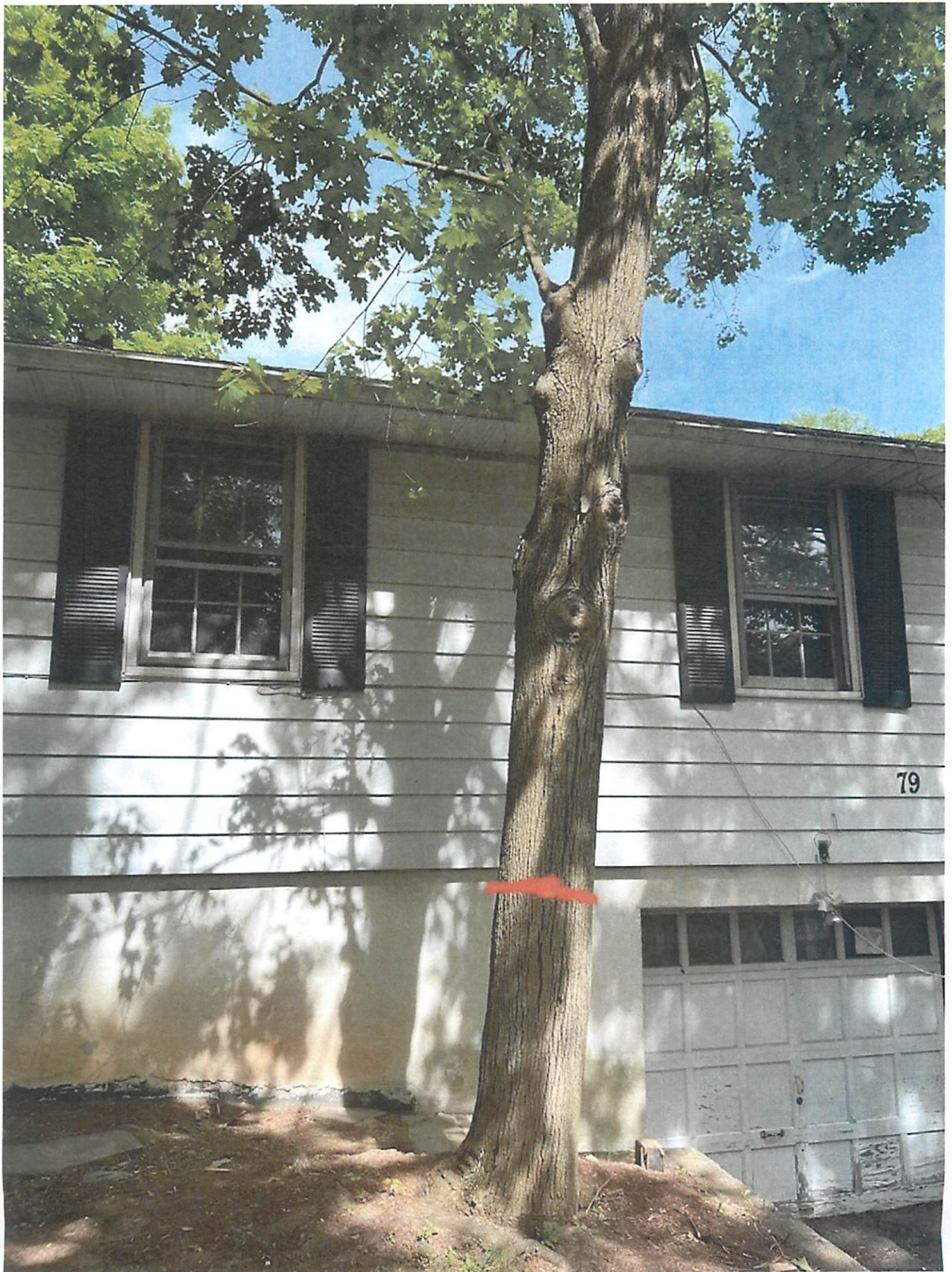
Workers' Compensation Law

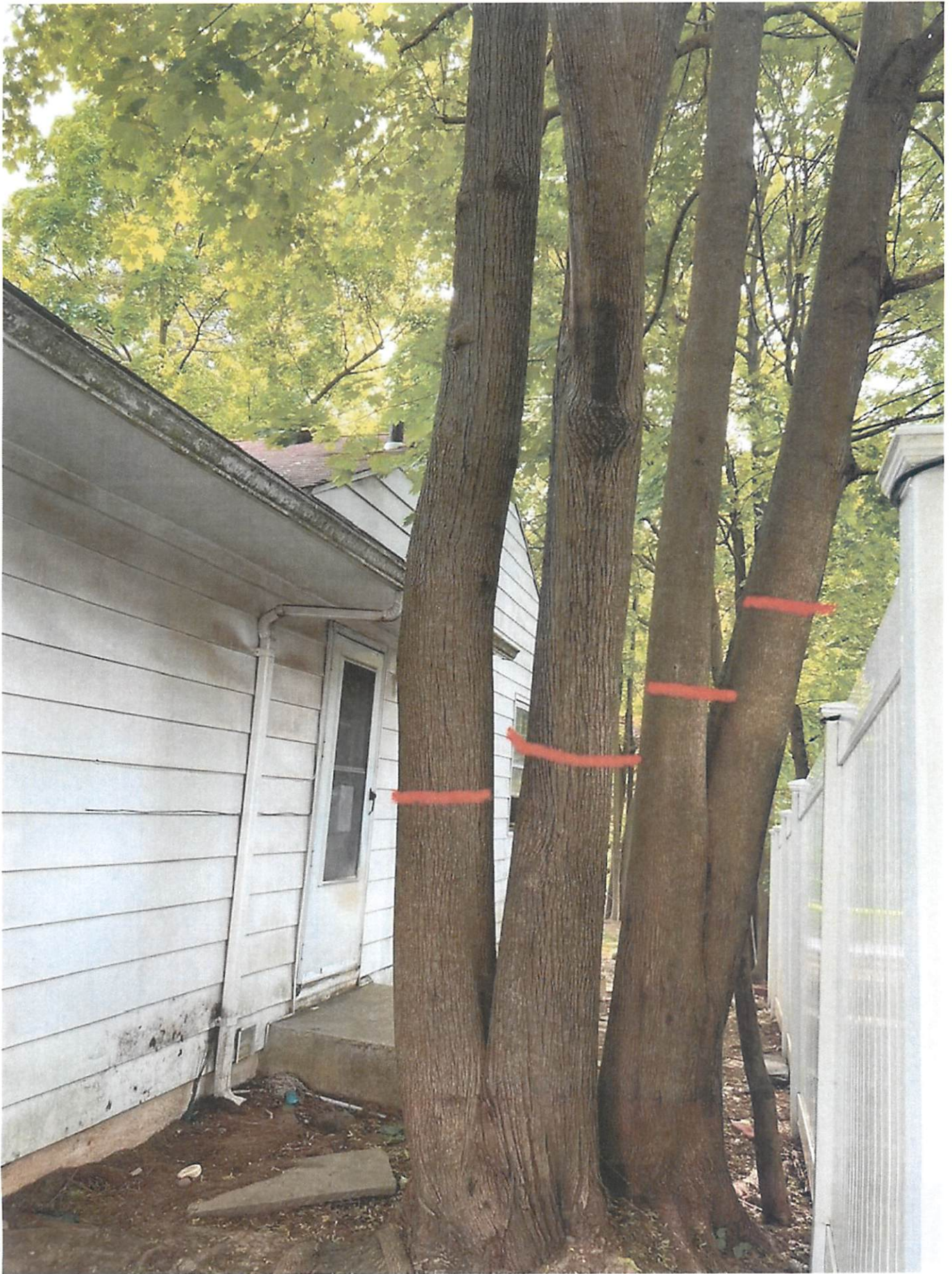
Section 57. Restriction on issue of permits and the entering into contracts unless compensation is secured.

1. The head of a state or municipal department, board, commission or office authorized or required by law to issue any permit for or in connection with any work involving the employment of employees in a hazardous employment defined by this chapter, and notwithstanding any general or special statute requiring or authorizing the issue of such permits, shall not issue such permit unless proof duly subscribed by an insurance carrier is produced in a form satisfactory to the chair, that compensation for all employees has been secured as provided by this chapter. Nothing herein, however, shall be construed as creating any liability on the part of such state or municipal department, board, commission or office to pay any compensation to any such employee if so employed.
2. The head of a state or municipal department, board, commission or office authorized or required by law to enter into any contract for or in connection with any work involving the employment of employees in a hazardous employment defined by this chapter, notwithstanding any general or special statute requiring or authorizing any such contract, shall not enter into any such contract unless proof duly subscribed by an insurance carrier is produced in a form satisfactory to the chair, that compensation for all employees has been secured as provided by this chapter.











Genesis Tree Service and Landscaping Inc.

41 Lincoln Ave.

White Plains, NY

United States

10606

Invoice

BILL TO:

Rosaura (Kika) Bollengier

79 Ogden Ave. *DOBBS FERRY*
~~White Plains, NY~~
United States
10605

INVOICE #

00000002

DATE

6/02/20

ITEMS	DESCRIPTION	QUANTITY
ITEM 1	Remove 2 Norway Maple - left side, backyard closer to the house - 12" and 11"	1
ITEM 2	Remove 3 Norway Maple - Left side, backyard closer to the street - 9", 12", 14"	1
ITEM 3	Remove 1 Norway Maple - Right side, backyard - 13"	1
ITEM 4	Remove 3 Norway Maple - Right side yard - 12", 14", 9"	1
ITEM 5	All trees growing over/leaning over the home. Trunk decay.	1

NOTES:

Scope of the work

TOTAL: \$--

\$--

77

est



79 Ogden Ave

83

Ogden