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 AT2023-0070 **Date** 07/31/2023

Job Location 4 SHADY LN **Lot #** 3.100-85-12

Owner: JENNIFER BOYDO'MEARA
4 SHADY LN
DOBBS FERRY, NY 10522
917-992-5028

Applicant: Robert Moscarello
531 Fayette Avenue
Mamaroneck, New York 10543
914 777-1399 rmoscarello@savatree.com

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

Description of Work: 22" cedar tree right side against house - Takedown and remove.

Form Questions:

Application Parcel Owner Contact:

Parcel Owner Email	Ryan O'Meara
Parcel Owner Phone	6466707479

Job Location: ~~44~~ 4 SHADY LN Parcel Id: 3.100-72-7

AFFIDAVIT OF APPLICANT

I Robert Moscare 110 being duly sworn, depose and says: That s/he does business as: SAVATREE, INC. with offices at: 531 FAYETTE AVENUE MAMARONECK NY 10543 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 26 day of July of 2023

Notary Public / Commission of Deeds

Applicant's Signature

TAMECA RANGEA KOFELE
NOTARY PUBLIC-STATE OF NEW YORK
No. 01KO6431948
Qualified in Bronx County
My Commission Expires 04-18-2026

PROPERTY OWNER'S AUTHORIZATION

I RYAN O'MEARA 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 6466707479. Owner email address Ryan O'Meara RYANOMEARA123@GMAIL.COM

RYAN O'MEARA 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 26 day of July of 2023

Notary Public / Commission of Deeds

PROPERTY OWNER's SIGNATURE

TAMECA RANGEA KOFELE
NOTARY PUBLIC-STATE OF NEW YORK
No. 01KO6431948
Qualified in Bronx County
My Commission Expires 04-18-2026

George Latimer
Westchester County Executive

Westchester gov.com

James Maisano
Director, Consumer Protection

Department of Consumer Protection
Home Improvement License

SAVATREE, LLC

550 BEDFORD ROAD

BEDFORD HILLS,NY-10507

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-30682-H18

Department of Consumer Protection
Westchester County-NY

Date of Expiration

05/21/2024

Client#: 1693739 SAVATLLC

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 07/31/2023

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 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 any rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME: Michael Scarcello	
USI Insurance Services LLC 726 Exchange St., Suite 618 Buffalo, NY 14210 716-314-2000	PHONE (A/C, No, Ext): 716-314-2082	FAX (A/C, No): 610-362-8107
	E-MAIL ADDRESS: michael.scarcello@usi.com	

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Zurich American Insurance Company	16535
INSURER B : American Guarantee & Liability Ins Co.	26247
INSURER C : Hanover Insurance Company	22292
INSURER D : Great American Insurance Company	16691
INSURER E : Lloyd's of London / Convex Insurance UK	1128791
INSURER F :	

INSURED
SavATree, LLC and all related DBA's
550 Bedford Road
Bedford Hills, NY 10507

COVERAGES **CERTIFICATE NUMBER: 40992960** **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	
A	X COMMERCIAL GENERAL LIABILITY	X	X	GLO0381388	07/01/2023	07/01/2024	EACH OCCURRENCE	$2,000,000
	CLAIMS-MADE X OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$1,000,000
	X XCU Included						MED EXP (Any one person)	$10,000
	X Contractual Liab						PERSONAL & ADV INJURY	$2,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$4,000,000
	POLICY X PRO-JECT X LOC						PRODUCTS - COMP/OP AGG	$4,000,000
	OTHER:							$
A	AUTOMOBILE LIABILITY	X	X	BAP0381389	07/01/2023	07/01/2024	COMBINED SINGLE LIMIT (Ea accident)	$2,000,000
	X ANY AUTO						BODILY INJURY (Per person)	$
	OWNED AUTOS ONLY / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	X HIRED AUTOS ONLY / X NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
E	X $250 Comp Ded X $500 Coll Ded	X	X	UC2202906	07/01/2023	07/01/2024	Excess Auto	$3,000,000
B	X UMBRELLA LIAB X OCCUR	X	X	AUC0178816	07/01/2023	07/01/2024	EACH OCCURRENCE	$15,000,000
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	$15,000,000
	DED X RETENTION $10,000							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N		X	WC0381387	07/01/2023	07/01/2024	X PER STATUTE / OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N (Mandatory in NH)	N/A					E.L. EACH ACCIDENT	$1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$1,000,000
							E.L. DISEASE - POLICY LIMIT	$1,000,000
C	Contractors Equip			RHSH654746	07/01/2023	07/01/2024	Leased/Rented $250,000	
D	Pollution Liab			PCM488481614	11/01/2022	11/01/2023	$10M Each Occ/Agg	
D	Professional Liab			PCM488481614	11/01/2022	11/01/2023	$10M Per Claim/Agg	

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

Please see additional pages for endorsements and project specific information.

To the extent covered by endorsement form(s):

General Liability:
(See Attached Descriptions)

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)

SAVATREE, LLC
631A PENNS PARK RD
NEWTON, PA 18940

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

914 864 3111

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

133257374

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

First Unum Life Insurance Company

3b. Policy Number of Entity Listed in Box "1a"

713699

3c. Policy effective period

08/03/2023 to 08/03/2024

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 8/3/2023 By Allison Randall

(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number 1-800-ASK-UNUM Name and Title Allison Randall, DBL Specialist

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) SavATree, LLC and all related DBA's 550 Bedford Road Bedford Hills NY 10507 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 1c. NYS Unemployment Insurance Employer Registration Number of Insured 19-407192 1d. Federal Employer Identification Number of Insured or Social Security Number
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 Zurich American Insurance 3b. Policy Number of Entity Listed in Box "1a" WC 0381387 3c. Policy effective period 7/1/2023 to 7/1/2024 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: Michael Bonetto
(Print name of authorized representative or licensed agent of insurance carrier)

Approved by: _____ 7/1/2023
(Signature) (Date)

Title: _____

Telephone Number of authorized representative or licensed agent of insurance carrier: _____

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 (9-17) www.wcb.ny.gov