

# TOWN OF NORTH CASTLE

WESTCHESTER COUNTY  
17 Bedford Road  
Armonk, New York 10504-1898

RESIDENTIAL PROJECT  
REVIEW COMMITTEE  
Adam R. Kaufman AICP, Chair

Telephone: (914) 273-3000 x 43  
Fax: (914) 273-3554  
www.nortcastleny.com

## RESIDENTIAL PROJECT REVIEW COMMITTEE (RPRC) APPLICATION

### Section I- PROJECT

ADDRESS: 1 The Knoll Armonk NY 10504

### Section III- DESCRIPTION OF WORK:

(2) Stone & concrete pillars 3'x6'H with light posts on top set back on either side of our driveway. (picture attached)  
Approx. 220 ft of pressure treated wood fence along the front of of our property set back from street. (picture attached). Natural wood

### Section III- CONTACT INFORMATION:

APPLICANT: Courtney and Russell Blaymore  
ADDRESS: 1 The Knoll Armonk NY 10504  
PHONE: 610 360 8021 MOBILE: 631 804 4418 EMAIL: courtneyblaymore@gmail.com  
blaymore27@gmail.com

PROPERTY OWNER: Courtney and Russell Blaymore  
ADDRESS: 1 The Knoll Armonk NY 10504  
PHONE: 610 360 8021 MOBILE: 631 804 4418 EMAIL: courtneyblaymore@gmail.com  
blaymore27@gmail.com

PROFESSIONAL: Colony Fence Company  
ADDRESS: 744 Hartsdale Rd White Plains NY 10607  
PHONE: 914-497-3442 MOBILE: \_\_\_\_\_  
EMAIL: colonyfence@gmail.com

### Section IV- PROPERTY INFORMATION:

Zone: \_\_\_\_\_ Tax ID (lot designation) \_\_\_\_\_

Surveyed in accordance with existing Code of Practice for Land Surveyors, as adopted by the New York State Board of Professional Land Surveyors, Inc.

Only copies from the original of this survey made with an original of the Land Surveyors combined shall be considered to be true, valid copies.

Land and water shall flow into the person for whom this survey is made, and the person for whom this survey is made shall be responsible for all existing and future encroachments, easements and other matters not shown on this survey, and shall be responsible for all existing and future encroachments, easements and other matters not shown on this survey.

Encumbrances shown on this survey are shown as they appear on the records of the County of Albany, New York, and are not intended to constitute a warranty of title, but are shown for informational purposes only.

Permittees only where indicated.

The location of underground utilities are not shown or verified.

Subject to easements, encroachments, points from, conditions and agreements of record.

Previous surveys being dependent on the Town of Albany, County of Albany, Map of the Survey of 1851, 1852 & 1853.

Surveyed in accordance with Labor Law, Part 209.

Topography shown thereon not true, but as shown.

**TOPOGRAPHICAL SURVEY OF PROPERTY PREPARED FOR DOUG MILLETT**  
 SITUATED IN THE TOWN OF ALBANY, COUNTY OF ALBANY, NEW YORK

SCALE: P = 39  
 GRAPHIC SCALE  
 1 inch = 39 feet  
 1 inch = 30 feet

Project No.	1005
Sheet No.	1 of 1
Date	08/15/11
Drawn by	MM
Checked by	MM



**PRESSURE TREATED WOOD FENCE**

**3' x 6' STONE PILARS**



**THOMAS C. MERRITTS LAND SURVEYORS, P.C.**  
 39 BEDFORD ROAD • PLEASANTVILLE • NY 10570  
 (914) 769-8001 • (914) 273-1663

Project: Survey of Property  
 Date: 08/15/11  
 Sheet: 1 of 1  
 Drawn by: MM  
 Checked by: MM

(no subject)

1 message

Courtney Blaymore <courtneyblaymore@gmail.com>  
To: courtneyblaymore@gmail.com

Mon, Apr 26, 2021 at 1:09 PM

6:58 ↵



Chappaqua  
Today 1:03 PM

Edit

📷 LIVE

pressure treated wood  
Fence in this style + color





(2) Stone pillars

Stone + concrete

3' x 6' H

light post on top.

RUBEN F. COLONIA  
**COLONY FENCE COMPANY INC.**

744 Hartsdale Road, White Plains, NY 10607

Phone: (914) 497-3442

Fax: (914) 468-1229

email: colonyfence@gmail.com



DATE 04/14/2021

INV. # \_\_\_\_\_

We propose to furnish and to install on your property a custom fence in accordance with sketch and quantities listed below.

NAME	<u>Courtney Blaymore</u>
ADDRESS	<u>1 The Knoll</u>
CITY	<u>Armonk</u>
STATE	<u>N.Y.</u>
HOME PHONE	ZIP
BUS/CELL PHONE	<u>610-360-8021</u>
EMAIL	<u>Courtney blaymore@gmail.com</u>

NOTES

QUANTITY	SKETCH
<u>2,20'</u>	
<u>of Wood Fence as showed</u>	
<u>on Picture From Client</u>	
<u>using Pressure Treated</u>	
<u>Wood on 4x4 Aca Post</u>	
<u>3 Rails + BRACE</u>	
	<u>\$5950.00</u>

**SPECIAL INSTRUCTIONS:**

- Posts to be embedded in concrete at least 2 1/2 feet deep.
- Take down and cart away old fence is included.

**DIRECTIONS:**  
 You, the buyer, may cancel this transaction at any time prior to midnight of the third business day after the date of this transaction. See the attached notice of cancellation form for an explanation of this right.

All quotations subject to conditions beyond our control. Customer is responsible to establish property lines. This quotation does not include cost of drilling in underlying rock or foundations, or clearing trees, brush or other obstructions from working area. This contract embodies the entire understanding between the parties, and there are no verbal agreements or representations in connection herewith.

COLONY FENCE COMPANY	SUBTOTAL _____
BY: <u>Jorge Lora 425-524-1277</u>	TAX _____
PURCHASER	TOTAL _____
* Sign to accept quote	50% DOWN PAYMENT _____
	50% BALANCE _____

TERMS: Balance is due upon completion of job - after customer's inspection and approval.

George Latimer  
Westchester County Executive

Westchester  
gov.com

James Mulsano  
Director, Consumer Protection

## Department of Consumer Protection Home Improvement License

COLONY FENCE COMPANY, INC  
744 HARTSDALE ROAD  
WHITE PLAINS, NY-10607

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-32913-H20

Date of Expiration  
07/02/2022





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)
COLONY FENCE COMPANY INC
744 WEST HARTSDALE ROAD
WHITE PLAINS, NY 10607
1b. Business Telephone Number of Insured
914-497-3442
1c. Federal Employer Identification Number of Insured or Social Security Number
454912167
2. Name and Address of Entity Requesting Proof of Coverage
Town of North Castle
15 Bedford Rd
Armonk, NY 10504
3a. Name of Insurance Carrier
ShelterPoint Life Insurance Company
3b. Policy Number of Entity Listed in Box "1a"
DBL633288
3c. Policy effective period
02/23/2021 to 02/22/2022

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 4/22/2021 By [Signature]
(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

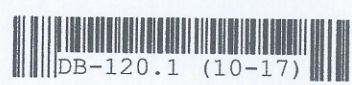
Telephone Number 516-829-8100 Name and Title Richard White, Chief Executive Officer

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.





**Workers' Compensation Board**

**CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE**

**Insured Detail**

<p><b>1a. Legal Name and address of Insured (Use street address only)</b>                  Colony Fence Company Inc                  744 Hartsdale Road                  White Plains, NY 10607</p> <p>Work Location of Insured (Only required if coverage is specifically limited to certain location in New York State, i.e. a Wrap-Up Policy)</p>	<p><b>1b. Business Telephone Number of Insured</b>                  845-279-5151</p> <p><b>1c. NYS Unemployment Insurance Employer Registration Number of Insured</b></p> <p><b>1d. Federal Employer Identification Number of Insured or Social Security Number</b>                  454912167</p>
<p><b>2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)</b>                  Town of North Castle                  15 Bedford Rd                  Armonk, NY 10504</p>	<p><b>3a. Name of Insurance Carrier</b>                  AmTrust Insurance Company</p> <p><b>3b. Policy Number of entity listed in box "1a":</b>                  KWC1246469</p> <p><b>3c. Policy effective period:</b>                  4/1/2021 to 4/1/2022</p> <p><b>3d. The Proprietor, Partners or Executive Officers are:</b></p> <p><input type="checkbox"/> included (Only check box if all partners/officers included)</p> <p><input checked="" type="checkbox"/> all excluded or certain partners/officers excluded</p>

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: Henry C. Sibley  
 (Print name of authorized representative or licensed agent of insurance carrier)

Approved By:  4/22/2021  
 (Signature) (Date)

Title: Underwriting Manager

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

Please Note: Only insurance carriers and their licensed agents are authorized to issue the C-105.2 form. Insurance brokers are NOT authorized to issue it.



C-105.2 (9-17)

www.wcb.ny.gov

**Workers' Compensation Law****Section 57. Restriction on issue of permits and the entering 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.**

C-105.2 (9-17) REVERSE



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
4/22/2021

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. 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).

<b>PRODUCER</b> World Insurance Associates, LLC 3 Starr Ridge Rd Ste 100 Brewster, NY 10509	<b>CONTACT NAME:</b>	
	<b>PHONE (A/C, No, Ext):</b> (845) 279-5151	<b>FAX (A/C, No):</b>
	<b>E-MAIL ADDRESS:</b>	
	<b>INSURER(S) AFFORDING COVERAGE</b>	
	<b>INSURER A:</b> Selective Insurance Co of South Carolina	<b>NAIC #</b> 19259
	<b>INSURER B:</b> Amtrust Insurance Company of Kansas Inc.	<b>15954</b>
<b>INSURED</b>  Colony Fence Company Inc. 744 West Hartsdale Rd White Plains, NY 10607	<b>INSURER C:</b>	
	<b>INSURER D:</b>	
	<b>INSURER E:</b>	
	<b>INSURER F:</b>	

**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	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR  GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:	X		S 2440908-00	2/1/2021	2/1/2022	EACH OCCURRENCE	\$ 2,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	\$ 500,000
							MED EXP (Any one person)	\$ 10,000
							PERSONAL & ADV INJURY	\$ 2,000,000
							GENERAL AGGREGATE	\$ 4,000,000
							PRODUCTS - COM/OP AGG	\$ 4,000,000
A	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY			S 2440908-00	2/1/2021	2/1/2022	COMBINED SINGLE LIMIT (Ea accident)	\$ 1,000,000
							BODILY INJURY (Per person)	\$
							BODILY INJURY (Per accident)	\$
							PROPERTY DAMAGE (Per accident)	\$
A	<input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED <input checked="" type="checkbox"/> RETENTION \$ 10,000			S 2440908-00	2/1/2021	2/1/2022	EACH OCCURRENCE	\$ 2,000,000
							AGGREGATE	\$ 2,000,000
B	<input type="checkbox"/> WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NY) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N N	N/A	KWC1246469	4/1/2021	4/1/2022	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER	
							E.L. EACH ACCIDENT	\$ 500,000
							E.L. DISEASE - EA EMPLOYEE	\$ 500,000
							E.L. DISEASE - POLICY LIMIT	\$ 500,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)  
Town of North Castle is named as Additional Insured where required by written contract or agreement subject to the terms and conditions of the policy

**CERTIFICATE HOLDER**

Town of North Castle  
15 Bedford Rd  
Armonk, NY 10504

**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  
*Jeffrey P. Delle*