

LOEWKE BRILL

C O N S U L T I N G G R O U P , I N C

Project # - 20-002

Project Name – GAM Property Corp

Inspections Dates/Compliance:

- 6/30/20 – 100%
- 7/28/20 – 100%
- 8/06/20 -100%
- 9/29/20 – 100%
- 10/27/20 – 100%
- 11/24/20 – 100%
- 12/15/20 – 100%
- 1/28/21 – 100%
- 2/04/21 – 86%
- 3/04/21 – 70%
- 4/01/21 – 92%
- 5/10/21 – 100%
- 6/08/21- 100%
- 7/15/21 – 100%
- 8/03/21- 100%
- 9/07/21 – No Activity
- 10/28/21 – 100%
- 11/08/21 – 100%
- 12/23/21 – 100%
- 1/06/22 – 100%

Total Worker Days Combined (6/26/20-1/21/22): 3,008

Weekly Out of Area Totals Combined (6/26/20-1/21/22): 53

Total Compliance: 98%

Waivers: 1

- MD Drilling & Blasting Inc

Conditional Certificate of Occupancy Issue Date: 12/23/21

Summary:

The project met all labor goals with all contractors achieving at least 85% local labor.

VILLAGE OF GOSHEN
ORANGE COUNTY
276 MAIN STREET
GOSHEN, NY 10924

(845) 294-8881

BUILDING DEPARTMENT
- CONDITIONAL -

CERTIFICATE OF OCCUPANCY

Building Permit No: 4836

Location: 3 POLICE DRIVE, GOSHEN, NY 10924

Sec-Blk-Lot: 122-1-11

CO No: 4836

CO Date: 12/23/2021

THIS CERTIFIES that the structure described herein, conforms substantially to the approved plans and specifications heretofore filed in this office with Application for Building Permit dated: 10/07/2020, pursuant to which Building Permit was issued.

The structure for which this certificate is issued is as follows:

WAREHOUSE ADDITION -- 68,600 SQUARE FEET

Remarks: VILLAGE OF GOSHEN PLANNING BOARD APPROVAL
GRANTED JUNE 16, 2020

This certificate is issued to: GAM PROPERTIES, 3 POLICE DRIVE,
or the aforesaid structure. GOSHEN, NY 10924

THIS CONDITIONAL CERTIFICATE
OF OCCUPANCY SHALL EXPIRE 6/30/22


THEODORE L. LEWIS, III
Building Inspector

(The Certificate of Occupancy will be issued only after affidavits or other competent evidence is submitted to the Building Inspector's Office that the completion of the construction in compliance with the State Uniform Fire Prevention and Building Code and with other laws, ordinances or regulations affecting the premises, and in conformity with the approved plans and specifications. A final electrical, plumbing, heating or sanitation certificate or other evidence of compliance may be required before the issuance of the Certificate of Occupancy).

cc: B.I. file
Violations file
Assessor
C.O.C. file



Empowering Businesses. Inspiring Growth.

APPLICATION FOR FINANCIAL ASSISTANCE

GAM Property Corp./King Zak Industries, Inc./3PD Transport

(Applicant Name)

August 28, 2018 Updated September 10, 2018

(Date of Application)

**Robert T. Armistead
Chairman**

Orange County Business Accelerator
4 Crotty Lane, Suite 100
New Windsor, NY 12553

Phone: 845-234-4192 Fax: 845-220-2228

www.ocnyida.com

business@ocnyida.com

Updated June 1, 2018

**ORANGE COUNTY
INDUSTRIAL DEVELOPMENT AGENCY**

APPLICATION FOR FINANCIAL ASSISTANCE

I. APPLICANT INFORMATION

Company Name: GAM Property Corp.
Mailing Address: 3 Police Drive, PO Box 1029, Goshen, NY 10924
Phone No.: 845-291-1200
Fax No.: _____
Fed Id. No.: 06-1238589
Contact Person: Herb Zakarin
Title: President
Contact Phone No.: 845-291-1200
Contact Email: hzakarin@kingzak.com

IDA Management must be able to reach the Applicant's Contact throughout the duration of the Agreement. Should this information change at any time IDA Management should be notified immediately. Please initial stating you understand and consent to the above JK

APPLICANT'S COUNSEL

Name: Isidor Friedenber
Address: 2 Cara Drive, Suffern, NY 10901
Phone No.: 845-362-0123
Fax No.: 845-362-0168
Counsel Email: sbenar@aol.com

IDA Management must be able to reach the Applicant's Counsel throughout the duration of the Agreement. Should this information change at any time IDA Management should be notified immediately. Please initial stating you understand and consent to the above JK

APPLICANT'S AUDIT CONTACT

Name: Michael Waschitz
Address: 3 Hatfield Lane, Suite 2C, Goshen, NY 10924
Phone No.: (845) 782-0013 x645
Fax No.: (845) 360-5352
Contact Email: mikew@wpcpany.com

The IDA submits a mandatory annual PARIS report to the state that requires information from each project. Applicant participation is not optional, and all information must be submitted in a complete and timely manner. Please initial stating you understand and consent to the above

APPLICANT'S GENERAL CONTRACTOR/CONSTRUCTION MANAGER

Name/Contact: Steve Esposito
Address: 262 Greenwich Avenue, Suite B, Goshen, NY 10924
Phone No.: 845-294-0558
Fax No.: 845-294-0580
Email: eanda@espositoandassociates.net

Principal Owners/Officers/Directors (list owners with 15% or more in equity holdings with percentage ownership):

Corporate Structure (*attach schematic if applicant is a subsidiary or otherwise affiliated with another entity*)

Form of Entity

Corporation

Date of Incorporation: May 15, 1997
State of Incorporation: New York

Partnership

General _____ or Limited _____
Number of general partners _____
If applicable, number of limited partners _____
Date of formation _____

Jurisdiction of Formation _____

Limited Liability Company/Partnership (number of members _____)

Date of organization: _____

State of Organization: _____

Sole Proprietorship

If a foreign organization, is the applicant authorized to do business in the State of New York?

If any of the above persons, or a group of them, owns more than a 50% interest in the company, list all other organizations which are related to the company by such persons having more than a 50% interest in such organizations.

Is the company related to any other organization by reason of more than 50% common ownership? If so, indicate name of related organization and relationship.

Has the company (or any related corporation or person) made a public offering or private placement of its stock within the last year? If so, please provide offering statement used.

II. PROJECT INFORMATION

A) Project Address: 3 Police Drive, Goshen

Tax Map Number 122-1-11
(Section/Block/Lot)

Located in City of _____

Located in Town of _____

Located in Village of Goshen

School District of Goshen

B) Are utilities on site?

Water Yes

Electric Yes

Gas Yes

Sanitary/Storm Sewer Yes

C) Present legal owner of the site GAM Property Corp
If other than from applicant, by what means will the site be acquired for this project? N/A

D) Zoning of Project Site: Current: IP Proposed: IP

E) Are any variances needed? All variances are approved

F) Furnish a copy of any environmental application presently in process of completion concerning this project, providing name and address of the agency, and copy all pending or completed documentation and determinations.

G) Statement describing project (i.e. land acquisition, construction of manufacturing facility, etc.):

A proposed 70,000 sf extension to an existing 130,000 sf distribution center.

**Please attach narrative if space provided is not sufficient.

H) Anticipated Date of Operation: October 1, 2019

I) Principal use of project upon completion:

- | | | | |
|--|---|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> manufacturing | <input checked="" type="checkbox"/> warehousing | <input type="checkbox"/> research | <input type="checkbox"/> offices |
| <input type="checkbox"/> industrial | <input type="checkbox"/> recreation | <input type="checkbox"/> retail | <input type="checkbox"/> residential |
| <input type="checkbox"/> training | <input type="checkbox"/> data process | <input type="checkbox"/> other | |

If other, explain: _____

J) Estimated Project Costs, including:

Value of property to be acquired: \$ N/A

Value of improvements: \$ 5,000,000.00

Value of equipment to be purchased: \$ 2,000,000.00

Estimated cost of engineering/architectural services: \$ 325,000.00

Other: \$ 35,350.00

Total Capital Costs: \$ 7,360,350.00

Project refinancing; estimated amount
(for refinancing of existing debt only) \$ 6,363,000.00

Sources of Funds for Project Costs:

Bank Financing: \$ 7,000,000.00

Equity (excluding equity that is attributed to grants/tax credits) \$ 0

Tax Exempt Bond Issuance (if applicable) \$ 0

Taxable Bond Issuance (if applicable) \$ 0

Public Sources (Include sum total of all state and federal grants and tax credits) \$ 0

Identify each state and federal grant/credit:

| | |
|---|----------|
| _____ | \$ _____ |
| _____ | \$ _____ |
| _____ | \$ _____ |
| _____ | \$ _____ |
| Total Sources of Funds for Project Costs: | \$ _____ |

K) Inter-Municipal Move Determination

Will the project result in the removal of a plant or facility of the applicant from one area of the State of New York to another?

Yes or No

Will the project result in the removal of a plant or facility of another proposed occupant of the project from one area of the State of New York to another area of the State of New York?

Yes or No

Will the project result in the abandonment of one or more plants or facilities located in the State of New York?

Yes or No

If Yes to any of the questions above, explain how, notwithstanding the aforementioned closing or activity reduction, the Agency's Financial Assistance is required to prevent the Project from relocating out of the State, or is reasonably necessary to preserve the Project occupant's competitive position in its respective industry:

Project Data

1. Project site (land)

(a) Indicate approximate size (in acres or square feet) of project site.

12.52 acres _____

(b) Are there buildings now on the project site? Yes No

(c) Indicate the present use of the project site.

Existing 130,000 sf distribution center, offices, sales and showroom. _____

(d) Indicate relationship to present user of project.

King Zak Industries, Inc. is a tenant of the existing facility which is owned by GAM Property Corp.

2. Does the project involve acquisition of an existing building or buildings? If yes, indicate number, size and approximate age of buildings:

No

3. Does the project consist of the construction of a new building or buildings? If yes, indicate number and size of new buildings:

No

4. Does the project consist of additions and/or renovations to existing buildings? If yes, indicate nature of expansion and/or renovation:

Project includes 70,000 sf addition including 6 additional loading docks,

acquisition of racking, and site improvements.

5. Estimated Start Date of Construction: March 2019

6. Estimated End Date of Construction: October 2019

7. What will the building or buildings to be acquired, constructed or expanded be used for by the company? (Include description of products to be manufactured, assembled or processed, and services to be rendered. . . .)

Warehousing & distribution of party/paper products to retailers in the metropolitan area.

. . . including the percentage of building(s) to be used for office space and an estimate of the percentage of the functions to be performed at such office not related to the day-to-day operations of the facilities being financed.)

The proposed expansion does not include any additional office space. Current

office space will be adequate to support the proposed expansion.

8. If any space in the project is to be leased to third parties, indicate total square footage of the project amount to be leased to each tenant and proposed use by each tenant.

N/A

9. List principal items or categories of equipment to be acquired as part of the project.

Racking, forklift, forklift charging station, surveillance equipment, packaging

equipment.

10. Has construction work on this project begun?

Complete the following

| | | | |
|----------------------------|-----------|-----------------|------------------|
| (a) site clearance | _____ Yes | <u> X </u> No | _____ % complete |
| (b) foundation | _____ Yes | <u> X </u> No | _____ % complete |
| (c) footings | _____ Yes | <u> X </u> No | _____ % complete |
| (d) steel | _____ Yes | <u> X </u> No | _____ % complete |
| (e) masonry work | _____ Yes | <u> X </u> No | _____ % complete |
| (f) other (describe below) | _____ Yes | <u> X </u> No | _____ % complete |

III. FINANCIAL ASSISTANCE REQUESTED

A) Benefits Requested:

Sales Tax Exemption Industrial Revenue Bond
 Mortgage Recording Tax Exemption Real Property Tax Agreement

B.) Value of Incentives:

IDA PILOT Benefit: Agency staff will indicate the amount of PILOT Benefit based on estimated Project Costs as contained herein and anticipated tax rates and assessed valuation, including the annual PILOT Benefit abatement amount for each year of the PILOT benefit year and the sum total of PILOT Benefit abatement amount for the term of the PILOT as depicted under the heading "Real Property Tax Benefit (Detailed)" of the Application.

Estimated duration of Property Tax exemption: 10 years

Sales and Use Tax:

Estimated value of Sales Tax exemption for facility construction: \$ 138,000.00

Estimated Sales Tax exemption for fixtures and equipment: \$ 162,500.00

Estimated duration of Sales Tax exemption: 18 months

Mortgage Recording Tax Exemption Benefit:

Estimated value of Mortgage: \$ 7,000,000.00

Estimated value of Mortgage Recording Tax exemption: \$ 73,500.00

Industrial Revenue Bond Benefit:

IRB inducement amount, if requested: \$ N/A

Is a purchaser for the Bonds in place?

Yes or No

Percentage of Project Costs financed from Public Sector sources:

Agency staff will calculate the percentage of Project Costs financed from Public Sector sources based upon Sources of Funds for Project Costs as depicted above under the heading "Estimated Project Costs" (Section II(I)) of the Application.

C.) Likelihood of Undertaking Project without Receiving Financial Assistance

Please confirm by checking the box below, if there is a likelihood that the Project will still be undertaken if Financial Assistance is not provided by the Agency?

Yes or No

If the Project could be undertaken without Financial Assistance provided by the Agency, then provide a statement in the space provided below indicating why the Project should be undertaken by the Agency:

N/A

IV. EMPLOYMENT PLAN

| | Current # of jobs at proposed project location or to be relocated to project location | IF FINANCIAL ASSISTANCE IS GRANTED – project the number of FTE and PTE jobs to be RETAINED | IF FINANCIAL ASSISTANCE IS GRANTED – project the number of FTE and PTE jobs to be CREATED upon THREE Years after Project completion | Estimate number of residents of the Labor Market Area in which the Project is located that will fill the FTE and PTE jobs to be created upon THREE Years after Project Completion ** |
|-----------------|---|--|---|--|
| Full time (FTE) | 65 | 90 | 25 | 25 |
| Part Time (PTE) | N/A | N/A | | |
| Total | 65 | 90 | 25 | 25 |

** For purposes of this question, please estimate the number of FTE and PTE jobs that will be filled, as indicated in the third column, by residents of the Labor Market Area, in the fourth column. The Labor Market Area includes Orange County and the surrounding region (or six other contiguous counties, including Orange County, chosen at the Agency's discretion).

Salary and Fringe Benefits for Jobs to be Created:

| Category of Jobs to be Retained and Created | Estimated Number of Jobs Per Category | Average Salary or Range of Salary | Average Fringe Benefits or Range of Fringe Benefits |
|---|---------------------------------------|-----------------------------------|---|
| Management | 2 | \$65,000.00 | \$6,500.00 |
| Professional | | | |
| Administrative | 2 | \$55,000.00 | \$5,500.00 |
| Production | | | |
| Independent Contractor | | | |
| Other | 21 | \$50,000.00 | \$5,000.00 |

Salary and Fringe Benefits for Jobs to be Retained:

| Category of Jobs to be Retained and Created | Estimated Number of Jobs Per Category | Average Salary or Range of Salary | Average Fringe Benefits or Range of Fringe Benefits |
|---|---------------------------------------|-----------------------------------|---|
| Management | 13 | \$284,750.94 | \$10,834.74 |
| Professional | | | |
| Administrative | 9 | \$35,454.22 | \$8,403.72 |
| Production | 33 | \$31,919.70 | \$8,403.72 |
| Independent Contractor | 5 | \$58,234.67 | 0 |
| Other | 16 | \$196,901.65 | \$40,246.84 |

III. REPRESENTATIONS BY THE APPLICANT

The Applicant understands and agrees with the Agency as follows:

- A. Job Listings In accordance with Section 858-b(2) of the New York General Municipal Law, the applicant understands and agrees that, if the proposed project receives any Financial Assistance from the Agency, except as otherwise provided by collective bargaining agreements, new employment opportunities created as a result of the proposed project must be listed with the New York State Department of Labor Community Services Division (the "DOL") and with the administrative entity (collectively with the DOL, the "JTPA Entitle") of the service delivery area created by the federal job training partnership act (Public Law 97-300) ("JPTA") in which the project is located.

- B. First Consideration for Employment In accordance with Section 858-b(2) of the General Municipal Law, the applicant understands and agrees that, if the proposed project receives any Financial Assistance from the Agency, except as otherwise provided by collective bargaining agreements, where practicable, the applicant must first consider persons eligible to participate in JTPA programs who shall be referred by the JPTA Entities for new employment opportunities created as a result of the proposed project.
- C. A liability and contract liability policy for a minimum of three million dollars will be furnished by the Applicant insuring the Agency.
- D. Annual Sales Tax Filings In accordance with Section 874(8) of the General Municipal Law, the Applicant understands and agrees that, if the proposed project receives any sales tax exemptions as part of the Financial Assistance from the Agency, in accordance with Section 874(8) of the General Municipal Law, the applicant agrees to file, or cause to be filed, with the New York State Department of Taxation and Finance, the annual form prescribed by the Department of Taxation and Finance, describing the value of all sales tax exemptions claimed by the applicant and all consultants or subcontractors retained by the Applicant.
- E. Annual Employment Reports: The applicant understands and agrees that, if the proposed project receives any Financial Assistance from the Agency, the applicant agrees to file, or cause to be filed, with the Agency, on an annual basis, reports regarding the number of people employed at the project site. The applicant will receive a request for information in the fourth quarter of each year that Financial Assistance is utilized and agrees to return the information by the end of January the following year.
- F. Compliance with N.Y. GML Sec. 862(1): Applicant understands and agrees that the provisions of Section 862(1) of the New York General Municipal Law, as provided below, will not be violated if Financial Assistance is provided for the proposed Project:
- § 862. Restrictions on funds of the agency. (1) No funds of the agency shall be used in respect of any project if the completion thereof would result in the removal of an industrial or manufacturing plant of the project occupant from one area of the state to another area of the state or in the abandonment of one or more plants or facilities of the project occupant located within the state, provided, however, that neither restriction shall apply if the agency shall determine on the basis of the application before it that the project is reasonably necessary to discourage the project occupant from removing such other plant or facility to a location outside the state or is reasonably necessary to preserve the competitive position of the project occupant in its respective industry.
- G. Compliance with Applicable Laws: The Applicant confirms and acknowledges that the owner, occupant, or operator receiving Financial Assistance for the proposed Project is in substantial compliance with applicable local, state and federal tax, worker protection and environmental laws, rules and regulations.
- H. False and Misleading Information: The Applicant confirms and acknowledges that the submission of any knowingly false or knowingly misleading information may lead to the immediate termination of any Financial Assistance and the reimbursement of an amount equal to all or part of any tax exemption claimed by reason of the Agency's involvement the Project.
- I. Recapture: Should the Applicant not expend or hire as presented, the Agency may view such information/status as failing to meet the established standards of economic

This Application should be submitted to the Orange County Industrial Development Agency, c/o Robert T. Armistead, Chairman, Orange County Business Accelerator, 4 Crotty Lane, Suite 100, New Windsor, NY 12553.

The Agency will collect an administrative fee at the time of closing.
SEE ATTACHED FEE SCHEDULE

Transaction Counsel
CHARLES SCHACHTER, ESQ./
RUSSELL GAENZLE, ESQ.
Harris Beach PLLC
99 Garnsey Road
Pittsford, New York 14534
Tel: (585) 419-8633
Fax: (585) 419-8817

Attach copies of preliminary plans or sketches of proposed construction or rehabilitation or both.

Attach the following Financial Information of the Company

1. Financial statements for last two fiscal years (unless included in company's Annual Reports).
2. Company's annual reports (or Form 10-K's) for the two most recent fiscal years.
3. Quarterly reports (Form 10Q's) and current reports (Form 8-K's) since the most recent Annual Report, if any.
4. In addition, please attach the financial information described above in items 1, 2 and 3 of any expected Guarantor of the proposed bond issue, if different from the company.

HOLD HARMLESS AGREEMENT

Applicant hereby releases the ORANGE COUNTY INDUSTRIAL DEVELOPMENT AGENCY and the members, officers, servants, agents and employees thereof (the "Agency") from, agrees that the Agency shall not be liable for and agrees to indemnify, defend and hold the Agency harmless from and against any and all liability arising from or expense incurred by (A) the Agency's examination and processing of, and action pursuant to or upon, the attached Application, regardless of whether or not the Application or the Project described therein or the tax exemptions and other assistance requested therein are favorably acted upon by the Agency, (B) the Agency's acquisition, construction and/or installation of the Project described therein and (C) any further action taken by the Agency with respect to the Project; including without limiting the generality of the foregoing, all causes of action and attorneys' fees and any other expenses incurred in defending any suits or actions which may arise as a result of any of the foregoing. If, for any reason, the Applicant fails to conclude or consummate necessary negotiations, or fails, within a reasonable or specified period of time, to take reasonable, proper or requested action, or withdraws, abandons, cancels or neglects the Application, or if the Agency or the Applicant are unable to reach final agreement with respect to the Project, then, and in the event, upon presentation of an invoice itemizing the same, the Applicant shall pay to the Agency, its agents or assigns, all costs incurred by the Agency in processing of the Application, including attorneys' fees, if any.



(Applicant Signature)

By: Herb Zakarin

Name: Herb Zakarin

Title: President



(Notary Public)

Sworn to before me this 13th day
of September, 2018

BRUCE C. THOMPSON
Notary Public, State Of New York
No. 01T116055498
Qualified In Orange County
Commission Expires February 26, 2019

Real Property Tax Benefits (Detailed):

** This section of this Application will be: (i) completed by IDA Staff based upon information contained within the Application, and (ii) provided to the Applicant for ultimate inclusion as part of this completed Application.

PILOT Estimate Table Worksheet

| Dollar Value of New Construction and Renovation Costs | Estimated New Assessed Value of Property Subject to IDA* | County Tax Rate/1000 | Local Tax Rate (Town/City/Village)/1000 | School Tax Rate/1000 |
|---|--|----------------------|---|----------------------|
| | | | | |

*Apply equalization rate to value

| PILOT Year | % Payment | County PILOT Amount | Local PILOT Amount | School PILOT Amount | Total PILOT | Full Tax Payment w/o PILOT | Net Exemption |
|--------------|-----------|---------------------|--------------------|---------------------|-------------|----------------------------|---------------|
| 1 | | | | | | | |
| 2 | | | | | | | |
| 3 | | | | | | | |
| 4 | | | | | | | |
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| 15 | | | | | | | |
| 16 | | | | | | | |
| 17 | | | | | | | |
| 18 | | | | | | | |
| 19 | | | | | | | |
| 20 | | | | | | | |
| TOTAL | | | | | | | |

*Estimates provided are based on current property tax rates and assessment values

Cost Benefit Analysis

To be completed/calculated by AGENCY

| | <u>Costs =</u> <u>Financial Assistance</u> | <u>Benefits =</u> <u>Economic Development</u> |
|--------------------------------------|---|---|
| *Estimated Sales Tax Exemption | \$ _____ | New Jobs Created Permanent _____ Temporary _____ |
| | | Existing Jobs Retained Permanent _____ Temporary _____ |
| Estimated Mortgage Tax Exemption | \$ _____ | Expected Yearly Payroll \$ _____ |
| Estimated Property Tax Abatement | \$ _____ | Expected Gross Receipts \$ _____ |
| | | Additional Revenues to School Districts _____ _____ _____ |
| | | Additional Revenues to Municipalities _____ _____ _____ |
| | | Other Benefits _____ |
| Estimated Interest Savings IRB Issue | \$ _____ | Private Funds invested \$ _____ |
| | | Likelihood of accomplishing proposed project within three (3) years <input type="checkbox"/> Likely or <input type="checkbox"/> Unlikely |

* Estimated Value of Goods and Services to be exempt from sales and use tax as a result of the Agency's involvement in the Project. PLEASE NOTE: These amounts will be verified and there is a potential for a recapture of sales tax exemptions (see "Recapture" on page 10).

\$ _____ (to be used on the NYS ST-60)

**FEE SCHEDULE FOR THE
ORANGE COUNTY IDA IS AS FOLLOWS:**

Application Fee:

\$5,000 non-refundable, due at application, broken down as follows:

IDA Administrative Fee: \$2,500

IDA Transaction Counsel Fee: \$2,500

Labor Policy Monitoring Fee, based on project cost, due before Final Resolution.

This fee will be deposited into a non-interest bearing escrow account and will fund the ongoing audit of Labor Policy compliance throughout construction. Any unused funds on deposit with the IDA will be returned to the company upon project completion.

| | |
|--|------------------|
| Projects less than \$5M: | \$5,000.00 |
| Projects greater than \$5M but less than \$15M: | \$10,000.00 |
| Projects greater than \$15M but less than \$25M: | \$20,000.00 |
| Projects greater than \$25M but less than \$50M: | \$30,000.00 |
| Projects greater than \$50M but less than \$100M: | \$45,000.00 |
| Projects greater than \$100M but less than \$500M: | \$55,000.00 |
| Projects greater than \$500M: | To be determined |

Closing Fee:

IDA Fee

One-percent of the first \$2,000,000 of the project cost (as identified on page 5 of this application), plus one-half percent of amount above that, due at closing (total project cost includes land acquisition costs).*

IDA Transaction Counsel Fee

One-third (1/3) of IDA fee (minimum of \$30,000 – to be reduced for smaller projects on case by case basis - plus out of pocket expenditures).

Local Labor Policy Monitoring

The IDA will use a third-party firm or firms to monitor compliance with the Local Labor Policy (attached hereto). All costs incurred by the IDA in connection with such monitoring, should they exceed the amount collected at application, shall be the responsibility of the Company.

NOTE: IDA reserves the right to seek additional IDA and Transaction Counsel fees for exceptionally complex/large transactions.

Please make all Checks payable to:

Orange County Industrial Development Agency

Mail to:

*In the event that an applicant does not seek or does not qualify for the IDA's enhanced PILOT or the equivalent of the State's 485-b program, the fee will be a straight one-half percent (0.5%) of the project cost (as identified on page 4 of this application).

The OCIDA Fee Schedule is the standard used when calculating all project fees. These fees are not open for negotiation. Please initial stating you understand and consent to the above

Closing Fee:

Please be advised should the Orange County IDA act to adopt the Final Resolution for your project a fee will be due at closing.

Per the Capital Cost provided on the Applicants Pre-Application, the current estimated Closing Fee owed to the OCIDA will be: _____ \$46,801.75 _____, in addition to legal fees due and payable to Harris Beach.

If at any time the project costs change prior to the Final Resolution, please inform management immediately for closing fee recalculation purposes.

Please initial stating you understand the foregoing, have provided accurate project costs, and consent to the estimated closing fee provided above

LABOR POLICY
ORANGE COUNTY INDUSTRIAL DEVELOPMENT AGENCY
Adopted 01-12-17

The Orange County Industrial Development Agency (IDA) was established for the purpose of creating employment opportunities for, and to promote the general prosperity and economic welfare of the residents of Orange County. The IDA offers economic incentives and benefits to qualified applicants who wish to locate or expand their businesses or facilities in Orange County. When the IDA approves a project, it enters into agreements to extend these incentives and benefits to the applicant.

Construction jobs, though limited in time duration, are vital to the overall employment opportunities and economic growth in Orange County. The IDA believes that companies benefiting from its incentive programs should employ local laborers, mechanics, craft persons, journey workers, equipment operators, truck drivers and apprentices (hereinafter "construction workers"), including those who have returned from military service, during the construction phase of projects. In this way, the IDA can generate significant benefits to advance the County's general prosperity. It is, therefore, the policy of the IDA that firms benefiting from its programs shall employ workers from Orange County and the "local labor" market during all project phases, including the construction phase.

For the purpose of this policy, the "local labor" market for construction workers shall be defined as those individuals living in Orange, Ulster, Sullivan, Dutchess, Putnam, Rockland and Westchester Counties. Applicants receiving IDA benefits shall ensure the contractor/developer hire at least 85% from the "local labor" market for their approved projects. The 85% shall be by contractor and in total at the time of completion of the project. The contractor/developer is mandated to keep daily log sheets of all field workers, commencing on the date of application. Any work performed after application shall be included in the determination of overall compliance with the 85% hiring requirements of this policy. A third-party auditing firm will be engaged to monitor construction work commencing on the date benefits are granted by resolution of the IDA Board.

However, the IDA recognizes that the use of local labor may not be possible for the following reasons and the applicant may request an exemption on a particular contract or trade scope for the following reasons:

1. Warranty issues related to installation of specialized equipment whereby the manufacturer requires installation by only approved installers;
2. Specialized construction is required and no local contractors or local construction workers have the required skills, certifications or training to perform the work;
3. Cost Differentials:
 - a. For projects whose project cost exceeds \$15M, significant cost differentials in bid prices whereby the use of local labor and materials significantly increases the sub contract or contract of a particular trade or work scope by at least 20%. Every reasonable effort should be made by the applicant and or the applicant's contractor to get below the 20% cost differential including, but not limited to, communicating and meeting with local construction trade organizations, such as the Hudson Valley Building and Construction Trades Council and other local Contractor Associations;

- b. For projects whose project cost is less than \$15M, significant cost differentials in bid prices whereby the use of local labor and materials significantly increases the sub contract or contract of a particular trade or work scope by 10% or more. Every reasonable effort should be made by the applicant and or the applicant's contractor to get below the 10% cost differential including, but not limited to, communicating and meeting with local construction trade organizations, such as the Hudson Valley Building and Construction Trades Council and other local Contractor Associations;
4. No labor is available for the project; and
5. The contractor requires key or core persons such as supervisors, foreman or "construction workers" having special skills that are not available in the "local labor" market.

The request to secure an exemption for the use of non-local labor must be received from the applicant on the exemption form provided by the IDA or the 3rd party monitor and received in advance of work commencing. The request will be reviewed by the 3rd party monitor and forwarded to the IDA, at which time the IDA's Audit Committee shall have the authority to approve or disapprove the exemption. The 3rd party monitor shall report each authorized exemption to the Board of Directors at its monthly meeting.

In addition, applicants receiving IDA benefits and Contractors on the project shall make every reasonable effort to utilize vendors, material suppliers, subcontractors and professional services from Orange County and the surrounding counties. Applicants and contractors shall be required to keep records of those local vendors, material suppliers, contractors and professional services whom they have solicited and with whom they have contracted with or awarded. This shall be stored in a binder on site and shall be easily available for review by an authorized representative of the IDA, such as the IDA's 3rd party monitor. It shall include any documents for solicitation and contracts. It is the goal of the County of Orange and the IDA to promote the use of local veterans on projects receiving IDA benefits. By partnering with local contractors, local contractor groups, local trade unions and contractors awarded work on IDA projects, there are opportunities for veterans to gain both short-term and long-term careers in the construction industry.

Once approved for IDA benefits, all applicants will be required to provide to IDA staff the following information:

1. Contact information for the applicant's representative who will be responsible and accountable for providing information about the bidding and awarding of construction contracts relative to the applicant's project;
2. Description of the nature of construction jobs created by the project, including in as much detail as possible, the number, type and duration of construction positions;
3. The names, contact information, certificate of authorization to do business in the State of New York and copies of current Certificates of NYS Workers' Compensation Insurance, NYS Disability Insurance, General Liability Insurance and proof of current OSHA training certification from all contractors' employees performing work on the site; and
4. A Construction Completion Report listing the names and business locations of prime contractors, subcontractors and vendors who have been engaged in the construction phase of the project.

All Orange County IDA projects are subject to local monitoring by the IDA and any 3rd party monitor. The applicant and/or the Construction Manager or General Contractor acting as agent

for the applicant on the project, shall keep a log book on site detailing the number of workers, hours worked and counties and states in which they reside. Proof of residency or copy of drivers' license shall be included in the log book, along with evidence of necessary OSHA certifications. Reports will be on forms provided by the IDA or weekly payroll reports which contain the same information as required on the IDA issued form. The applicant and contractors are subject to periodic inspection or monitoring by the IDA or 3rd party monitor.

The 3rd party monitor shall issue a report to the IDA staff immediately when an applicant or applicant's contractor is not in compliance with this labor policy. IDA staff shall advise the Audit Committee and/or IDA Board of non-compliance by email or at the next scheduled meeting. If a violation of policy has occurred, IDA staff shall notify the applicant and contractor in writing of non-compliance and give applicant a warning of violation and 72 hours in which to correct such violation. Upon evidence of continued non-compliance or additional violations, the IDA and/or its 3rd party monitor shall notify the applicant that the project is in violation of the Orange County IDA Labor Policy and is subject to IDA Board action which may result in the revocation, termination and/or recapture of any or all benefits conferred by the IDA.

The IDA will use a third party firm or firms to monitor and audit compliance with this local labor policy, the cost of which shall be paid for by the Company in advance of the audits and held in a non-interest bearing escrow account until audits are complete.

The applicant of an IDA approved project shall be required to maintain a 4' X 8' bulletin board on the project site containing the following information:

1. Contact information of the applicant;
2. Summary of the IDA benefits received;
3. Contractors names and contact information on IDA provided form;
4. Copies of proof of exemption from labor policy;
5. Copies of any warnings or violations of policy;
6. Copy of the Executed Labor Policy.

The bulletin board shall be located in an area that is accessible to onsite workers and visitors, which should be clear and legible at least 10 feet from said board.

The applicant has read the OCIDA Labor Policy and agrees to adhere to it without changes and shall require its construction manager, general contractor and sub-contractors who are not exempt to acknowledge the same. The Applicant understands and agrees that it is responsible for all third-party auditing and monitoring costs.



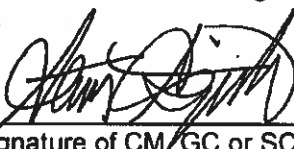
Applicant Signature
GAM Property Corp. & King Zak Industries, Inc

Company Name
Herb Zakarin

Print Name of above signer
hzakarin@kingzak.com

Email/phone of Applicant
8/28/18 Updated 9/10/18

Date



Signature of CM/GC or SC
Esposito & Associates

Company Name
Steven T. Esposito

Print Name of above signer
eanda@espositoandassociates.net

Email/phone of CM/GC/SC
8/28/18 Updated 9/10/18

Date

AGREEMENT

AGREEMENT

THIS AGREEMENT is entered into as of the _____ day of March, 2020, by and between the Orange County Industrial Development Agency, a Public Benefit Corporation organized under the Laws of the State of New York, with offices at 4 Crotty Lane, New Windsor, New York 12553, hereinafter "the OCIDA" and Loewke Brill Consulting Group, Inc., a New York corporation, with offices at 491 Elmgrove Road, Suite #2, Rochester, New York 14606, hereinafter "LOEWKE."

WITNESSETH:

WHEREAS, the OCIDA provides tax incentives designed to attract, expand or retain qualified businesses in Orange County thereby increasing economic development and creating employment opportunities for its residents; and

WHEREAS, the OCIDA has instituted a Local Labor Policy that requires recipients of OCIDA benefits to employ local labor during the construction phase of a project; and

WHEREAS, the OCIDA determined that it needed expert technical assistance in monitoring construction projects relative to compliance with its Local Labor Policy; and

WHEREAS, LOEWKE has the knowledge, capability and experience to provide such services to the OCIDA and has submitted a written proposal for providing such services which proposal was approved by the OCIDA Board of Directors; and

WHEREAS, the parties hereto wish to memorialize their understanding as set forth herein.

NOW, THEREFORE, in consideration of the mutual covenants herein contained, the parties agree as follows:

SECTION 1: TERMS

- A. The OCIDA agrees to retain the services of LOEWKE to assist the OCIDA in monitoring adherence to the OCIDA's Local Labor Policy (Exhibit "A") for construction projects that have received OCIDA benefits.
- B. The OCIDA will assign specific projects on a case by case basis (Exhibit "B") to LOEWKE and will provide LOEWKE with the necessary project information sufficient for LOEWKE to carry out its responsibilities hereunder.

- C. LOEWKE represents that it has the knowledge and experience to perform the services to be rendered and further represents that it shall use its best efforts to perform said services to the satisfaction of the OCIDA.
- D. LOEWKE will provide appropriate personnel to monitor each assigned project and will be compensated according to the Schedule of Fees submitted by LOEWKE as part of its proposal to OCIDA (Exhibit "C").
- E. OCIDA expects LOEWKE to monitor assigned projects on a monthly basis or more frequently if it is determined that the project is not in compliance with the Local Labor Policy.
- F. LOEWKE agrees to file reports with OCIDA within ten to fourteen (10-14) calendar days of each monthly inspection.
- G. The OCIDA and LOEWKE have the mutual option to terminate this Agreement upon ten (10) days written notice. LOEWKE shall be compensated for all work performed up to and including the specified termination date.
- H. LOEWKE agrees to procure and maintain NYS worker's compensation and NYS disability insurance and comprehensive liability insurance (including contractual and contractor's protective liability coverage) with combined single limits of \$1,000,000 per occurrence for bodily injury and property damage, automobile liability coverage including owned and hired vehicles with a combined single limit of \$1,000,000 per occurrence for bodily injury and property damage and professional liability insurance in the amount of \$1,000,000 per claim. LOEWKE shall name the OCIDA as an additional insured on its liability insurance policy and shall provide evidence of coverage to the OCIDA on all policies prior to performance of any services hereunder.
- I. LOEWKE shall defend, indemnify and hold harmless the OCIDA, its directors, officers, employees and agents from and against all claims, damages, losses, costs and expenses, including reasonable attorney's fees, arising out of or in any manner connected with, the performance of the services to the extent caused by LOEWKE's negligence.
- J. OCIDA shall defend, indemnify and hold harmless LOEWKE, its officers, directors, employees, agents and subcontractors (for the purposes of this agreement "subcontractors" shall mean those persons or entities retained by LOEWKE to perform services related to this agreement) from and against all claims, losses, damages, costs and expenses, including reasonable attorney's fees, arising out of or in any manner connected with, the performance of the services to the extent caused by OCIDA's negligence.
- K. LOEWKE understands and agrees that it is acting as an independent contractor of the OCIDA. This agreement and the relationship of the parties shall not be deemed to create or be one of employment, agency, partnership, joint venture or any other association .

SECTION 2. NOTICES.

Notices pursuant to this Agreement shall be given by deposit into the custody of the United States Postal Service, postage paid, addressed as follows:

(1) OCIDA The Orange County Industrial Development Agency, 4 Crotty Lane, Suite 100, New Windsor, NY 12553

(2) LOEWKE Loewke Brill Consulting Group, Inc, 491 Elmgrove Road, Suite #2, Rochester, NY 14606

Alternatively, notices may be personally served in the same manner as is applicable to civil judicial process. Notice shall be deemed given as of the date of personal service or five (5) days after the date of deposit of such written notice in the course or transmission in the United States Postal Service.

SECTION 3. GENERAL PROVISIONS.

- A. The text herein shall constitute the entire agreement between the parties.
- B. This Agreement may not be assigned by LOEWKE without prior written consent of OCIDA.
- C. This Agreement shall be governed by the laws of the State of New York. Any disputes arising hereunder shall be resolved by the Courts of Orange County, New York.
- D. If any provision, or any portion thereof, contained in this Agreement is held invalid, illegal or unenforceable by a court of competent jurisdiction, the remainder of this Agreement shall be deemed severable, shall not be affected and shall remain in full force and effect.

IN WITNESS WHEREOF, the OCIDA has caused this agreement to be signed and executed on its behalf by its Chief Operating Officer and LOEWKE has caused this agreement to be signed and executed on its behalf by its Principal, both in duplicate, on the day and year first above written.

Orange County IDA

Loewke Brill Consulting Group, Inc.



By: Laurie Villasuso
Chief Operating Officer

Exhibit "A"

Orange County Industrial Development Agency Local Labor Policy

The Orange County Industrial Development Agency (IDA) was created for the purpose of creating employment opportunities for, and to promote the general prosperity and economic welfare of the residents of Orange County. The IDA offers economic incentives and benefits to qualified applicants who wish to locate or expand their businesses or facilities in Orange County. When the IDA approves a project, it enters into agreements to extend these incentives and benefits to the applicant.

Construction jobs, though limited in time duration, are vital to the overall employment opportunities in Orange County. The IDA believes that companies benefiting from its incentive programs should employ local laborers, mechanics, craft persons, journey workers, equipment operators, truck drivers and apprentices (hereinafter "construction workers"), including those who have returned from military service, during the construction phase of projects. In this way, the IDA can generate significant benefits to advance the County's general prosperity. It is, therefore, the policy of the IDA that firms benefiting from its programs shall employ workers in Orange County during all project phases, including the construction phase.

For the purposes of this Policy, the local labor market for construction workers shall be defined as those individuals living in Orange, Ulster, Sullivan, Dutchess, Putnam, Rockland and Westchester Counties. Applicants receiving IDA benefits shall utilize at least 85% local labor for their approved projects. However, the IDA recognizes that the use of local labor may not be possible for the following reasons :

- 1) Warranty issues related to installation of specialized equipment whereby the manufacturer requires installation by only approved installers;
- 2) Specialized construction is required, and no local contractors or local construction workers have the required skills, certifications or training to perform the work;
- 3) Significant cost differentials in bid prices whereby the use of local labor significantly increases the cost of the project. A cost differential of 10% is deemed significant. Every effort should be made by the contractor or applicant to get below the 10% cost differential including, but not limited to, meeting with local construction trade organizations and local contractor associations;
- 4) No local labor is available for the project; and
- 5) The contractor requires the use of key or core persons such as supervisors, foremen, or construction workers having special skills.

The request to secure an exemption for use of non-local labor must be received in writing from the applicant. The request will be reviewed by the Executive Director who shall have the authority to approve or disapprove the request. The Executive Director shall report each authorized exemption to the Board of Directors at its monthly meeting .

In addition, applicants receiving IDA benefits and Contractors on the project shall make every effort to utilize vendors, material suppliers, subcontractors and professional services from Orange County and the surrounding counties. Applicants and contractors shall be required to keep records of those local vendors, material suppliers, contractors and professional services who they have solicited and with whom they have contracted with or awarded.

It is the goal of the County of Orange and the IDA to promote the use of local veterans on projects receiving IDA benefits. By partnering with local contractors, local contractor groups, local trade unions and contractors awarded work on IDA projects there is opportunity for veterans to gain both short term and long-term careers in the construction industry.

Once approved for IDA benefits, all applicants will be required to provide to the IDA's Executive Director the following information:

- 1) Contact information for the applicant's representative who will be responsible and accountable for providing information about the bidding and awarding of construction contracts relative to the application and project;
- 2) Description of the nature of construction jobs created by the project, including in as much detail as possible, the number, type and duration of construction positions;
- 3) The names, contact information, certificate of authorization to do business in the State of New York and copies of current Certificates of NYS Workers' Compensation Insurance, NYS Disability Insurance, General Liability Insurance and proof of current OSHA training certification for all contractors and their employees performing work on the site; and
- 4) A Construction Completion Report listing the names and business locations of prime contractors, subcontractors and vendors who have been engaged in the construction phase of the project.

All Orange County IDA projects are subject to local monitoring by the IDA. The Construction Manager, acting as agent for the applicant, on the project shall keep a log book on site detailing the number of workers on the job for each trade and the counties in which they reside which shall be subject to periodic inspection by the monitoring entity. The monitor shall issue a report to the Executive Director relative to compliance with this labor policy who shall share such information with the IDA Board of Directors. If a violation of the policy has occurred, the Executive Director shall notify the applicant in writing and give such applicant a warning of such violation. In the event there is a subsequent violation of the policy, the Executive Director shall bring such information to the Board of Directors which may, in its discretion, take action to revoke IDA benefits.

The applicant of an IDA approved project shall be required to maintain a 4' x 8' bulletin board on the project site containing the following information:

- 1) Contact information of the applicant;
- 2) Summary of the IDA benefits received; and
- 3) Contractors' names and contact information.

The bulletin board shall be located in an area that is accessible to onsite workers and visitors.

Exhibit "B"

Project Name: GAM Property Corp./King Zak Industries, Inc./3PD Transport

1. Project Location and Description.

3 Police Drive, PO Box 1029
Goshen, NY 10924

2. Project Contact Information

Herb Zakarin
845-291-1200
hzakarin@kingzak.com

Audit Contact

Michael Waschitz
845-7823-0013 (ext 645)
mikew@wpcpany.com

3. Construction Cost Estimate

Total Capital Cost: \$7,360,350.00

Exhibit "C"

Schedule of Fees

LOEWKE BRILL CONSULTING GROUP, INC

SUMMARY:

Further fee breaks down of original proposal dated May 6, 2016, as requested by OCIDA Director, Ms. Villasuso.

Loewke Brill has assessed a fee base structure for each approved project based on potential project size per inspection to include one-time fees.

Fee based structure based on size of each approved project per inspection.

Per Project/per Inspection fee:

| | |
|---------------------------|-----------|
| o <5 Million | \$ 315.00 |
| o >5 Million <15 Million | \$ 540.00 |
| o >15 Million <25 Million | \$ 900.00 |

Additional fees:

| | |
|---------------------------------|-------------|
| Project Set Up/per project | \$ 1,050.00 |
| Monthly Reporting | \$ 1,400.00 |
| o Waiver fee: per waiver | \$ 230.00 |
| o Annual Reporting | \$ 270.00 |
| o Project Close out/per project | \$ 575.00 |
| o Sign age: | |
| Initial Art work Set Up fee | \$ 250.00 |
| o Signage per unit | \$ 40.00 |

Note: You could have the potential to exceed the proposal by the number of additional inspections requested on a project.

ENGAGEMENT LETTER



BOARD OF DIRECTORS

Mary Ellen Rogulski
- CHAIRMAN

Edward A. Diana
- VICE CHAIRMAN

James DiSalvo
- SECOND VICE CHAIRMAN

Stephen Brescia
- SECRETARY

Michael Gaydos
- ASSISTANT SECRETARY

Robert J. Schreiber, Sr.

John McCarey

OPERATIONS STAFF

Laurie Villasuso
- CHIEF EXECUTIVE OFFICER

Melanie Schouten
- CHIEF OPERATING OFFICER

Joel Kleiman
- CHIEF FINANCIAL OFFICER

Kevin T. Dowd
- ATTORNEY

March 03, 2020

Herb Zakarin, President
GAM Property Corp.
3 Police Drive, PO Box 1029
Goshen, NY 10924

RE: GAM Property Corp.
OCIDA Local Labor Policy Monitoring

Dear Mr. Zakarin:

The Orange County Industrial Development Agency has engaged the services of Loewke Brill Consulting Group, Inc. of Rochester, NY to provide it with the technical assistance in monitoring compliance with the OCIDA's Local Labor Policy for construction projects that have received OCIDA benefits. In a few short days, you will be receiving an introductory communication from a representative of Loewke Brill requesting preparatory information and documents regarding your construction project in Goshen, NY. Thereafter, in the coming weeks, a representative of Loewke Brill will visit the site and will want to meet with members of your construction team and review records of the workers who are or have been involved in the construction of the facility. Loewke Brill will then prepare a report for the OCIDA regarding its evaluation of your compliance with the Local Labor Policy.

The OCIDA expects your company's complete cooperation with Loewke Brill. In addition, the OCIDA expects that you will notify your general contractor that it must cooperate fully with Loewke Brill as well.

On behalf of the OCIDA, I thank you in advance for your anticipated cooperation. If you have any questions, please don't hesitate to reach out to Kelly Reilly at: (845) 220-2208 or email kreilly@ocnyida.com.

Very truly yours,

Laurie Villasuso
Chief Executive Officer

JOB ✓ LIST



Applicant: GAM Property Corp. Job#: 20-002
Address: 3 Police Drive Goshen, NY 10924

OCIDA Job Check List

- Engagement Letter from OCIDA to new contact is received: 3/03/20
- Job is added to upcoming jobs category on master spreadsheet: 3/16/20
- Applicant contact is e-mailed L&B introduction letter: 3/09/20
- Confirmed project contact information (via L&B Intro email): 3/09/20

Applicant:

Contact: Herb Zakarin Phone#: 845-291-1200
Office Address: 3 Police Drive P.O. Box 1029 Goshen, NY 10924
Email: hzakarin@kingzak.com

Job Site Contact:

Contact: Ramon Gonzalez Phone#: 845-866-4091
Office Address: 12 Scheibe Road Liberty, NY 12754
Email: ramon@triplerd.com

- Confirmed job site address is same as above (via L&B Intro email):
3/09/20
- Estimated job (construction) start date given by project contact: Summer 2020
- Initial Site Visit/ Local Labor review: ___/___/___
- Actual construction start date moved to ACTIVE Status : ___/___/___
- Job # 20-002 is assigned for job and created in computer: ___/___/___
- Completion of project is confirmed: ___/___/___
- Project moved to completed jobs list: ___/___/___

INSPECTIONS



Job No. 20-002

ORANGE COUNTY I.D.A. JOB-SITE INSPECTION SHEET

DATE: 6 / 30 / 2020 Day: M T W T H F Inspector: Kevin Loewke

OCIDA

APPLICANT: GAM Property Corp Address: 3 Police Drivs Goshen, NY

Sign Status: ACTIVE / INACTIVE Sign Location: Post

Table with 7 columns: CONTRACTOR, Monthly Visit, Request Visit, # of Workers Checked, # of Allowed Exceptions, # Non-Compliant, Comments. Row 1: Baycc, X, [empty], 1, [empty], [empty], [empty].



CONSULTING GROUP, INC

Job No. 20-002

ORANGE COUNTY I.D.A. JOB-SITE INSPECTION SHEET

OCIDA
Inspector: Kevin Loewke

DATE: 7/28/2020 Day: MTWTF

APPLICANT: GAM Property Corp Address: 3 Police Drive Goshen NY

Sign Status: ACTIVE Sign Location: Post

| CONTRACTOR | Monthly Visit | Request Visit | # of Workers Checked | # of Allowed Exceptions | # Non-Compliant | Comments |
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WEEKLY LABOR

| Sub Contractor | Sunday | | | Monday | | | Tuesday | | | Wednesday | | | Thursday | | | Friday | | | Saturday | | | Weekly Total Local OOA | Contractor Total | Compliance % | | | | | | | | | | | | | | | | | | |
|---------------------|-------------------|------------|--|--------|-----|--|---------|-----|--|-----------|-----|--|----------|-----|--|--------|-----|--|----------|-----|--|---------------------------|---------------------|--------------|--|----|---|--------------------------------------|---------|--|---|--|--|--|--|--|--|--|--|--|--|--|
| | Local | OOA | | Local | OOA | | Local | OOA | | Local | OOA | | Local | OOA | | Local | OOA | | Local | OOA | | | | | | | | | | | | | | | | | | | | | | |
| | GAM Property Corp | 10/24/2020 | | | | | | | | | | | | | | | | | | | | | | | Local Counties: Orange, Sullivan, Ulster, Dutchess, Putnam, Rockland, Westchester. If 0, leave blank | | | OOA = Out of Area. If 0, leave blank | | | Submit Weekly Labor Reports to Kevin Loewke, Kevin@Loewkebrill.com on the Monday following the completed week | | | | | | | | | | | |
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| Sub Contractor | Sunday | | Monday | | Tuesday | | Wednesday | | Thursday | | Friday | | Saturday | | Weekly Total | Contractor Total | Compliance % | |
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| | Local | OOA | Local | OOA | Local | OOA | Local | OOA | Local | OOA | Local | OOA | Local | OOA | | | | |
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| | | | | | | | | | | | | | | 0 | 0 | 0 | 0 | #DIV/0! |
| | | | | | | | | | | | | | | 0 | 0 | 0 | 0 | #DIV/0! |
| | | | | | | | | | | | | | | 0 | 0 | 0 | 0 | #DIV/0! |
| | | | | | | | | | | | | | | 0 | 0 | 0 | 0 | #DIV/0! |
| | | | | | | | | | | | | | | 0 | 0 | 0 | 0 | #DIV/0! |

Submit Weekly Labor Reports to Kevin Loewke, Kevin@Loewkebrill.com on the Monday following the completed week

OOA = Out of Area. If 0, leave blank

Local Counties: Orange, Sullivan, Ulster, Dutchess, Putnam, Rockland, Westchester. If 0, leave blank

5.01.21

GAM Property Corp

| Sub Contractor | Sunday | | Monday | | Tuesday | | Wednesday | | Thursday | | Friday | | Saturday | | Weekly Total | | Contractor Total | Compliance % | | | | | | | | | | | | | | |
|-------------------------|--|-----|--------|-----|---------|-----|-----------|-----|----------|-----|--------|-----|----------|-----|--------------|-----|------------------|--|--|--|---|--------------------------------------|--|--|--|--|---|----|---|----|---|---------|
| | Local | OOA | Local | OOA | Local | OOA | Local | OOA | Local | OOA | Local | OOA | Local | OOA | Local | OOA | | | | | | | | | | | | | | | | |
| | Submit Weekly Labor Reports to Kevin Loewke, Kevin@Loewkebrill.com on the Monday following the completed week | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| GAM Property Corp | 09.18.21 | | | | | | | | | | | | | | | | | Local Counties: Orange, Sullivan, Ulster, Dutchess, Putnam, Rockland, Westchester. If 0, leave blank | | | | OOA = Out of Area. If 0, leave blank | | | | Submit Weekly Labor Reports to Kevin Loewke, Kevin@Loewkebrill.com on the Monday following the completed week | | | | | | |
| Boyce Excavating Co | | | 6 | | | | 6 | | | | | 8 | | | | | 0 | | | | 5 | | | | | 25 | 0 | 25 | 0 | 25 | 1 | |
| Michael & Sons Equities | | | | | | | | | | | | 2 | | | | | | | | | 2 | | | | | | 4 | 0 | 4 | 0 | 4 | 1 |
| VanGrol HVAC | | | | | | | | | | | | 2 | | | | | | | | | 2 | | | | | | 4 | 0 | 4 | 0 | 4 | 1 |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | 0 | 0 | 0 | 0 | 0 | #DIV/0! |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | 0 | 0 | 0 | 0 | 0 | #DIV/0! |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | 0 | 0 | 0 | 0 | 0 | #DIV/0! |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | 0 | 0 | 0 | 0 | 0 | #DIV/0! |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | 0 | 0 | 0 | 0 | 0 | #DIV/0! |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | 0 | 0 | 0 | 0 | 0 | #DIV/0! |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | 0 | 0 | 0 | 0 | 0 | #DIV/0! |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | 0 | 0 | 0 | 0 | 0 | #DIV/0! |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | 0 | 0 | 0 | 0 | 0 | #DIV/0! |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | 0 | 0 | 0 | 0 | 0 | #DIV/0! |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | 0 | 0 | 0 | 0 | 0 | #DIV/0! |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | 0 | 0 | 0 | 0 | 0 | #DIV/0! |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | 0 | 0 | 0 | 0 | 0 | #DIV/0! |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | 0 | 0 | 0 | 0 | 0 | #DIV/0! |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | 0 | 0 | 0 | 0 | 0 | #DIV/0! |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | 0 | 0 | 0 | 0 | 0 | #DIV/0! |

CONTRACTOR ✓ LIST

Permits: Required for the general contractor as well as all eligible subcontractors on site. Not all subcontractors will require a permit including but not limited to: painters, flooring companies, other finishing trades.

General Liability Insurance: Since the Orange County Industrial Development Agency is a named entity on the project, we want to make sure in the event of a liability incident (pedestrian falling into a hole next to sidewalk) that the GC has sufficient coverage to cover the IDA. We are looking for a minimum of \$1,000,000 in total GL coverage.

Workers Comp Insurance / Certificate- Since the Orange County Industrial Development Agency is a named entity on the project, we need to make sure in the event of a worker injury (carpenter falls off scaffolding) that the I.D.A. has sufficient coverage.

Umbrella Policy - This is only in the case that the G.C. or subcontractors do not have \$1M in coverage. The Umbrella plus the general liability insurance should add up to \$1M+ (for example \$500k of GL + \$500K UL is \$1M total)

Automobile Insurance - Since the Orange County Industrial Development Agency is a named entity on the project, we want to make sure in the event of an automobile accident that everyone is covered. This covers if a contractor is delivering materials to a site and his ladder falls off the truck and hits another car. Again we're looking for a total of \$1 million in coverage inc. UL. (For example \$500k of AI + \$500K UL is \$1M total)

NYS Disability Insurance - This covers an employee if he/she is hurt off-site. This goes hand in hand with workers compensation insurance and the reason for why we need it. Also, lack of WCI or DBL typically confirms the workers are 1099 employees and then additional information is required (W-9).

TRIPLE R



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

6/10/2020

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 Jason D. Hoffman Insurance Agency LLC 301 Main Street, Suite 2F Goshen NY 10924 | | CONTACT NAME: PHONE (A/C, No, Ext): (845) 239-4787 FAX (A/C, No): E-MAIL ADDRESS: jason@jhoffmaninsurance.com | |
| INSURED Triple R Development LLC 200 Smith Lane Grahamsville NY 12740 | | INSURER(S) AFFORDING COVERAGE | |
| | | INSURER A : EVANSTON INS CO | NAIC # 35378 |
| | | INSURER B : NGM INS CO | 14788 |
| | | INSURER C : National Union Fire Insurance Co. | 19445 |
| | | INSURER D : | |
| | | INSURER E : | |
| | | INSURER F : | |

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 | ADDITIONAL INSURED | SUBROGATION WAIVED | 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"/> PROJECT <input type="checkbox"/> LOC OTHER: | Y | | 3EW4310 | 10/22/2019 | 10/22/2020 | EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000 MED EXP (Any one person) \$ 5,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000 |
| B | AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY | Y | | B1U1759S | 10/22/2019 | 10/22/2020 | COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ |
| C | <input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR <input checked="" type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED <input checked="" type="checkbox"/> RETENTION \$ 10000.00 | Y | | BE 020770063 | 10/22/2019 | 10/22/2020 | EACH OCCURRENCE \$ 1,000,000 AGGREGATE \$ 1,000,000 |
| | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? <input type="checkbox"/> Y/N (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below | N/A | | | | | PER STATUTE <input type="checkbox"/> OTHER <input type="checkbox"/> E.L. EACH ACCIDENT \$ 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)

Certificate holder is additional insured as per written contract. AI status is subject to attached policy form MEGL0009.

| | |
|--|---|
| CERTIFICATE HOLDER Orange County IDA 4 Crotty Lane Suite 100 New Windsor NY 12553 | 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 |
|--|---|

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CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

10/19/2020

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 | | CONTACT NAME: | |
| Jason D. Hoffman Insurance Agency LLC 301 Main Street, Suite 2F | | PHONE (A/C, No, Ext): (845) 239-4787 | |
| Goshen NY 10924 | | FAX (A/C, No): | |
| | | E-MAIL ADDRESS: jason@jhoffmaninsurance.com | |
| | | INSURER(S) AFFORDING COVERAGE | |
| | | NAIC # | |
| INSURED | | INSURER A : EVANSTON INS CO | |
| Triple R Development LLC 200 Smith Lane | | INSURER B : Merchant's Mutual Insurance Co | |
| Grahamsville NY 12740 | | INSURER C : National Union Fire Insurance Co. | |
| | | INSURER D : New York State Insurance Fund | |
| | | INSURER E : | |
| | | INSURER F : | |

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 SUBR INSD WVD | POLICY NUMBER | POLICY EFF (MM/DD/YYYY) | POLICY EXP (MM/DD/YYYY) | LIMITS |
|----------|---|--------------------|---------------|-------------------------|-------------------------|---|
| A | <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY | Y | 3EW4310 | 10/22/2020 | 10/22/2021 | EACH OCCURRENCE \$ 1,000,000 |
| | <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR | | | | | DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000 |
| | | | | | | MED EXP (Any one person) \$ 5,000 |
| | GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER: | | | | | PERSONAL & ADV INJURY \$ 1,000,000 |
| B | AUTOMOBILE LIABILITY | Y | CAPI077039 | 10/22/2020 | 10/22/2021 | COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 |
| | <input type="checkbox"/> ANY AUTO | | | | | BODILY INJURY (Per person) \$ |
| | <input type="checkbox"/> OWNED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS | | | | | BODILY INJURY (Per accident) \$ |
| | <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY | | | | | PROPERTY DAMAGE (Per accident) \$ |
| C | <input type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR | Y | EBU 020654935 | 10/22/2020 | 10/22/2021 | EACH OCCURRENCE \$ 1,000,000 |
| | <input checked="" type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE | | | | | AGGREGATE \$ 1,000,000 |
| | DED <input checked="" type="checkbox"/> RETENTION \$ 10000.00 | | | | | |
| D | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY | N/A | 23468572 | 04/01/2020 | 04/01/2021 | <input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER |
| | ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) | | | | | E.L. EACH ACCIDENT \$ unlimited |
| | If yes, describe under DESCRIPTION OF OPERATIONS below | | | | | E.L. DISEASE - EA EMPLOYEE \$ unlimited |
| | | | | | | E.L. DISEASE - POLICY LIMIT \$ unlimited |

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

Certificate holder is additional insured as per written contract. AI status is subject to attached policy form MEGL0009.

| | |
|---|---|
| CERTIFICATE HOLDER | CANCELLATION |
| Orange County IDA 4 Crotty Lane Suite 100 New Windsor NY 12553 | 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 |

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CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

11/12/2021

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).

| | | | |
|---------------------------------------|--|---|-----------------------|
| PRODUCER | | CONTACT NAME: Shannon Kent | |
| Jason D. Hoffman Insurance Agency LLC | | PHONE (A/C, No, Ext): (845) 239-4787 | FAX (A/C, No): |
| 301 Main Street, Suite 2F | | E-MAIL ADDRESS: shannon@jhoffmaninsurance.com | |
| Goshen NY 10924 | | INSURER(S) AFFORDING COVERAGE | |
| | | INSURER A: EVANSTON INS CO | NAIC # 35378 |
| | | INSURER B: MERCHANTS MUT INS CO | 23329 |
| | | INSURER C: NATIONAL UNION FIRE INS CO OF PITTS | 19445 |
| | | INSURER D: New York State Insurance Fund | |
| | | INSURER E: | |
| | | INSURER F: | |

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 | Y | Y | 3FD1048 | 10/22/2021 | 10/22/2022 | EACH OCCURRENCE \$ 1,000,000 |
| | <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR | | | | | | DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000 |
| | | | | | | | MED EXP (Any one person) \$ 5,000 |
| | GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PROJECT <input type="checkbox"/> LOC OTHER: | | | | | | PERSONAL & ADV INJURY \$ 1,000,000 |
| | | | | | | | GENERAL AGGREGATE \$ 2,000,000 |
| | | | | | | | PRODUCTS - COMP/OP AGG \$ 2,000,000 |
| | | | | | | | \$ |
| B | AUTOMOBILE LIABILITY | Y | | CAPI077039 | 10/22/2021 | 10/22/2022 | COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 |
| | <input type="checkbox"/> ANY AUTO | | | | | | BODILY INJURY (Per person) \$ |
| | <input type="checkbox"/> OWNED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS | | | | | | BODILY INJURY (Per accident) \$ |
| | <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY | | | | | | PROPERTY DAMAGE (Per accident) \$ |
| | | | | | | | \$ |
| C | <input checked="" type="checkbox"/> UMBRELLA LIAB | Y | | EBU 015991355 | 10/22/2021 | 10/22/2022 | EACH OCCURRENCE \$ 1,000,000 |
| | <input type="checkbox"/> EXCESS LIAB | | | | | | AGGREGATE \$ 1,000,000 |
| | <input type="checkbox"/> DED <input checked="" type="checkbox"/> RETENTION \$ | | | | | | \$ |
| D | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY | N/A | | 23468572 | 04/01/2021 | 04/01/2022 | <input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTHER |
| | ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) | | | | | | E.L. EACH ACCIDENT \$ unlimited |
| | If yes, describe under DESCRIPTION OF OPERATIONS below | | | | | | E.L. DISEASE - EA EMPLOYEE \$ unlimited |
| | | | | | | | E.L. DISEASE - POLICY LIMIT \$ unlimited |

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

Certificate holder is additional insured on a primary and non-contributory basis with respect to work being performed by the insured. AI status is subject to attached policy form MEGL0009.

CERTIFICATE HOLDER

Orange County IDA
4 Crotty Lane
Suite 100
New Windsor NY 12553

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

CERTIFICATE OF WORKERS' COMPENSATION INSURANCE

***** 472111396
LOVELL SAFETY MGMT CO., LLC
110 WILLIAM STREET 12TH FLR
NEW YORK NY 10038



SCAN TO VALIDATE
AND SUBSCRIBE

| | | | |
|--|-------------------------------------|--|--------------------------|
| POLICYHOLDER TRIPLE R DEVELOPMENT LLC 200 SMITH LANE GRAHAMSVILLE NY 12740 | | CERTIFICATE HOLDER ORANGE COUNTY IDA 4 CROTTY LANE, SUITE 100 NEW WINDSOR NY 12553 | |
| POLICY NUMBER Z2346 857-2 | CERTIFICATE NUMBER 280453 | POLICY PERIOD 04/01/2020 TO 04/01/2021 | DATE 6/10/2020 |

THIS IS TO CERTIFY THAT THE POLICYHOLDER NAMED ABOVE IS INSURED WITH THE NEW YORK STATE INSURANCE FUND UNDER POLICY NO. 2346 857-2, COVERING THE ENTIRE OBLIGATION OF THIS POLICYHOLDER FOR WORKERS' COMPENSATION UNDER THE NEW YORK WORKERS' COMPENSATION LAW WITH RESPECT TO ALL OPERATIONS IN THE STATE OF NEW YORK, EXCEPT AS INDICATED BELOW.

IF YOU WISH TO RECEIVE NOTIFICATIONS REGARDING SAID POLICY, INCLUDING ANY NOTIFICATION OF CANCELLATIONS, OR TO VALIDATE THIS CERTIFICATE, VISIT OUR WEBSITE AT [HTTPS://WWW.NYSIF.COM/CERT/CERTVAL.ASP](https://www.nysif.com/cert/certval.asp). THE NEW YORK STATE INSURANCE FUND IS NOT LIABLE IN THE EVENT OF FAILURE TO GIVE SUCH NOTIFICATIONS.

THIS POLICY DOES NOT COVER THE SOLE PROPRIETOR, PARTNERS AND/OR MEMBERS OF A LIMITED LIABILITY COMPANY.

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS NOR INSURANCE COVERAGE UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICY.

NEW YORK STATE INSURANCE FUND

DIRECTOR, INSURANCE FUND UNDERWRITING

VALIDATION NUMBER: 149513063

CERTIFICATE OF WORKERS' COMPENSATION INSURANCE (RENEWED)



SCAN TO VALIDATE
AND SUBSCRIBE

***** 472111396
LOVELL SAFETY MGMT CO., LLC
110 WILLIAM STREET 12TH FLR
NEW YORK NY 10038

POLICYHOLDER
TRIPLE R DEVELOPMENT LLC
200 SMITH LANE
GRAHAMSVILLE NY 12740

CERTIFICATE HOLDER
ORANGE COUNTY IDA
4 CROTTY LANE, SUITE 100
NEW WINDSOR NY 12553

| | | | |
|-------------------------------------|-------------------------------------|--|--------------------------|
| POLICY NUMBER Z2346 857-2 | CERTIFICATE NUMBER 119757 | POLICY PERIOD 04/01/2021 TO 04/01/2022 | DATE 3/31/2021 |
|-------------------------------------|-------------------------------------|--|--------------------------|

THIS IS TO CERTIFY THAT THE POLICYHOLDER NAMED ABOVE IS INSURED WITH THE NEW YORK STATE INSURANCE FUND UNDER POLICY NO. 2346 857-2, COVERING THE ENTIRE OBLIGATION OF THIS POLICYHOLDER FOR WORKERS' COMPENSATION UNDER THE NEW YORK WORKERS' COMPENSATION LAW WITH RESPECT TO ALL OPERATIONS IN THE STATE OF NEW YORK, EXCEPT AS INDICATED BELOW.

IF YOU WISH TO RECEIVE NOTIFICATIONS REGARDING SAID POLICY, INCLUDING ANY NOTIFICATION OF CANCELLATIONS, OR TO VALIDATE THIS CERTIFICATE, VISIT OUR WEBSITE AT [HTTPS://WWW.NYSIF.COM/CERT/CERTVAL.ASP](https://www.nysif.com/cert/certval.asp). THE NEW YORK STATE INSURANCE FUND IS NOT LIABLE IN THE EVENT OF FAILURE TO GIVE SUCH NOTIFICATIONS.

THIS POLICY DOES NOT COVER THE SOLE PROPRIETOR, PARTNERS AND/OR MEMBERS OF A LIMITED LIABILITY COMPANY.

THE POLICY INCLUDES A WAIVER OF SUBROGATION ENDORSEMENT UNDER WHICH NYSIF AGREES TO WAIVE ITS RIGHT OF SUBROGATION TO BRING AN ACTION AGAINST THE CERTIFICATE HOLDER TO RECOVER AMOUNTS WE PAID IN WORKERS' COMPENSATION AND/OR MEDICAL BENEFITS TO OR ON BEHALF OF AN EMPLOYEE OF OUR INSURED IN THE EVENT THAT, PRIOR TO THE DATE OF THE ACCIDENT, THE CERTIFICATE HOLDER HAS ENTERED INTO A WRITTEN CONTRACT WITH OUR INSURED THAT REQUIRES THAT SUCH RIGHT OF SUBROGATION BE WAIVED.

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS NOR INSURANCE COVERAGE UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICY.

NEW YORK STATE INSURANCE FUND

DIRECTOR, INSURANCE FUND UNDERWRITING

VALIDATION NUMBER: 352564446



**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

| | |
|---|---|
| <p>1a. Legal Name & Address of Insured (use street address only) TRIPLE R DEVELOPMENT LLC 12 SCHEIBE ROAD LIBERTY, NY 12754</p> <p><i>Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e., Wrap-Up Policy)</i></p> | <p>1b. Business Telephone Number of Insured 8458664091</p> <p>1c. Federal Employer Identification Number of Insured or Social Security Number 47-2111396</p> |
| <p>2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) Orange County IDA 4 Crotty Lane Suite 100 New Windsor, NY 12553</p> | <p>3a. Name of Insurance Carrier Standard Security Life Insurance Company of New York</p> <p>3b. Policy Number of Entity Listed in Box "1a" R61636-000</p> <p>3c. Policy effective period <u>10/25/2017</u> to <u>6/9/2021</u></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 6/10/2020 By *Beth J. Adornil*
(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number (212) 355-4141 Name and Title SUPERVISOR-DBL/POLICY SERVICES

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.





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)
TRIPLE R DEVELOPMENT LLC
12 SCHEIBE ROAD
LIBERTY, NY 12754
1b. Business Telephone Number of Insured
8458664091
1c. Federal Employer Identification Number of Insured or Social Security Number
47-2111396
2. Name and Address of Entity Requesting Proof of Coverage
Orange County IDA
4 Crotty Lane
Suite 100
New Windsor, NY 12553
3a. Name of Insurance Carrier
Standard Security Life Insurance Company of New York
3b. Policy Number of Entity Listed in Box "1a"
R61636-000
3c. Policy effective period
10/25/2017 to 6/6/2022

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 6/7/2021 By [Signature]
(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)
Telephone Number (212) 355-4141 Name and Title SUPERVISOR-DBL/POLICY SERVICES

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.



BOYCE

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 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 Cool Insuring Agency Inc 784 Troy Schenectady Road Latham, NY 12110 518 783-2665 | CONTACT NAME: PHONE (A/C, No, Ext): 518 783-2665 FAX (A/C, No): 5187838754 E-MAIL ADDRESS: | |
| | INSURER(S) AFFORDING COVERAGE | |
| INSURED Boyce Excavating Co., Inc. PO Box 367; 2817 US Route 6 Slate Hill, NY 10973 | INSURER A : American Alternative Insurance Corp | NAIC # 19720 |
| | INSURER B : Berkley Insurance Company | |
| | INSURER C : Technology Insurance Company, Inc | 42376 |
| | INSURER D : Hanover Insurance company | 22292 |
| | INSURER E : American Family Home Ins Co | 23450 |
| | INSURER F : Standard Security Co | 22837 |

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 SUBR INSR 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 <input checked="" type="checkbox"/> Contractual Liab | | 88A5CP000004700 | 01/15/2020 | 01/15/2021 | EACH OCCURRENCE \$1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$1,000,000 MED EXP (Any one person) \$15,000 PERSONAL & ADV INJURY \$1,000,000 GENERAL AGGREGATE \$2,000,000 PRODUCTS - COMP/OP AGG \$2,000,000 OTHER \$ |
| | GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PRO-JECT <input checked="" type="checkbox"/> LOC OTHER: | | | | | |
| | AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO <input checked="" type="checkbox"/> ALL OWNED AUTOS <input checked="" type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS | | 88A5CA000073900 | 01/15/2020 | 01/15/2021 | COMBINED SINGLE LIMIT (Ea accident) \$1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ OTHER \$ |
| | <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 | | | MKC11100071 | 01/15/2020 | 01/15/2021 |
| C | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below | Y/N N | TWC3852151 | 01/15/2020 | 01/15/2021 | <input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$1,000,000 E.L. DISEASE - EA EMPLOYEE \$1,000,000 E.L. DISEASE - POLICY LIMIT \$1,000,000 |
| D | Lease/Rent Equip f Disability | | HSH136574 E09150000 | 01/15/2020 01/01/2020 | 01/15/2021 Continuous | \$750,000 NY Statutory |

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
 Gam Properties - King Zak and Triple R Development LLC is included as an additional insured under the General Liability coverage for work done by or on behalf of the named insured when required by written contract.

| | |
|--|--|
| CERTIFICATE HOLDER Gam Properties - King Zak 3 Police Drive Goshen, NY 10924 | 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  |
|--|--|

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
1/07/2021

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

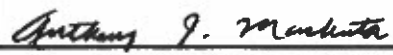
| | | |
|--|--|----------------------------------|
| PRODUCER Cool Insuring Agency Inc 784 Troy Schenectady Road Latham, NY 12110 518 783-2665 | CONTACT NAME: Heather M. Bearder | |
| | PHONE (A/C, No, Ext): 518 783-2665 | FAX (A/C, No): 5187838754 |
| E-MAIL ADDRESS: hmbearder@coolins.com | | |
| INSURED Boyce Excavating Co., Inc. PO Box 367; 2817 US Route 6 Slate Hill, NY 10973 | INSURER(S) AFFORDING COVERAGE | |
| | INSURER A: Valley Forge Insurance Company | NAIC # 20508 |
| | INSURER B: Continental Insurance Company | 35289 |
| | INSURER C: Hanover Insurance company | 22292 |
| | INSURER D: Standard Security Life | |
| | INSURER E: | |
| INSURER F: | | |

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 | ADDLSUBR INSR 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 <input checked="" type="checkbox"/> Contractual Liab GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PRO-JECT <input checked="" type="checkbox"/> LOC OTHER: | | 7011510449 | 01/15/2021 | 01/15/2022 | EACH OCCURRENCE \$1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$1,000,000 MED EXP (Any one person) \$15,000 PERSONAL & ADV INJURY \$1,000,000 GENERAL AGGREGATE \$2,000,000 PRODUCTS - COMPIOP AGG \$2,000,000 \$ |
| | AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS NON-OWNED AUTOS ONLY | | 7011510435 | 01/15/2021 | 01/15/2022 | COMBINED SINGLE LIMIT (Ea accident) \$1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$ |
| B | <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 | | 7011510466 | 01/15/2021 | 01/15/2022 | EACH OCCURRENCE \$5,000,000 AGGREGATE \$5,000,000 \$ |
| A | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? <input type="checkbox"/> Y <input checked="" type="checkbox"/> N (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below | N/A | 7011510452 | 01/15/2021 | 01/15/2022 | <input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTHER E.L. EACH ACCIDENT \$1,000,000 E.L. DISEASE - EA EMPLOYEE \$1,000,000 E.L. DISEASE - POLICY LIMIT \$1,000,000 |
| C | Lease/Rent Equip | | RHSH136574 | 01/15/2021 | 01/15/2022 | \$750,000 |
| D | Disability | | E09150000 | 01/01/2021 | Continuous | NY Statutory |

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Project: King Zak
 Orange County IDA is added to the General Liability and Auto Liability coverage as Additional Insured if required by written contract with respect to the above project.

| | |
|---|---|
| CERTIFICATE HOLDER Orange County IDA 4 Crotty Lane, Suite 100 New Windsor, NY 12553 | 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  |



CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

Form with fields for: 1a. Legal Name & Address of Insured, 1b. Business Telephone Number of Insured, 1c. NYS Unemployment Insurance Employer Registration Number of Insured, 1d. Federal Employer Identification Number of Insured or Social Security Number, 2. Name and Address of Entity Requesting Proof of Coverage, 3a. Name of Insurance Carrier, 3b. Policy Number of Entity Listed in Box "1a", 3c. Policy effective period, 3d. The Proprietor, Partners or Executive Officers are included/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 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.

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: Arthur J. Gallagher Risk Management Services, Inc. (Print name of authorized representative or licensed agent of insurance carrier)

Approved by: [Signature] 1/12/2022 (Signature) (Date)

Title: Area President

Telephone Number of authorized representative or licensed agent of insurance carrier: 518-558-3103

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.



**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

| | |
|---|--|
| <p>1a. Legal Name & Address of Insured (use street address only) BOYCE EXCAVATING CO., INC. 2817 ROUTE 6 SLATE HILL, NY 10973</p> <p><i>Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e., Wrap-Up Policy)</i></p> | <p>1b. Business Telephone Number of Insured 8453435400</p> <p>1c. Federal Employer Identification Number of Insured or Social Security Number 14-1437669</p> |
| <p>2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) Orange County IDA 4 Crotty Lane, Suite 100 New Windsor, NY 12553</p> | <p>3a. Name of Insurance Carrier Standard Security Life Insurance Company of New York</p> <p>3b. Policy Number of Entity Listed in Box "1a" E09150-000</p> <p>3c. Policy effective period <u>1/1/1994</u> to <u>6/14/2021</u></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 6/15/2020 By 
(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number (212) 355-4141 Name and Title SUPERVISOR-DBL/POLICY SERVICES

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)

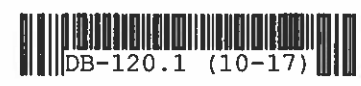
**State of New York
Workers' Compensation Board**

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.





CERTIFICATE OF INSURANCE COVERAGE under the NYS DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

PART 1. To be completed by Disability Benefits Carrier or Licensed Insurance Agent of that Carrier

| | |
|--|--|
| <p>1a. Legal Name and Address of Insured (Use street address only)</p> <p>Boyce Excavating Co., Inc. PO Box 367; 2817 US Route 6 Slate Hill, NY 10973</p> | <p>1b. Business Telephone Number of Insured 845 343-5400</p> <p>1c. NYS Unemployment Insurance Employer Registration Number of Insured</p> <p>1d. Federal Employer Identification Number of Insured or Social Security Number 14-1437669</p> |
|--|--|

| | |
|--|--|
| <p>2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)</p> <p>Orange County IDA 4 Crotty Lane, Suite 100 New Windsor, NY 12553</p> | <p>3a. Name of Insurance Carrier Standard Security Life</p> <p>3b. Policy Number of entity listed in box "1a": E09150000</p> <p>3c. Policy effective period: <u>01/01/2021</u> to <u>01/01/2022</u></p> |
|--|--|

4. Policy provides the following benefits:

- a. Both disability & 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 New York Disability & Paid Family Leave Benefit 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 Benefits insurance coverage as described above.

Date Signed June 17, 2021 By *Anthony J. Macchato*
 (Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number (800) 233-0115 Title Authorized Representative

IMPORTANT: If box "4a" is 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 Disability and Paid Family Leave Benefits Law. It must be mailed for completion to the Workers' Compensation Board, DB Plans Acceptance Unit, 20 Park Street, Albany, New York 12207.

PART 2. To be completed by NYS Workers' Compensation Board (Only if box "4b" 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 Benefits Law with respect to all of his/her employees.

Date Signed _____ By _____
 (Signature of NYS Workers' Compensation Board Employee)

Telephone Number _____ Title _____

Please Note: Only insurance carriers licensed to write NYS disability 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.





**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

| | |
|---|---|
| <p>1a. Legal Name & Address of Insured (use street address only) Boyce Excavating Co., Inc. PO Box 367, 2617 US Route 6 State Hill, NY 10973</p> <p><i>Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e., Wrap-Up Policy)</i></p> | <p>1b. Business Telephone Number of Insured 845-343-5400</p> <p>1c. Federal Employer Identification Number of Insured or Social Security Number 141437669</p> |
| <p>2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) Orange County IDA 4 Crotty Lane, Suite 100 New Windsor, NY 12553 USA</p> | <p>3a. Name of Insurance Carrier Standard Security Life Ins Co of NY</p> <p>3b. Policy Number of Entity Listed in Box "1a" E09150000</p> <p>3c. Policy effective period 01/01/2022 to 01/01/2023</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 1/12/2022 By Robert Y. Crandall
(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number 518-556-3103 Name and Title Robert Crandall Area President

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.



RANCOURT



**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

| | |
|--|--|
| <p>1a. Legal Name & Address of Insured (use street address only) RANCOURT AND SON LAND CLEARING CORP. PO BOX 444 POUGHQUAG, NY 12570 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 845-724-5705 1c. Federal Employer Identification Number of Insured or Social Security Number 651160829</p> |
| <p>2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) Orange County IDA 4 Crotty Lane, Suite 100 New Windsor, NY 12553</p> | <p>3a. Name of Insurance Carrier ShelterPoint Life Insurance Company 3b. Policy Number of Entity Listed in Box "1a" DBL395761 3c. Policy effective period 01/01/2020 to 12/31/2021</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 7/10/2020 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.





CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

07/13/2020

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 Bisland Agency, Inc. 1681 Forestburgh Rd PO Box 500 Glen Spey NY 12737 | CONTACT NAME: TAMMY BISLAND PHONE (A/C, No, Ext): (845) 856-6180 E-MAIL ADDRESS: tbisland@bislandinsurance.com | FAX (A/C, No): (845) 856-1551 |
| | INSURER(S) AFFORDING COVERAGE | |
| INSURED TDS Electric LLC PO Box 135 Barryville NY 12719 | INSURER A: Calicoon Co-Operative Insurance Company | |
| | INSURER B: | |
| | INSURER C: | |
| | INSURER D: | |
| | INSURER E: | |
| | INSURER F: | |

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 | Y | | S4 2101 19165 01 | 01/24/2018 | 01/24/2021 | EACH OCCURRENCE \$ 1,000,000 |
| | GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER: | | | | | | DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ 1,000 PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000 Personal Injury \$ 1million/2million |
| | AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY | | | | | | COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ |
| | <input type="checkbox"/> UMBRELLA LIAB <input type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$ | | | | | | EACH OCCURRENCE \$ AGGREGATE \$ |
| | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) <input type="checkbox"/> If yes, describe under DESCRIPTION OF OPERATIONS below | | N/A | | | | PER STATUTE OTH-ER E.L. EACH ACCIDENT \$ 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)
 Electrical work for a small office and warehouse, located at King Zac Industries, 3 Police Drive, Goshen NY, from 7/13/2020 - 1/24/2021. The Certificate Holder is also an Additional Insured, as per form LS-22 (1/88 ed).

| | |
|---|---|
| CERTIFICATE HOLDER Orange County IDA 4 Crotty Lane, Suite 100 New Windsor, NY 12553 | 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  |
|---|---|

BISLAND AGENCY, INC.
GENERAL INSURANCE
1681 FORESTBURGH ROAD
PO BOX 500
GLEN SPEY, NY 12737

Phone: 845-856-6180
Fax: 845-856-1551

August 25, 2020

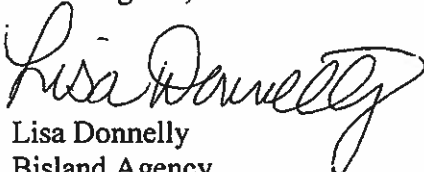
Re: Jack Sardina

To whom it may concern:

Mr. Sardina's 2005 GMC Pickup Truck, Vin #1GTHK29285E265269, is insured with Preferred Mutual Insurance Company- Personal Auto Policy # PPA 0100 55 35 53, and is rated with Business Use.

If you have any questions, please feel free to contact this office.

With Regards,


Lisa Donnelly
Bisland Agency



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
08/20/2020

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.

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| | | | |
|--|--------------------------------------|--|--------|
| PRODUCER Bisland Agency, Inc. 1681 Forestburgh Rd PO Box 500 Glen Spey NY 12737 | CONTACT NAME: Kelly Kolvenbach | FAX (A/C, No): (845) 856-1551 | |
| | PHONE (A/C, No, Ext): (845) 856-6180 | E-MAIL ADDRESS: kkolvenbach@bislandinsurance.com | |
| INSURED Jack Sardina PO Box 135 Barryville NY 12719 | INSURER(S) AFFORDING COVERAGE | | NAIC # |
| | INSURER A: Preferred Mutual | | 15024 |
| | INSURER B: | | |
| | INSURER C: | | |
| | INSURER D: | | |
| | INSURER E: | | |

COVERAGES

CERTIFICATE NUMBER: CL2081901070

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 | |
|----------|---|-----------|----------|-------------------|-------------------------|-------------------------|-------------------------------------|-------|
| | COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC OTHER: | | | | | | EACH OCCURRENCE | \$ |
| A | AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> NON-OWNED AUTOS ONLY | | | PPA 0100 55 35 53 | 06/15/2020 | 06/15/2021 | COMBINED SINGLE LIMIT (Ea accident) | \$ |
| | UMBRELLA LIAB <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$ | | | | | | EACH OCCURRENCE | \$ |
| | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory In NH) If yes, describe under DESCRIPTION OF OPERATIONS below | | N/A | | | | PER STATUTE | OTHER |
| | | | | | | | E.L. EACH ACCIDENT | \$ |
| | | | | | | | 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)

2005 GMC Pick up Vin # 1GTHK29285E265269

CERTIFICATE HOLDER

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

© 1988-2015 ACORD CORPORATION. All rights reserved.



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
02/19/2021

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.

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| PRODUCER The Briggs & Sipple Agency, Inc. 26 Katrina Falls Road PO Box 804 Rock Hill NY 12775 | CONTACT NAME: Susan Carnell PHONE (A/C No. Ext): (845) 794-2666 FAX (A/C No.): (845) 794-3091 E-MAIL ADDRESS: scamell@briggsandsippleagency.com | | | | | | | | | | | | | | | | | | | | |
|---|---|-------------------------------|--|--------|------------|--------------------------------------|-------|------------|---------------------------|--|------------|--|--|------------|--|--|------------|--|--|------------|--|
| | <table border="1"> <tr> <th colspan="2">INSURER(S) AFFORDING COVERAGE</th> <th>NAIC #</th> </tr> <tr> <td>INSURER A:</td> <td>National Grange Mutual Insurance Co.</td> <td>14788</td> </tr> <tr> <td>INSURER B:</td> <td>Main Street America Group</td> <td></td> </tr> <tr> <td>INSURER C:</td> <td></td> <td></td> </tr> <tr> <td>INSURER D:</td> <td></td> <td></td> </tr> <tr> <td>INSURER E:</td> <td></td> <td></td> </tr> <tr> <td>INSURER F:</td> <td></td> <td></td> </tr> </table> | INSURER(S) AFFORDING COVERAGE | | NAIC # | INSURER A: | National Grange Mutual Insurance Co. | 14788 | INSURER B: | Main Street America Group | | INSURER C: | | | INSURER D: | | | INSURER E: | | | INSURER F: | |
| INSURER(S) AFFORDING COVERAGE | | NAIC # | | | | | | | | | | | | | | | | | | | |
| INSURER A: | National Grange Mutual Insurance Co. | 14788 | | | | | | | | | | | | | | | | | | | |
| INSURER B: | Main Street America Group | | | | | | | | | | | | | | | | | | | | |
| INSURER C: | | | | | | | | | | | | | | | | | | | | | |
| INSURER D: | | | | | | | | | | | | | | | | | | | | | |
| INSURER E: | | | | | | | | | | | | | | | | | | | | | |
| INSURER F: | | | | | | | | | | | | | | | | | | | | | |
| INSURED TDS ELECTRIC, LLC PO BOX 135 BARRYVILLE NY 12719-0135 | | | | | | | | | | | | | | | | | | | | | |

COVERAGES **CERTIFICATE NUMBER:** CL2121902092 **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 | ADDITIONAL INSURED | WARRANTY | 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"/> PROJECT <input type="checkbox"/> LOC OTHER: | Y | | MPZ5483E | 10/26/2020 | 10/26/2021 | EACH OCCURRENCE \$ 2,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 500,000 MED EXP (Any one person) \$ 10,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 4,000,000 PRODUCTS - COMP/OP AGG \$ 4,000,000 Empl Practices Liab Ins \$ |
| B | AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS ONLY <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY | | | B1Z5483E | 10/26/2020 | 10/26/2021 | COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ Uninsured motorist \$ 1,000,000 |
| | UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$ | | | | | | EACH OCCURRENCE \$ AGGREGATE \$ PER STATUTE OTH-FR |
| | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below | Y/N | N/A | | | | E.L. EACH ACCIDENT \$ 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)

| | |
|--|---|
| CERTIFICATE HOLDER Orange County IDA 4 County Lane Suite 100 New Windsor NY 12553 | 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  |
|--|---|



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
11/19/2021

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.

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| | | |
|--|---|-----------------------------------|
| PRODUCER The Briggs & Sipple Agency, Inc. 26 Katina Falls Road PO Box 804 Rock Hill NY 12775 | CONTACT NAME: Susanna Carroll PHONE (AC, Ho, Ext): (845) 794-2658 E-MAIL ADDRESS: scarroll@briggsandsippleagency.com | FAX (AC, Ho): 845-794-3051 |
| INSURED TDS ELECTRIC, LLC PO BOX 135 BARRYVILLE NY 12719-0135 | INSURER(S) AFFORDING COVERAGE | |
| | INSURER A: Main Street America | RAC # 2293 |
| | INSURER B: National Grange Mutual | |
| | INSURER C: Main Street America Group | |
| | INSURER D: | |
| | INSURER E: | |
| | INSURER F: | |

COVERAGES **CERTIFICATE NUMBER:** CL21111902351 **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 COVR INSD WYD | 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"/> PROJECT <input type="checkbox"/> LOC OTHER: | Y | MPZ5483E | 10/26/2021 | 10/26/2022 | EACH OCCURRENCE \$ 2,000,000 DAMAGE TO RENTED PREMISES (EA OCCURRENCE) \$ 500,000 MED EXP (Any one person) \$ 10,000 PERSONAL & ADY INJURY \$ 2,000,000 GENERAL AGGREGATE \$ 4,000,000 PRODUCTS - COMP/PROP AGG \$ 4,000,000 Empl Practices Liab Ins \$ |
| B | AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY | | B1Z5483E | 10/26/2021 | 10/26/2022 | COMBINED SINGLE LIMIT (EA accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ Uninsured motorist \$ 1,000,000 |
| C | <input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$ | | CUZ6366F | 10/26/2021 | 10/26/2022 | EACH OCCURRENCE \$ 5,000,000 AGGREGATE \$ 5,000,000 PER STATUTE OTH-ER \$ |
| C | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below | Y/N N | WCZ5483E | 04/26/2021 | 04/26/2022 | 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)

| | |
|--|--|
| CERTIFICATE HOLDER Orange County IDA 4 Country Lane, Ste 100 New Windsor NY 12553 | 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 <i>Susanna Carroll</i> |
|--|--|

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| | |
|--|--|
| PRODUCER USI Insurance Services LLC 40 Bay Lea Road, Suite A201 Toms River, NJ 08753 | CONTACT NAME: Donna M. Volz |
| | PHONE (A/C, No, Ext): 732-908-5554 FAX (A/C, No): 732-349-0186 E-MAIL ADDRESS: |
| INSURED TDS Electric LLC PO Box 135 Barryville, NY 12719 | INSURER(S) AFFORDING COVERAGE INSURER A : NorGuard Insurance Company NAIC # 31470 |
| | INSURER B : |
| | INSURER C : |
| | INSURER D : |
| | INSURER E : |
| | INSURER F : |

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

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| INSR LTR | TYPE OF INSURANCE | ADDL INSR | SUBR INSR | POLICY NUMBER | POLICY EFF (MM/DD/YYYY) | POLICY EXP (MM/DD/YYYY) | LIMITS |
|----------|---|-----------|-----------|-------------------|-------------------------|-------------------------|--|
| | COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER: | | | | | | EACH OCCURRENCE \$ DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS - COMP/OP AGG \$ \$ |
| | AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> NON-OWNED AUTOS ONLY | | | | | | COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$ |
| | UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$ | | | | | | EACH OCCURRENCE \$ AGGREGATE \$ \$ |
| A | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? <input checked="" type="checkbox"/> Y / <input type="checkbox"/> N (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below | | N/A | TDWC126673 | 06/25/2020 | 06/25/2021 | PER STATUTE OTH-ER E.L. EACH ACCIDENT \$100,000 E.L. DISEASE - EA EMPLOYEE \$100,000 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)

This Certificate is issued for insured operations usual to Electrical Contracting

| | |
|---|--|
| CERTIFICATE HOLDER Orange County IDA 4 Crotty Lane, Suite 100 New Windsor, NY 12553 | 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 <i>Ullie Scott</i> |
|---|--|



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
04/29/2021

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).

| | | | |
|----------------------------------|--|--|--------------------------------------|
| PRODUCER | | CONTACT NAME: Susanne Camell | |
| The Briggs & Sipple Agency, Inc. | | PHONE (A/C No. Ext): (845) 794-2666 | FAX (A/C No.): (845) 794-3091 |
| 26 Katrina Falls Road | | E-MAIL ADDRESS: scamell@briggsandsippleagency.com | |
| PO Box 804 | | INSURER(S) AFFORDING COVERAGE | |
| Rock Hill NY 12775 | | INSURER A: Main Street America Group | NAIC # |
| INSURED | | INSURER B: | |
| TDS ELECTRIC LLC | | INSURER C: | |
| PO BOX 135 | | INSURER D: | |
| BARRYVILLE NY 12719-0135 | | INSURER E: | |
| | | INSURER F: | |

COVERAGES **CERTIFICATE NUMBER:** CL2142902164 **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 |
|----------|---|-----------|----------|---------------|-------------------------|-------------------------|---|
| | COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER: | | | | | | EACH OCCURRENCE \$ DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS - COM/OP AGG \$ \$ |
| | AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY <input type="checkbox"/> | | | | | | COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$ |
| | UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$ | | | | | | EACH OCCURRENCE \$ AGGREGATE \$ \$ |
| A | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below | Y/N | N/A | WCZ5483E | 04/26/2021 | 04/26/2022 | PER STATUTE 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)

| | |
|---|--|
| CERTIFICATE HOLDER | CANCELLATION |
| Orange County IDA 4 Crotty Lane, Suite 100 New Windsor NY 12553 | 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 <i>Susanne Camell</i> |

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**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

| | |
|--|--|
| <p>1a. Legal Name & Address of Insured (use street address only) TDS Electrical LLC</p> <p>21 Kern Road BARRYVILLE, NY 12719 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 (845) 807-8768 x</p> <p>1c. Federal Employer Identification Number of Insured or Social Security Number 82-4298519</p> |
| <p>2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) Orange County IDA</p> <p>4 Crotty Lane, Suite 100 New Windsor, NY 12553</p> | <p>3a. Name of Insurance Carrier Standard Security Life Insurance Company of New York</p> <p>3b. Policy Number of Entity Listed in Box "1a" L88548-000</p> <p>3c. Policy effective period 6/25/2019 to 7/9/2021</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 7/10/2020 By *Bebi A. Ishmail*
(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number (212) 355-4141 Name and Title Bebi Ishmail, Supervisor-DBL/Policy Services

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.





**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

| | |
|--|---|
| <p>1a. Legal Name & Address of Insured (use street address only) TDS ELECTRIC, LLC ATTN: JACK SARDINA PO BOX 135 BARRYVILLE, NY 12719</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 845-807-8768</p> <p>1c. Federal Employer Identification Number of Insured or Social Security Number 824298519</p> |
| <p>2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) Orange County IDA 4 Crotty Lane, Suite 100 New Windsor, New York 12553</p> | <p>3a. Name of Insurance Carrier ShelterPoint Life Insurance Company</p> <p>3b. Policy Number of Entity Listed in Box "1a" DBL644227</p> <p>3c. Policy effective period <u>07/28/2021</u> to <u>07/27/2022</u></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 7/28/2021 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.



MD DRILLING

BOARD OF DIRECTORS

August 20, 2020

Mary Ellen Rogulski
- CHAIRMAN

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- SECOND VICE CHAIRMAN

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- SECRETARY

Michael Gaydos
- ASSISTANT SECRETARY

John McCarey

Herb Zakarin
GAM Property Corp.
3 Police Drive, PO Box 1029
Goshen, NY 10924

Dear Mr. Zakarin:

Please be advised our independent auditor, Loewke Brill Consulting Group, has reviewed the Local Labor Verified Exemption Request you submitted related to the GAM Property Corp. application for Drilling and Blasting by MD Drilling at the 3 Police Dr, Goshen, NY 10924 project site.

Based on our independent auditor's findings on information you supplied them and related to the Exemption Request, as well as the criteria established by the Orange County Industrial Development Agency, your Local Verified Exemption Request has been approved.

OPERATIONS STAFF

Laurie Villasuso
- CHIEF EXECUTIVE
OFFICER

Melanie Schouten
- CHIEF OPERATING
OFFICER

Edward Januskiewicz
- CHIEF FINANCIAL OFFICER

Kevin T. Dowd
- ATTORNEY

A copy of this letter approving the exemption from the local labor requirement must be kept on site for the inspector to see when making site visits to monitor for compliance with the local labor requirements.

Should you have any further questions or concerns or would like to discuss in greater detail I can be reached at 845-220-2208.

Sincerely,



Laurie Villasuso
Chief Executive Officer

LOEWKE BRILL CONSULTING GROUP, INC

August 3rd, 2020

Laurie Villasuso
Chief Operating Officer
Executive Vice President of Economic Development
Orange County IDA – The Accelerator
4 Crotty Lane, Suite 100
New Windsor, NY 12553

Project: GAM Property Corp – Requests for Verified Exemptions
Specialty Services: Blasting

GAM Property Corp is seeking a waiver for specialty services related to drilling and blasting at the project site located at 3 Police Drive in Goshen NY. **Background:**

MD Blasting and Drilling is a Connecticut based company that performs blasting of this nature in confined spaces and around dated utility connections. There was only one other local company that we had Ramon Gonzalez (Project manager, Triple R Development) reach out to, Roehrs Construction. After submitting designs and Geotech report to Roehrs, it was determined they could not perform the job due to the age of the utility wires surrounding the project.

Loewke Brill considers this waiver request to be valid and recommends the waiver to be processed.

Sincerely,

Kevin E Loewke



Orange County Industrial Development Agency

Local Labor
Verified Exemption Request

The request to secure a verified exemption for use of non-local labor must be received in writing from the applicant, and must allow 60 days for processing and required due diligence. Loewke Brill does not accept exemption requests for companies located within the local labor area.

APPLICANT NAME: Gam Property Corp

CONTACT: Ramon Gonzalez

PHONE (B) (845) 866-4091 PHONE (CELL) Same

FAX (845) 985-2418 EMAIL Ramon@TripleRD.com

REASON FOR REQUEST

- 1) Warranty issues related to installation of specialized equipment whereby the manufacturer requires installation by only approved installers. - EXPLAIN
2) Specialized construction in which a local contractor is not available - EXPLAIN
3) Significant cost differentials in bids; whereby use of local labor significantly increases the cost of the project. A cost differential of 10% is deemed significant. Where there is a significant cost differential, if the local contractor agrees to reduce the bid to the average of the two bids, no waiver will be granted. However, if the average is still 10% or more, a waiver will be granted - EXPLAIN (PROVIDE COPIES OF ALL BIDS)
4) No local labor available for the project - EXPLAIN

Applicant Signature: [Signature] Date: 2020.07.29

Amount of Contract Needing Verified Exemption: \$513,300.00

Number of Workers Needing Verified Exemption(s): 4 - 5

Send Completed Form and Attachments to our auditors: Kevin E. Loewke
Loewke Brill Consulting Group
491 Elmgrove Road - Suite 2
Rochester, NY 14606
Kevin@loewkebrill.com



July 29, 2020

Kevin Loewke
Loewke Brill Consulting Group, Inc.
491 Elmgrove Rd.
Suite 2
Rochester, NY 14606

Project: Gam Property Corp – 3 Police Drive, Goshen, NY 10924
Specialty Services: Rock Blasting

Kevin,

As the construction manager for the above noted project I am writing to you seeking a waiver for specialty services. The service is the blasting that needs to take place to complete the site work required for this project. While you and I have had multiple conversations regarding this situation, I have included a summary of our efforts below.

The only local contractor that can perform this service is Roehrs Construction. We have made many attempts to obtain a formal proposal from this vendor. Boyce Excavating, the project's site vendor, has reached out to Roehrs on multiple occasions. Aside from the initial conversation, they received no written responses. In an effort to make sure we were trying all avenues, I (Ramon Gonzalez, Triple R Development) also reached out to Dave Roehrs. I was able to speak with him and personally re-sent the plans for him to look at and price. From that point on, I did not get a response. Two weeks ago, Boyce received a call from Brian at Roehrs who said that their price for this job would be between \$700,000.00 - \$800,000.00 to complete. Although this was requested in writing, nothing more was received. From there, I know you (Kevin Loewke) also tried to speak with Dave. On or about July 22nd, Dave indicated that they are not able to do this work because of the high voltage power lines running near the site. This was due to restrictions from their insurance carrier.

In summary, we need a specialty services waiver to keep this project moving. We have spent weeks trying to get the only known local vendor to work with us and all avenues have resulted in no positive results. Roehrs has not complied with our requests to send an email to





summarize their price and inability to complete this project. I am including the emails from Boyce and myself to Roehrs to show that attempts have been made. On top of the written requests there have been multiple calls made to them as well. At this point, it is critical to secure this waiver.

Regards,

A handwritten signature in black ink, appearing to read 'Ramon Gonzalez', is written over a light gray circular stamp.

Ramon Gonzalez
Triple R Development





Original Boyce Email Chain

Ramon Gonzalez III <ramon@triplerd.com>

Fwd: King Zak Blasting

7 messages

Ashley Allensworth <ashleya@boyceexcavating.net>
To: Ramon Gonzalez III <ramon@triplerd.com>
Cc: Josh Strang <josh@boyceexcavating.net>, Matthew Quinlan <matthewq@boyceexcavating.net>

Wed, Jul 8, 2020 at 3:44 PM

Ramon,

Please see the below emailing showing our requests for a quote with no response from Roehrs. Is this sufficient?

Thank you,

----- Forwarded message -----

From: Josh Strang <josh@boyceexcavating.net>
Date: Wed, Jul 8, 2020 at 8:42 AM
Subject: Re: King Zak Blasting
To: Ashley Allensworth <ashleya@boyceexcavating.net>
Cc: <brian@roehrsconstruction.com>, Matthew Quinlan <matthewq@boyceexcavating.net>

Brian,

We really needed a price prior to today bc we have a blasting meeting today. Please let us know today either way if you will be pricing.

Thank you

Josh Strang
Vice President
Boyce Excavating Co. Inc.

Cell: (845)741-6849
Office: (845)343-5400
Fax: (845)343-2194

On Wed, Jul 8, 2020 at 8:37 AM Ashley Allensworth <ashleya@boyceexcavating.net> wrote:
Brian,

Can you please let me know if you plan on bidding this project? We are looking to get this work started ASAP. If you are not able to price please let me know via email as soon as possible.

Thank you,

On Tue, Jul 7, 2020 at 9:49 AM Ashley Allensworth <ashleya@boyceexcavating.net> wrote:
Brian,

Can you update us on when we can expect pricing for the above mentioned project?

Thank you,

On Thu, Jul 2, 2020 at 1:13 PM Ashley Allensworth <ashleya@boyceexcavating.net> wrote:
Good afternoon,

Can you please provide us with pricing for the above mentioned project? We are awarded this project and would be looking to start blasting as soon as possible.

Would you be able to provide a quote by Monday?

Drawings and Geotech are attached.

Thank you,

ActivePlan.KingZak.Revision4. 6.16.20 .pdf

--
Ashley Allensworth
Assistant Project Manager
Assistant Estimator



ashleya@boyceexcavating.net
office- 845-343-5400
fax- 845-343-2194
cell- 845-775-1136

--
Ashley Allensworth
Assistant Project Manager
Assistant Estimator



ashleya@boyceexcavating.net
office- 845-343-5400
fax- 845-343-2194
cell- 845-775-1136

Ashley Allensworth
Assistant Project Manager
Assistant Estimator



ashleya@boyceexcavating.net
office- 845-343-5400
fax- 845-343-2194
cell- 845-775-1136

Ashley Allensworth
Assistant Project Manager
Assistant Estimator



ashleya@boyceexcavating.net
office- 845-343-5400
fax- 845-343-2194
cell- 845-775-1136

Ramon Gonzalez III <ramon@triplerd.com>
To: Ashley Allensworth <ashleya@boyceexcavating.net>
Cc: Josh Strang <joshs@boyceexcavating.net>, Matthew Quinlan <matthewq@boyceexcavating.net>

Wed, Jul 8, 2020 at 4:06 PM

Ashley - Thank you for sending this.

Josh - You spoke to them initially and they were interested but have been non responsive since rite?

Thank you.

Ramon Gonzalez

Triple R Development

E: Ramon@TripleRD.com

P: (845) 866-4091

F: (845) 985-2418

[Quoted text hidden]

Josh Strang <joshs@boyceexcavating.net>
To: Ramon Gonzalez III <ramon@triplerd.com>
Cc: Ashley Allensworth <ashleya@boyceexcavating.net>, Matthew Quinlan <matthewq@boyceexcavating.net>

Thu, Jul 9, 2020 at 6:33 AM

That is correct!

Josh Strang
Vice President
Boyce Excavating Co. Inc

Cell: (845)741-6849
Office: (845)343-5400
Fax: (845)343-2194

Second Request from Boyce for a proposal

[Quoted text hidden]

Matthew Quinlan <matthewq@boyceexcavating.net>
To: brian@roehrsconstruction.com, dave@roehrsconstruction.com
Cc: Josh Strang <joshs@boyceexcavating.net>, Ashley Allensworth <ashleya@boyceexcavating.net>, Ramon Gonzalez III <ramon@triplerd.com>

Fri, Jul 10, 2020 at 4:15 PM

Dave/Brian,

This is the second attempt at sending the plans to you. Please confirm receipt of this email and its attachments at your earliest convenience and let us know your interest in bidding the blasting portion of this job.

Thank you.

Matthew Quinlan Project Manager, Boyce Excavating Co., Inc.



Phone (845) 343-5400 Fax (845) 343-2194
Cell. (973) 479-6696
Email matthewq@boyceexcavating.net
Website www.boyceexcavating.net
Address 2817 Route 6, P.O. Box 367, State Hill, NY 10973

We Move The Earth

[Quoted text hidden]

GeoTechReport_KingZak.pdf
2008K

Josh Strang <joshs@boyceexcavating.net>
To: Ramon Gonzalez III <ramon@triplerd.com>, Ashley Allensworth <ashleya@boyceexcavating.net>, Matthew Quinlan <matthewq@boyceexcavating.net>

Mon, Jul 13, 2020 at 9:13 AM

Ramon still no response from these guys and we're expecting to receive signed contract from Maine drilling and blasting shortly.

Josh Strang
Vice President
Boyce Excavating Co. Inc

Cell: (845)741-6849
Office: (845)343-5400
Fax: (845)343-2194

[Quoted text hidden]

 **GeoTechReport_KingZak.pdf**
2008K

Ashley Allensworth <ashleya@boyceexcavating.net>
To: Ramon Gonzalez III <ramon@triplerd.com>
Cc: Josh Strang <joshs@boyceexcavating.net>, Matthew Quinlan <matthewq@boyceexcavating.net>

Wed, Jul 15, 2020 at 12:50 PM

Ramon,

See the full thread of emails with no responses from Roehrs. We have also not received any phone calls or texts regarding this project, from them.

Thank you,
[Quoted text hidden]

 **GeoTechReport_KingZak.pdf**
2008K

Ramon Gonzalez III <ramon@triplerd.com>
To: Ashley Allensworth <ashleya@boyceexcavating.net>
Cc: Josh Strang <joshs@boyceexcavating.net>, Matthew Quinlan <matthewq@boyceexcavating.net>

Wed, Jul 15, 2020 at 1:21 PM

Ashley,

The only new email I see is Matts from Friday. Is there more than that?

Thank you,

Ramon Gonzalez

Triple R Development

E: Ramon@TripleRD.com

P: (845) 866-4091

F: (845) 985-2418

[Quoted text hidden]

Ashley Allensworth <ashleya@boyceexcavating.net>
To: Ramon Gonzalez III <ramon@triplerd.com>
Cc: Josh Strang <joshs@boyceexcavating.net>, Matthew Quinlan <matthewq@boyceexcavating.net>

Wed, Jul 15, 2020 at 1:25 PM

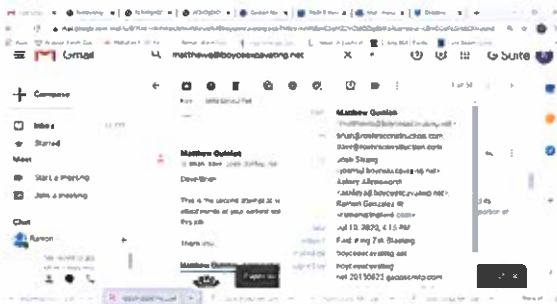
No there isn't.
[Quoted text hidden]

Ramon Gonzalez III <ramon@triplerd.com>
To: Kevin Loewke <kevin@loewkebill.com>

Wed, Jul 15, 2020 at 1:31 PM

Kevin,

Here is the email from Friday that was sent from Boyce to Roehrs. Below is also a screenshot from that email showing the two Roehrs email addresses it was sent to.



Thank you,

Ramon Gonzalez

Triple R Development

E: Ramon@TripleRD.com

P: (845) 866-4091

7/29/2020

Triple R Development LLC Mail - Fwd: King Zak Blasting

F: (845) 985-2418

----- Forwarded message -----

From: **Matthew Quinlan** <matthewq@boyceexcavating.net>

Date: Fri, Jul 10, 2020 at 4:15 PM

Subject: Fwd: King Zak Blasting

To: <bnan@rohrsconstruction.com>, <dave@rohrsconstruction.com>

Cc: Josh Strang <josh@boyceexcavating.net>, Ashley Allensworth <ashleya@boyceexcavating.net>, Ramon Gonzalez III <ramon@triplerd.com>

(Quoted text hidden)

 **GeoTechReport_KingZak.pdf**
2008K



Ramon Gonzalez III <ramon@triplerd.com>

Fwd: King Zak Blasting

Ashley Allensworth <ashleya@boyceexcavating.net>

Wed, Jul 29, 2020 at 12:55 PM

To: brian@roehrsconstruction.com, dave@roehrsconstruction.com

Cc: Josh Strang <josh@boyceexcavating.net>, Ramon Gonzalez III <ramon@triplerd.com>, Matthew Quinlan <matthewq@boyceexcavating.net>

Brian/Dave,

Would you mind responding VIA EMAIL stating what you told Josh as to why you wouldn't be able to bid this project? We need this to help satisfy the Orange County IDA.

Thank you,
[Quoted text hidden]

**Written Request to Roehrs
asking for a response in writing**



Request for proposal from Triple R. This was sent immediately after speaking with Dave

Ramon Gonzalez III <ramon@triplerd.com>

King Zak

1 message

Ramon Gonzalez III <ramon@triplerd.com>

To: Dave@roehrsconstruction.com

Cc: Bnan@roehrsconstruction.com, Kevin Loewke <kevin@loewkebrill.com>

Wed, Jul 15, 2020 at 4:11 PM

Dave,

Thank you for taking the time to speak with me. Below is a link to the site plan and the geo-tech report is attached. The plan is too large to send as an attachment. Since a large portion of the hill on the east side is going to be rock the goal is to use that rock face in place of the retaining wall shown on the site plan. The face of the rock does not need to be perfect but it does need to be stable. Based on what I have there is aprox 61,000 cubic yards of rock to drill and blast. Please call me if you have any questions.

Full Site Plan

Thank you,

Ramon Gonzalez

Triple R Development

E: Ramon@TripleRD.com

P: (845) 866-4091

F: (845) 985-2418

GeoTechReport_KingZak.pdf
2008K

Subcontractor:

MD Drilling & Blasting
103 Old Windsor RD
Bloomfield, CT 06002

Phone: 860-242-5993
Fax: 860-242-9375



www.mdandb.com

Contractor:

Boyce Excavating
2817 US Route 6
PO Box 367
Slate Hill, NY 10973

Cust. ID: 81425
Contact: Neil Andre
Cust. Phone: 845 343-5400
Cust. Fax: 845 343-2194

Quote No: 19-14221-02
Date: September 17, 2019

Vendor for which we are
seeking the waiver

King Zak Warehouse

3 Police Highway Goshen, NY

Thank you for the opportunity to quote your drilling and blasting needs on the above referenced project. The following are our prices:

SCOPE OF WORK:

Our pricing is based upon:

- A civil plan set titled "Warehouse Expansion Site Plan" prepared by Esposito & Associates drawn April 10, 2018, last revised April 25, 2019.
- A geotechnical report titled "Geotechnical Assessment Report" prepared by Kevin L. Patton, P.E. dated July 27, 2018.

Clarifications

- No blasting specifications provided, blast design will be based upon the USBM Alternative Blasting Level Criteria, Appendix B.
- No test pit or boring data is available for this site at this time. Quantities assume average of 1.5 ft of overburden across entire site.
- Pricing is based on 61,000 CY with an 11 ft average cut.
- No drilling or blasting will be performed within 25ft of Orange & Rockland structures or conductors. Pricing does not include costs associated with special inspections or monitoring of O&R property, facilities, or equipment.
- Mechanical ledge removal by the contractor in the blasting zone will substitute for blasting as long as the result meets subgrade. If this effort leaves high spots, Subcontractor will drill and blast the high spots on a daily rate basis.
- A minimum depth drillhole of 9 ft will be used, which will create the potential for overblast within the proposed building footprint. MD D&B will work with the contractor on developing an overburden removal plan in order to minimize overblast
- Trench blasting is not included at this time.
- A minimum of a 330 Cat Class excavator is required for handling and setting of blasting mats.
- No blasting will be performed within 25ft of the existing warehouse or utilities that are to remain.
- Blasting for the building addition and slope will be measured and billed by the Cubic Yard.

- Blasting for the detention ponds will be measured and billed by the square foot. Square footage will be measured as the burden x the spacing x number of holes shot.

EXCLUSIONS

- Rock removal by mechanical methods, our price is for Drilling and Blasting only.
- Blasting within 25ft of existing structures and utilities.
- Drilling or blasting within 25ft of Orange & Rockland structures or conductors.
- Blasting, if any concrete is placed within 300' of a blast zone unless we have a hold harmless agreement with the contractor.
- Boulder reduction (negotiated separately).
- Costs associated with blasting inspector, independent seismic monitoring or pre-blast surveys, if required.
- Line drilling or presplit.
- Reducing All Oversize
- Damages and related expenses caused to pavement and utilities
- All structural backfill and concrete replacement

MEASUREMENT & PAYMENT

- Open rock blasting will be measured and billed by the cubic yard.

| <u>Item Description</u> | <u>Quantity</u> | <u>Unit Price</u> | <u>Extension</u> |
|--|-----------------|-------------------|--|
| Drill and Blast Mass Rock | 61,000.00 CY | \$8.50 | \$518,500.00 ^{\$ 8.30 PER PHONE CONVERSATION} \$ 509,800 |
| Drill & Blast Mass Rock - Pond | SF | \$5.50 | - |
| Mobilization, Blast Permit, Preblast Surveys | 1.00 LS | \$3,500.00 | \$3,500.00 |
| | | Total: | \$522,000.00 \$ 513,300 |

THIS PRICE DOES NOT ALLOW FOR RETAINAGE TO BE WITHHELD.

Quantities will be approved by Contractor (owner) and MD Drilling & Blasting on a Daily basis and Contractor (Owner) will sign time and material acceptance report.

MD Drilling & Blasting will bill on a Monthly basis. Contractor (Owner) will make payment TBD - To Be Determined of receipt of invoice without holding any retainage. Contractor (Owner) will pay interest at a rate of 1 1/2% per month on past due balances. Any legal fees, costs or expenses, incurred by the Subcontractor to collect payment shall be paid by the Contractor. Contractor will waive all claims for consequential and/or liquidated damages.

MD Drilling & Blasting TO SUPPLY:

- Mobilization
- Preblast survey by Subcontractor employees
- Seismic monitoring by Subcontractor employees
- Necessary manpower and equipment to meet production needs
- Blasting mats as necessary
- On site technical support as necessary
- Ten Million Dollars (\$10,000,000.00) Commercial Umbrella Liability Insurance Coverage
- All blasting permits, plans, submittals, and explosive storage
- Fuel for MD&B's equipment
- Test drilling as directed by the Contractor at \$345 / hour
- Standby time at \$400 / per hour
- The supply and set up of the necessary sign package for Blasting Activities

CONTRACTOR TO BE RESPONSIBLE FOR:

- De-watering if necessary
- No Backcharges without prior written authorization
- Adequate access to work area for equipment and materials
- Layout, grade and cut marks

- Traffic control, site security, road/ROW clean-up, and related expenses, including liquidated damages
- Supplying and delivering 3/8" stemming stone to the blast area at no cost to Subcontractor
- Handling and placement of 12,000 lbs blasting mats with at least a 330 Cat Class machine in a timely manner
- All structural backfill and concrete replacement
- Damages and related expenses caused to pavement and utilities
- Not withholding any retainage
- Reducing All Oversize
- Excavation of blasted rock in a timely manner
- Blasting surface conducive to efficient drilling, blasting, and matting practices

Price and terms will be held for 60 days from the above date.

By allowing Subcontractor to begin work at the Project, Contractor (Owner) accepts and agrees to be bound by all of the terms of this quotation. This quotation may be altered only by a document signed by both parties.

Thank you again for the opportunity to quote you. If you have any questions, feel free to call me.

Jereme Caron



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
08/25/2020

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 Marsh USA Inc. 2929 Allen Parkway, Suite 2500 Houston, TX 77019 | CONTACT NAME: _____ | |
| | PHONE (A/C, No, Ext): _____ FAX (A/C, No): _____ E-MAIL ADDRESS: _____ | |
| CN102007851-MD-pro-20-21 INSURED MD Drilling & Blasting, Inc. 103 Old Windsor Road Bloomfield, CT 06002 | INSURER(S) AFFORDING COVERAGE | NAIC # |
| | INSURER A : Starr Indemnity & Liability Company | 38318 |
| | INSURER B : American Guarantee and Liability Insurance Company | 26247 |
| | INSURER C : | |
| | INSURER D : | |
| | INSURER E : | |

COVERAGES **CERTIFICATE NUMBER:** HOU-003698493-01 **REVISION NUMBER:** 3

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 checked="" type="checkbox"/> POLICY <input checked="" type="checkbox"/> PRO-JECT <input checked="" type="checkbox"/> LOC <input checked="" type="checkbox"/> OTHER: SIR: \$50,000 | X | X | 1000090515201 | 08/01/2020 | 08/01/2021 | EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 250,000 MED EXP (Any one person) \$ 10,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000 |
| A | <input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY | X | X | 1000198813201 (AOS) 1000198816201 (MA) | 08/01/2020 08/01/2020 | 08/01/2021 08/01/2021 | COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ |
| B | <input checked="" type="checkbox"/> UMBRELLA LIAB <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> DED <input type="checkbox"/> RETENTION \$ | | | AUC379306112 | 04/01/2020 | 04/01/2021 | <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS-MADE EACH OCCURRENCE \$ 5,000,000 AGGREGATE \$ 5,000,000 |
| A | <input checked="" type="checkbox"/> WORKERS COMPENSATION AND EMPLOYERS' LIABILITY <input type="checkbox"/> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below | | | 1000003304 (AOS) 1000003302 (MA) SIR: \$100,000 | 08/01/2020 08/01/2020 | 08/01/2021 08/01/2021 | <input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ 1,000,000 E.L. DISEASE - EA EMPLOYEE \$ 1,000,000 E.L. DISEASE - POLICY LIMIT \$ 1,000,000 |

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 104, Additional Remarks Schedule, may be attached if more space is required)
 RE: Job number: 706-08-00243 - Project: King Zak
 Orange County IDA is included as additional insured (except workers' compensation) where required by written contract.

CERTIFICATE HOLDER

Orange County IDA
 4 Crotty Lane, Suite 100
 New Windsor, NY 12553

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
 of Marsh USA Inc.

Manashi Mukherjee

Manashi Mukherjee

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**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

| | |
|---|--|
| <p>1a. Legal Name & Address of Insured (use street address only)</p> <p>MD DRILLING & BLASTING, INC. 103 OLD WINDSOR ROAD BLOOMFIELD, CT 10516</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</p> <p>207-203-1611</p> <p>1c. Federal Employer Identification Number of Insured or Social Security Number</p> <p>01-0413494</p> |
| <p>2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)</p> <p>Orange County IDA 4 Crotty Lane suite 100 New Windsor, NY 12553</p> | <p>3a. Name of Insurance Carrier</p> <p>First Unum Life Insurance Company</p> <p>3b. Policy Number of Entity Listed in Box "1a"</p> <p>141175</p> <p>3c. Policy effective period</p> <p>08/26/2020 to 08/26/2021</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 8/26/2020 By Shanon Logan

Digitally signed by Shanon Logan
DN: cn=Shanon Logan, o=unum.com
Reason: I am the author of this signature
Location: and signing device=not
Date: 2020.08.26 09:51:51
Full Name=Shanon Logan

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

Telephone Number 1-800-275-8686 Name and Title Shanon Logan, 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.



MICHAEL & SONS



MICHA-5

OP ID: TZ

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
10/26/2020

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.

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| | |
|--|---|
| PRODUCER The Faley Corporation 2116 Central Park Avenue Yonkers, NY 10710 Michael Faley | CONTACT NAME: Mary Scharf PHONE (A/C, No, Ext): 914-337-5201 FAX (A/C, No): 914-337-5029 E-MAIL ADDRESS: MSCHARF@FALEYCORP.COM |
| INSURER(S) AFFORDING COVERAGE | |
| INSURER A: Main Street America Assurance | NAIC # 29939 |
| INSURER B: National Grange Mutual | 14788 |
| INSURER C: Ohio Security Ins Company | 24082 |
| INSURER D: | |
| INSURER E: | |
| INSURER F: | |

INSURED: MICHAEL & SONS EQUITIES INC
P O Box 686
Putnam Valley, NY 10579-0686

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 | X | | MPZ8317C | 04/06/2020 | 04/06/2021 | EACH OCCURRENCE \$ 2,000,000 |
| | <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR | | | | | | DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 500,000 |
| | <input checked="" type="checkbox"/> CONTRACTUAL | | | | | | MED EXP (Any one person) \$ 10,000 |
| | <input checked="" type="checkbox"/> RENTL LEASED EQUI | | | | | | PERSONAL & ADV INJURY \$ 2,000,000 |
| GEN'L AGGREGATE LIMIT APPLIES PER: | | | | | | | GENERAL AGGREGATE \$ 4,000,000 |
| <input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PER SUBJECT <input type="checkbox"/> LOC | | | | | | | PRODUCTS - COM/POP AGG \$ 4,000,000 |
| OTHER: | | | | | | | \$ |
| B | <input checked="" type="checkbox"/> AUTOMOBILE LIABILITY | | | B1U3340Z | 04/06/2020 | 04/06/2021 | COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 |
| | <input type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS | | | | | | BODILY INJURY (Per person) \$ |
| | <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY | | | | | | BODILY INJURY (Per accident) \$ |
| | | | | | | | PROPERTY DAMAGE (Per accident) \$ |
| | | | | | | | \$ |
| B | <input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR | X | | CUZ8319C | 04/06/2020 | 04/06/2021 | EACH OCCURRENCE \$ 4,000,000 |
| | <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE | | | | | | AGGREGATE \$ 4,000,000 |
| | DED <input checked="" type="checkbox"/> RETENTION \$ 10,000 | | | | | | \$ |
| WORKERS COMPENSATION AND EMPLOYERS' LIABILITY | | | | | | | PER STATUTE OTH-ER |
| ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) <input type="checkbox"/> Y/N N/A | | | | | | | E.L. EACH ACCIDENT \$ |
| If yes, describe under DESCRIPTION OF OPERATIONS below | | | | | | | E.L. DISEASE - EA EMPLOYEE \$ |
| C | <input checked="" type="checkbox"/> INLAND MARINE | | | BMO59357647 | 11/29/2019 | 11/29/2020 | EQUIPMENT \$ 67,900 |
| | | | | | | | |

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

WHEN REQUIRED BY WRITTEN CONTRACT, OR WRITTEN AGREEMENT, ORANGE COUNTY IDA IS INCLUDED AS ADDITIONAL INSURED, SUBJECT TO THE LANGUAGE OF THE POLICY.

| | |
|---|--|
| CERTIFICATE HOLDER <div style="text-align: center;">ORANGEC</div> ORANGE COUNTY IDA 4 CROTTY LANE, SUITE 100 NEW WINDSOR, NY 12553 | 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 Michael Faley |
|---|--|



MICHA-5

OP ID: MF

CERTIFICATE OF LIABILITY INSURANCEDATE (MM/DD/YYYY)
04/06/2021

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.

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| | | |
|--|--------------------------------------|---|
| PRODUCER The Faley Corporation 2116 Central Park Avenue Yonkers, NY 10710 Michael Faley | 914-337-5201 | CONTACT NAME: Mary Scharf PHONE (A/C, No, Ext): 914-337-5201 FAX (A/C, No): 914-337-5029 E-MAIL ADDRESS: MSCHARF@FALEYCORP.COM |
| | INSURER(S) AFFORDING COVERAGE | |
| INSURED MICHAEL & SONS EQUITIES INC P O Box 686 Putnam Valley, NY 10579-0686 | INSURER A: | Main Street America Assurance NAIC # 29939 |
| | INSURER B: | National Grange Mutual NAIC # 14788 |
| | INSURER C: | Ohio Security Ins Company NAIC # 24082 |
| | INSURER D: | |
| | INSURER E: | |
| | INSURER F: | |

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 INSD | 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 <input checked="" type="checkbox"/> CONTRACTUAL GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PROJECT <input type="checkbox"/> LOC OTHER: | Y | | MPZ8317C | 04/06/2021 | 04/06/2022 | 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 - COMP/OP AGG \$ 4,000,000 |
| B | <input type="checkbox"/> AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY | | | B2U3340Z | 04/06/2021 | 04/06/2022 | COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ |
| B | <input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> DED <input checked="" type="checkbox"/> RETENTION \$ 10,000 | Y | | CUZ8319C | 04/06/2021 | 04/06/2022 | EACH OCCURRENCE \$ 4,000,000 AGGREGATE \$ 4,000,000 |
| | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NY) <input type="checkbox"/> Y/N <input type="checkbox"/> N/A If yes, describe under DESCRIPTION OF OPERATIONS below | | | | | | PER STATUTE <input type="checkbox"/> OTH-ER <input type="checkbox"/> E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$ |
| C | INLAND MARINE | | | BMO59357647 | 11/29/2020 | 11/29/2021 | EQUIPMENT \$ 67,900 |

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

WHEN REQUIRED BY WRITTEN CONTRACT, OR WRITTEN AGREEMENT, ORANGE COUNTY IDA IS INCLUDED AS ADDITIONAL INSURED, SUBJECT TO THE LANGUAGE OF THE POLICY.

CERTIFICATE HOLDER

ORANGEC

ORANGE COUNTY IDA
 4 CROTTY LANE, SUITE 100
 NEW WINDSOR, NY 12553

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



ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
10/26/2020

PRODUCER 914-806-5853
BGES GROUP
 216A LARCHMONT ACRES WEST
 LARCHMONT, NY 10538

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 POLICIES BELOW.

INSURED
MICHAEL & SON EQUITIES INC.
 22 WHITEHALL ROAD
 PUTNAM VALLEY, NY 10579

| INSURERS AFFORDING COVERAGE | NAIC # |
|--|--------|
| INSURER A: CONTINENTAL INDEMNITY CO | 28258 |
| INSURER B: | |
| INSURER C: | |
| INSURER D: | |
| INSURER E: | |

COVERAGES

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. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

| INSR ADD'L LTR INSRD | TYPE OF INSURANCE | POLICY NUMBER | POLICY EFFECTIVE DATE (MM/DD/YY) | POLICY EXPIRATION DATE (MM/DD/YY) | LIMITS |
|----------------------|---|-----------------|----------------------------------|-----------------------------------|--|
| | GENERAL LIABILITY <input type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PROJ. <input type="checkbox"/> LOC | | | | EACH OCCURRENCE \$ DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS & COMP/OP AGG \$ |
| | AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS | | | | COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ |
| | GARAGE LIABILITY <input type="checkbox"/> ANY AUTO | | | | AUTO ONLY > EA ACCIDENT \$ OTHER THAN AUTO ONLY: EA ACC \$ AGG \$ |
| | EXCESS/UMBRELLA LIABILITY <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> DEDUCTIBLE <input type="checkbox"/> RETENTION \$ | | | | EACH OCCURRENCE \$ AGGREGATE \$ \$ \$ \$ |
| A | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below | 46-597161-01-02 | 1/4/2020 | 1/4/2021 | <input checked="" type="checkbox"/> WC STATUTORY LIMITS <input type="checkbox"/> OTHER E.L. EACH ACCIDENT \$ 1,000,000 E.L. DISEASE > EA EMPLOYEE \$ 1,000,000 E.L. DISEASE > POLICY LIMIT \$ 1,000,000 |
| | OTHER | | | | |

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS
COVERS ALL LOCATIONS IN NEW YORK AND CONNECTICUT

CERTIFICATE HOLDER

ORANGE COUNTY IDA
 4 CROTTY LANE,
 SUITE 100
 NEW WINDSOR, NY 12553

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 15 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE
 Gary Wallach *Gary Wallach*

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
01/05/2021

| | | | |
|---|--|---|------------------------|
| PRODUCER BGES GROUP 216A LARCHMONT ACRES WEST LARCHMONT, NY 10538 | 914-806-5853 | 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 POLICIES BELOW. | |
| | INSURERS AFFORDING COVERAGE | | |
| INSURED MICHAEL & SON EQUITIES INC. 22 WHITEHALL ROAD PUTNAM VALLEY, NY 10579 | INSURER A: CONTINENTAL INDEMNITY CO | | NAIC # 28258 |
| | INSURER B: | | |
| | INSURER C: | | |
| | INSURER D: | | |
| | INSURER E: | | |

COVERAGES

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. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

| INSR ADD'L LTR INSRD | TYPE OF INSURANCE | POLICY NUMBER | POLICY EFFECTIVE DATE (MM/DD/YY) | POLICY EXPIRATION DATE (MM/DD/YY) | LIMITS |
|----------------------|---|-----------------|----------------------------------|-----------------------------------|--|
| | GENERAL LIABILITY <input type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PROJ/JECT <input type="checkbox"/> LOC | | | | EACH OCCURRENCE \$ DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS & COMP/OP AGG \$ |
| | AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS | | | | COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ |
| | GARAGE LIABILITY <input type="checkbox"/> ANY AUTO | | | | AUTO ONLY > EA ACCIDENT \$ OTHER THAN AUTO ONLY: EA ACC \$ AGG \$ |
| | EXCESS/UMBRELLA LIABILITY <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE DEDUCTIBLE RETENTION \$ | | | | EACH OCCURRENCE \$ AGGREGATE \$ \$ \$ |
| A | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below | 46-597161-01-03 | 1/4/2021 | 1/4/2022 | <input checked="" type="checkbox"/> WC STATUS <input type="checkbox"/> OTH'ER E.L. EACH ACCIDENT \$ 1,000,000 E.L. DISEASE > EA EMPLOYEE \$ 1,000,000 E.L. DISEASE > POLICY LIMIT \$ 1,000,000 |
| | OTHER | | | | |

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS
 COVERS ALL LOCATIONS IN NEW YORK AND CONNECTICUT

CERTIFICATE HOLDER

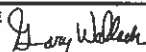
ORANGE COUNTY IDA
 4 CROTTY LANE,
 SUITE 100
 NEW WINDSOR, NY 12553

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 15 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE

Gary Wallach





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)
MICHAEL & SONS EQUITIES, INC
22 WHITEHALL ROAD
PUTNAM VALLEY, NY 10579
1b. Business Telephone Number of Insured
1c. Federal Employer Identification Number or Social Security Number
050618350
2. Name and Address of Entity Requesting Proof of Coverage
(Being Listed as the Certificate Holder)
Orange County IDA
4 Crotty Lane
Suite 100
New Windsor, NY 12553
3a. Name of Insurance Carrier
ShelterPoint Life Insurance Company
3b. Policy Number of Entity Listed in Box "1a"
DBL576663
3c. Policy effective period
01/01/2020 to 12/31/2021

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.

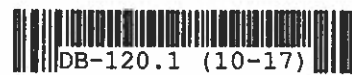
Date Signed 10/26/2020 By [Signature]
(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)
Telephone Number 516-829-8100 Name and Title Richard White, Chief Executive Officer

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.



SULLIVAN



SULLCON-01

KRIPPERT

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
11/13/2020

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 License # 8041821 Rue Insurance 3812 Quakerbridge Road Hamilton, NJ 08618 | CONTACT NAME: PHONE (A/C, No, Ext): (609) 586-7474 FAX (A/C, No): (609) 586-3991 E-MAIL ADDRESS: cmailto@RUEINSURANCE.com |
| | INSURER(S) AFFORDING COVERAGE INSURER A : Selective Insurance Company of America INSURER B : INSURER C : INSURER D : INSURER E : INSURER F : |
| INSURED Sullivan Construction Group, LLC PO Box 789 Wurtsboro, NY 12790 | NAIC # 12572 |

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 INSR | SUBR INSD | 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 GENL AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PROJECT <input type="checkbox"/> LOC OTHER: | | | \$ 2310629 | 10/17/2020 | 10/17/2021 | EACH OCCURRENCE \$ 2,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 500,000 MED EXP (Any one person) \$ 15,000 PERSONAL & ADV INJURY \$ 2,000,000 GENERAL AGGREGATE \$ 4,000,000 PRODUCTS - COMP/OP AGG \$ 4,000,000 |
| I | <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 | | | \$ 2310629 | 10/17/2020 | 10/17/2021 | COMBINED SINGLE LIMIT (Ea accident) \$ 2,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ |
| A | <input 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 | | | \$ 2310629 | 10/17/2020 | 10/17/2021 | EACH OCCURRENCE \$ 4,000,000 AGGREGATE \$ 4,000,000 |
| A | <input checked="" type="checkbox"/> WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below | | Y/N N | WC 9047985 | 10/17/2020 | 10/17/2021 | <input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ 1,000,000 E.L. DISEASE - EA EMPLOYEE \$ 1,000,000 E.L. DISEASE - POLICY LIMIT \$ 1,000,000 |
| A | Equipment Floater | | | \$ 2310629 | 10/17/2020 | 10/17/2021 | Leased/Rented Equip 175,000 |

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Orange County IDA is included as additional insured as respects General Liability if required by written contract

CERTIFICATE HOLDER

CANCELLATION

Orange County IDA
4 Crotty Lane, Suite 100
New Windsor, NY 12553

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



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

| | |
|---|--|
| <p>1a. Legal Name & Address of Insured (use street address only)</p> <p>SULLIVAN CONSTRUCTION GROUP, LLC 289 BUDD RD. WOODBOURNE, NY 12788</p> <p><i>Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e., Wrap-Up Policy)</i></p> | <p>1b. Business Telephone Number of Insured</p> <p>845-640-2200</p> <p>1c. Federal Employer Identification Number or Social Security Number</p> <p>815486372</p> |
|---|--|

| | |
|---|--|
| <p>2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)</p> <p>Orange County IDA 4 Crotty Lane, Suite 100 New Windsor NY 12553</p> | <p>3a Name of Insurance Carrier</p> <p>HARTFORD LIFE AND ACCIDENT</p> <p>3b Policy Number of Entity Listed in Box "1a"</p> <p>LNY796696</p> <p>3c Policy effective period</p> <p>07-01-2020 to 06-30-2021</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 11-13-2020 *Elizabeth Tello*
(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number (212) 553-8074 Name and Title: Elizabeth Tello – Assistant Director, Statutory Services

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)

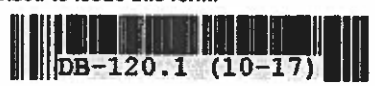
**State of New York
Workers' Compensation Board**

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.





**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

| | |
|---|--|
| <p>1a. Legal Name & Address of Insured (use street address only)</p> <p>SULLIVAN CONSTRUCTION GROUP, LLC 289 BUDD RD. WOODBOURNE, NY 12788</p> <p><i>Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e., Wrap-Up Policy)</i></p> | <p>1b. Business Telephone Number of Insured</p> <p>845-640-2200</p> <p>1c. Federal Employer Identification Number or Social Security Number</p> <p>815486372</p> |
|---|--|

| | |
|--|--|
| <p>2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)</p> <p>Orange County IDA 4 Crotty Lane, Suite 100 New Windsor, NY 12553</p> | <p>3a Name of Insurance Carrier</p> <p>HARTFORD LIFE AND ACCIDENT</p> <p>3b Policy Number of Entity Listed in Box "1a"</p> <p>LNY796696</p> <p>3c Policy effective period</p> <p>07-01-2021 to 06-30-2022</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 07-27-2021 *Elizabeth Tello*
(Signature of Insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number (212) 553-8074 Name and Title: Elizabeth Tello – Assistant Director, Statutory Services

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.

AMP MASONRY



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
5/3/2021

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).


| | | |
|--|--|--|
| PRODUCER Seely & Durland 13 Oakland Ave Warwick NY 10990 | CONTACT NAME: PHONE (A/C No. Ext): 845-986-1177 FAX (A/C No): 845-986-0094 E-MAIL ADDRESS: dpinckney@seely-durland.com | |
| | INSURER(S) AFFORDING COVERAGE NAIC # | |
| INSURED AMP Masonry Inc. 11 Edsall Lane Pine Island NY 10969 | INSURER A : SELECTIVE INS CO OF AMER 12572 | |
| | INSURER B : | |
| | INSURER C : | |
| | INSURER D : | |
| | INSURER E : | |
| | INSURER F : | |

COVERAGES **CERTIFICATE NUMBER: 1360200626** **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"/> PROJECT <input type="checkbox"/> LOC OTHER: | Y | Y | S2440095 | 2/20/2021 | 2/20/2022 | EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 500,000 MED EXP (Any one person) \$ 15,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 3,000,000 PRODUCTS - COMP/OP AGG \$ 3,000,000 \$ |
| A | <input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY | Y | Y | S2440095 | 2/20/2021 | 2/20/2022 | 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 <input type="checkbox"/> DED <input checked="" type="checkbox"/> RETENTION \$ 10,000 | Y | N | S2440095 | 2/20/2021 | 2/20/2022 | EACH OCCURRENCE \$ 5,000,000 AGGREGATE \$ 5,000,000 \$ |
| | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below | | Y/N | N/A | | | <input type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ 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)
Certificate holder is listed as additional insured in relation to the work our insured performs for them provided a written contract exists and subject to the terms and conditions of the policy in regard to commercial general liability.

| | |
|---|---|
| CERTIFICATE HOLDER Orange County IDA 4 Crotty Lane Ste 100 New Windsor NY 12553 | 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 Insurance Fund

WESTCHESTER ONE, 44 SOUTH BROADWAY, 10TH FLOOR, WHITE PLAINS, NY 10601-4411

| nysif.com

CERTIFICATE OF WORKERS' COMPENSATION INSURANCE

***** 202230614
ACRISURE LLC DBA
SEELY & DURLAND
13 OAKLAND AVE
WARWICK NY 10990



SCAN TO VALIDATE
AND SUBSCRIBE

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| POLICYHOLDER AMP MASONARY INC 11 EDSALL LN PINE ISLAND NY 10969 |
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| CERTIFICATE HOLDER GAM PROPERTY CORP 3 POLICE DRIVE GOSHEN NY 10924 |
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|-------------------------------------|-------------------------------------|--|-------------------------|
| POLICY NUMBER W2007 814-3 | CERTIFICATE NUMBER 489409 | POLICY PERIOD 12/12/2020 TO 12/12/2021 | DATE 5/3/2021 |
|-------------------------------------|-------------------------------------|--|-------------------------|

THIS IS TO CERTIFY THAT THE POLICYHOLDER NAMED ABOVE IS INSURED WITH THE NEW YORK STATE INSURANCE FUND UNDER POLICY NO. 2007 814-3, COVERING THE ENTIRE OBLIGATION OF THIS POLICYHOLDER FOR WORKERS' COMPENSATION UNDER THE NEW YORK WORKERS' COMPENSATION LAW WITH RESPECT TO ALL OPERATIONS IN THE STATE OF NEW YORK, EXCEPT AS INDICATED BELOW, AND, WITH RESPECT TO OPERATIONS OUTSIDE OF NEW YORK, TO THE POLICYHOLDER'S REGULAR NEW YORK STATE EMPLOYEES ONLY.

IF YOU WISH TO RECEIVE NOTIFICATIONS REGARDING SAID POLICY, INCLUDING ANY NOTIFICATION OF CANCELLATIONS, OR TO VALIDATE THIS CERTIFICATE, VISIT OUR WEBSITE AT [HTTPS://WWW.NYSIF.COM/CERT/CERTVAL.ASP](https://www.nysif.com/cert/certval.asp). THE NEW YORK STATE INSURANCE FUND IS NOT LIABLE IN THE EVENT OF FAILURE TO GIVE SUCH NOTIFICATIONS.

THIS POLICY DOES NOT COVER CLAIMS OR SUITS THAT ARISE FROM BODILY INJURY SUFFERED BY THE OFFICERS OF THE INSURED CORPORATION.

ALDEN PREIS, PRESIDENT
AMP MASONARY INC
1 OF 1

THE POLICY INCLUDES A WAIVER OF SUBROGATION ENDORSEMENT UNDER WHICH NYSIF AGREES TO WAIVE ITS RIGHT OF SUBROGATION TO BRING AN ACTION AGAINST THE CERTIFICATE HOLDER TO RECOVER AMOUNTS WE PAID IN WORKERS' COMPENSATION AND/OR MEDICAL BENEFITS TO OR ON BEHALF OF AN EMPLOYEE OF OUR INSURED IN THE EVENT THAT, PRIOR TO THE DATE OF THE ACCIDENT, THE CERTIFICATE HOLDER HAS ENTERED INTO A WRITTEN CONTRACT WITH OUR INSURED THAT REQUIRES THAT SUCH RIGHT OF SUBROGATION BE WAIVED.

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS NOR INSURANCE COVERAGE UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICY.

NEW YORK STATE INSURANCE FUND

DIRECTOR, INSURANCE FUND UNDERWRITING

VALIDATION NUMBER: 706040141



**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

| | |
|--|--|
| <p>1a. Legal Name & Address of Insured (use street address only) AMP MASONARY INC</p> <p>11 EDSALL LANE Pine Island NY 10969 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 (845) 258-6028 x</p> <p>1c. Federal Employer Identification Number of Insured or Social Security Number 20-2230614</p> |
| <p>2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) Orange County IDA</p> <p>4 Crotty Lane Ste 100 NEW WINDSOR, NY 12553</p> | <p>3a. Name of Insurance Carrier SHELTERPOINT LIFE INSURANCE COMPANY</p> <p>3b. Policy Number of Entity Listed in Box "1a" D300785</p> <p>3c. Policy effective period 7/22/2020 to 7/21/2022</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 5/20/2021 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)

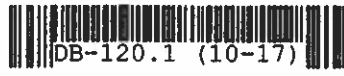
**State of New York
Workers' Compensation Board**

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.





CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
07/15/2021

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).

| | |
|---|--|
| PRODUCER Fields Group Insurance Services LLC 110 East 42nd Street 16th Floor New York NY 10017 | CONTACT NAME: Adam Herfield PHONE (A.C. No. Ext.): (848) 979-9010 FAX (A.C. No.): (848) 979-9011 E-MAIL ADDRESS: aherfield@fieldsgroupins.com |
| | INSURER(S) AFFORDING COVERAGE INSURER A: Neutilus Insurance Company INSURER B: Ohio Security Insurance Co INSURER C: INSURER D: INSURER E: INSURER F: |
| INSURED Sullivan Fire Protection Corp P.O. Box 2021 16 Railroad Plaza South Fallsburg NY 12779 | |

COVERAGES CERTIFICATE NUMBER: Certificate Master: 20-21 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.

| FORM LTR | TYPE OF INSURANCE | ADDITIONAL (RIBD) (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"/> PROJECT <input type="checkbox"/> LOC OTHER: | Y | Y | ECP201241716 | 08/08/2020 | 08/09/2021 | EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 50,000 MED EXP (Any one person) \$ 5,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMPROP AGG \$ 2,000,000 Employee Benefits \$ 1,000,000 |
| B | <input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY | Y | Y | BAS58167355 | 08/08/2020 | 08/09/2021 | COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ Uninsured motorist \$ 1,000,000 |
| A | <input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED / RETENTION \$ | Y | Y | FFX201241816 | 08/08/2020 | 08/09/2021 | EACH OCCURRENCE \$ 5,000,000 AGGREGATE \$ 5,000,000 |
| | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below | Y/N | N/A | | | | PER STATUTE / OTHER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$ |
| A | Contractor Pollution Liability Contractor Liability | Y | Y | ECP201241716 | 08/08/2020 | 08/09/2021 | Per Claim \$1,000,000 |

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Certificate holder and King Zack IDA are listed as additional insured per written contract subject to limits of the policies listed.

CERTIFICATE HOLDER

CANCELLATION

| | |
|---|--|
| Orange County IDA 4 Crotty Lane, Suite 100 New Windsor NY 12553 | 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 <i>Joseph LaVecchia</i> |
|---|--|

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CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
08/09/2021

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).

| | | | |
|---|--|---|--|
| PRODUCER Fields Group Insurance Services LLC 110 East 42nd Street 16th Floor New York NY 10017 | | CONTACT NAME: Adam Herfield PHONE (ACT. No. Ext.): (646) 979-9010 E-MAIL ADDRESS: aherfield@fieldsgroupins.com FAX (AG. No.): (646) 979-9011 | |
| INSURED Sullivan Fire Protection Corp P.O. Box 2021 6 Railroad Plaza South Fallsburg NY 12779 | | INSURER(S) AFFORDING COVERAGE INSURER A: Nautilus Insurance Company INSURER B: Ohio Security Insurance Co INSURER C: INSURER D: INSURER E: INSURER F: | |

COVERAGES **CERTIFICATE NUMBER:** CL218601352 **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.

| INSUR LTR | TYPE OF INSURANCE | ADDCSUBR (INSR) (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: | Y | Y | ECP201241717 | 08/09/2021 | 08/09/2022 | EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 50,000 MED EXP (Any one person) \$ 5,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMPROP AGG \$ 2,000,000 Employee Benefits \$ 1,000,000 |
| B | <input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY <input type="checkbox"/> AUTOS ONLY | Y | Y | BAS58167358 | 08/09/2021 | 08/09/2022 | COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ Uninsured motorist \$ 1,000,000 |
| A | <input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$ | Y | Y | FFX201241817 | 08/09/2021 | 08/09/2022 | EACH OCCURRENCE \$ 5,000,000 AGGREGATE \$ 5,000,000 |
| | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below | Y/N | N/A | | | | PER STATUTE OTH-ER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$ |
| A | <input checked="" type="checkbox"/> Contractor Pollution Liability <input checked="" type="checkbox"/> Contractor Liability | Y | Y | ECP201241717 | 08/09/2021 | 08/09/2022 | Per Claim \$1,000,000 |

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Certificate holder and King Zack IDA are listed as additional insured per written contract subject to limits of the policies listed.

| | |
|--|---|
| CERTIFICATE HOLDER Orange County IDA 4 Crotty Lane, Suite 100 New Windsor NY 12553 | 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 <i>Joseph LaVecchia</i> |
|--|---|

CERTIFICATE OF WORKERS' COMPENSATION INSURANCE

***** 141746342
KEEVILY, SPERO-WHITELAW INC.
500 MAMARONECK AVENUE
HARRISON NY 10528



SCAN TO VALIDATE
AND SUBSCRIBE

| | | | |
|---|-------------------------------------|--|--------------------------|
| POLICYHOLDER SULLIVAN FIRE PROTECTION CORP P. O. BOX 2021 16 RAILROAD PLAZA SOUTH FALLSBURG NY 12779 | | CERTIFICATE HOLDER ORANGE COUNTY IDA 4 CROTTY LANE, SUITE 100 NEW WINDSOR NY 12553 | |
| POLICY NUMBER G 839 109-6 | CERTIFICATE NUMBER 701877 | POLICY PERIOD 05/01/2021 TO 05/01/2022 | DATE 7/19/2021 |

THIS IS TO CERTIFY THAT THE POLICYHOLDER NAMED ABOVE IS INSURED WITH THE NEW YORK STATE INSURANCE FUND UNDER POLICY NO. 839 109-6, COVERING THE ENTIRE OBLIGATION OF THIS POLICYHOLDER FOR WORKERS' COMPENSATION UNDER THE NEW YORK WORKERS' COMPENSATION LAW WITH RESPECT TO ALL OPERATIONS IN THE STATE OF NEW YORK, EXCEPT AS INDICATED BELOW.

IF YOU WISH TO RECEIVE NOTIFICATIONS REGARDING SAID POLICY, INCLUDING ANY NOTIFICATION OF CANCELLATIONS, OR TO VALIDATE THIS CERTIFICATE, VISIT OUR WEBSITE AT [HTTPS://WWW.NYSIF.COM/CERT/CERTVAL.ASP](https://www.nysif.com/cert/certval.asp). THE NEW YORK STATE INSURANCE FUND IS NOT LIABLE IN THE EVENT OF FAILURE TO GIVE SUCH NOTIFICATIONS.

THIS CERTIFICATE DOES NOT APPLY TO THOSE JOB SITES WHICH ARE COVERED BY OTHER INSURANCE AND ARE SPECIFICALLY EXCLUDED BY ENDORSEMENT.

THE POLICY INCLUDES A WAIVER OF SUBROGATION ENDORSEMENT UNDER WHICH NYSIF AGREES TO WAIVE ITS RIGHT OF SUBROGATION TO BRING AN ACTION AGAINST THE CERTIFICATE HOLDER TO RECOVER AMOUNTS WE PAID IN WORKERS' COMPENSATION AND/OR MEDICAL BENEFITS TO OR ON BEHALF OF AN EMPLOYEE OF OUR INSURED IN THE EVENT THAT, PRIOR TO THE DATE OF THE ACCIDENT, THE CERTIFICATE HOLDER HAS ENTERED INTO A WRITTEN CONTRACT WITH OUR INSURED THAT REQUIRES THAT SUCH RIGHT OF SUBROGATION BE WAIVED.

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS NOR INSURANCE COVERAGE UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICY.

NEW YORK STATE INSURANCE FUND

DIRECTOR, INSURANCE FUND UNDERWRITING

VALIDATION NUMBER: 775957965



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 | |
| <p>1a. Legal Name & Address of Insured (use street address only) Sullivan Fire Protection Corp</p> <p>16 Railroad Plaza, PO Drawer 2021 SOUTH FALLSBURG NY 12779 <i>Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e., Wrap-Up Policy)</i></p> | <p>1b. Business Telephone Number of Insured (845)434-4030 x</p> <p>1c. Federal Employer Identification Number of Insured or Social Security Number 14-1746342</p> |
| <p>2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) Orange County IDA</p> <p>4 Crotty Lane, Suite 100 NEW WINDSOR, NY 12553</p> | <p>3a. Name of Insurance Carrier Standard Security Life Insurance Company of New York</p> <p>3b. Policy Number of Entity Listed in Box "1a" L76781-000</p> <p>3c. Policy effective period 1/1/2014 to 7/18/2022</p> |
| <p>4. Policy provides the following benefits:</p> <p><input checked="" type="checkbox"/> A. Both disability and paid family leave benefits.</p> <p><input type="checkbox"/> B. Disability benefits only.</p> <p><input type="checkbox"/> C. Paid family leave benefits only.</p> <p>5. Policy covers:</p> <p><input checked="" type="checkbox"/> A. All of the employer's employees eligible under the NYS Disability and Paid Family Leave Benefits Law.</p> <p><input type="checkbox"/> B. Only the following class or classes of employer's employees:</p> <p>_____</p> <p>_____</p> | |
| <p>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.</p> <p>Date Signed <u>7/19/2021</u> By <u><i>Bebi A. Johnson</i></u> <small>(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)</small></p> <p>Telephone Number <u>(212) 355-4141</u> Name and Title <u>Bebi Johnson, Supervisor-DBL/Policy Services</u></p> | |
| <p>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.</p> <p>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.</p> | |
| PART 2. To be completed by the NYS Workers' Compensation Board (Only if Box 4C or 5B of Part 1 has been checked) | |
| <p>State of New York Workers' Compensation Board</p> <p>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.</p> <p>Date Signed _____ By _____ <small>(Signature of Authorized NYS Workers' Compensation Board Employee)</small></p> <p>Telephone Number _____ Name and Title _____</p> | |

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.



FUMAROLA



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

7/15/2021

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).

| | | | |
|--|--|--|------------------------|
| PRODUCER Jason D. Hoffman Insurance Agency LLC 301 Main Street, Suite 2F Goshen NY 10924 | | CONTACT NAME: Jason Hoffman PHONE (A/C, No, Ext): 8452394787 FAX (A/C, No): E-MAIL ADDRESS: jason@jhoffmaninsurance.com | |
| | | INSURER(S) AFFORDING COVERAGE | |
| | | INSURER A : MERCHANTS PREFERRED INS CO | NAIC # 12901 |
| | | INSURER B : NYSIF | |
| | | INSURER C : | |
| | | INSURER D : | |
| | | INSURER E : | |
| | | INSURER F : | |


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 type="checkbox"/> PRO-JECT <input checked="" type="checkbox"/> LOC OTHER: | | Y | CTRI000971 | 06/1/2021 | 06/1/2022 | EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 500,000 MED EXP (Any one person) \$ 5,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000 |
| A | AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY | | Y | CAPI075932 | 06/01/2021 | 06/01/2022 | COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ |
| | UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$ | | Y | | | | EACH OCCURRENCE \$ AGGREGATE \$ |
| B | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below | | Y/N Y | 2471800-9 | 04/01/2021 | 04/01/2022 | PER STATUTE OTH-ER E.L. EACH ACCIDENT \$ Unlimited E.L. DISEASE - EA EMPLOYEE \$ Unlimited E.L. DISEASE - POLICY LIMIT \$ Unlimited |

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

Certificate holder is additional insured with respect to plumbing and related work being performed by the insured. AI status is subject to attached policy forms CG2001, CG2033, CG2038, MU8977, and MU9064.

| | |
|--|--|
| CERTIFICATE HOLDER Orange County IDA 4 Crotty Lane Suite 100 New Windsor NY 12553 | 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  |
|--|--|

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CERTIFICATE OF WORKERS' COMPENSATION INSURANCE

***** 464648049
LOVELL SAFETY MGMT CO., LLC
110 WILLIAM STREET 12TH FLR
NEW YORK NY 10038

SCAN TO VALIDATE
AND SUBSCRIBE

| | | | |
|--|-------------------------------------|--|--------------------------|
| POLICYHOLDER MIKE FUMAROLA PLUMBING AND HEATING, LLC 230 MAC ARTHUR AVENUE NEW WINDSOR NY 12553 | | CERTIFICATE HOLDER ORANGE COUNTY IDA 4 CROTTY LANE SUITE 100 NEW WINDSOR NY 12553 | |
| POLICY NUMBER Z2471 800-9 | CERTIFICATE NUMBER 704938 | POLICY PERIOD 04/01/2021 TO 04/01/2022 | DATE 7/15/2021 |

THIS IS TO CERTIFY THAT THE POLICYHOLDER NAMED ABOVE IS INSURED WITH THE NEW YORK STATE INSURANCE FUND UNDER POLICY NO. 2471 800-9, COVERING THE ENTIRE OBLIGATION OF THIS POLICYHOLDER FOR WORKERS' COMPENSATION UNDER THE NEW YORK WORKERS' COMPENSATION LAW WITH RESPECT TO ALL OPERATIONS IN THE STATE OF NEW YORK, EXCEPT AS INDICATED BELOW.

IF YOU WISH TO RECEIVE NOTIFICATIONS REGARDING SAID POLICY, INCLUDING ANY NOTIFICATION OF CANCELLATIONS, OR TO VALIDATE THIS CERTIFICATE, VISIT OUR WEBSITE AT [HTTPS://WWW.NYSIF.COM/CERT/CERTVAL.ASP](https://www.nysif.com/cert/certval.asp). THE NEW YORK STATE INSURANCE FUND IS NOT LIABLE IN THE EVENT OF FAILURE TO GIVE SUCH NOTIFICATIONS.

THIS POLICY DOES NOT COVER THE SOLE PROPRIETOR, PARTNERS AND/OR MEMBERS OF A LIMITED LIABILITY COMPANY.

THE POLICY INCLUDES A WAIVER OF SUBROGATION ENDORSEMENT UNDER WHICH NYSIF AGREES TO WAIVE ITS RIGHT OF SUBROGATION TO BRING AN ACTION AGAINST THE CERTIFICATE HOLDER TO RECOVER AMOUNTS WE PAID IN WORKERS' COMPENSATION AND/OR MEDICAL BENEFITS TO OR ON BEHALF OF AN EMPLOYEE OF OUR INSURED IN THE EVENT THAT, PRIOR TO THE DATE OF THE ACCIDENT, THE CERTIFICATE HOLDER HAS ENTERED INTO A WRITTEN CONTRACT WITH OUR INSURED THAT REQUIRES THAT SUCH RIGHT OF SUBROGATION BE WAIVED.

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS NOR INSURANCE COVERAGE UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICY.

NEW YORK STATE INSURANCE FUND



DIRECTOR, INSURANCE FUND UNDERWRITING

VALIDATION NUMBER: 964136590



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)
MIKE FUMAROLA PLUMBING AND HEATING LLC
230 MAC ARTHUR AVE
NEW WINDSOR, NY 12553
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
1c. Federal Employer Identification Number of Insured or Social Security Number
464648049

2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)
Orange County IDA
4 Crotty Lane
New Windsor, NY 12553

3a. Name of Insurance Carrier
ShelterPoint Life Insurance Company
3b. Policy Number of Entity Listed in Box "1a"
DBL600119
3c. Policy effective period
01/01/2021 to 12/31/2022

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 7/15/2021 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.



VAN GROL



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
07/16/2021

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).

| | | | |
|--|--|--|--|
| PRODUCER FEDERATED MUTUAL INSURANCE COMPANY HOME OFFICE: P.O. BOX 328 OWATONNA, MN 55060 | | CONTACT NAME: CLIENT CONTACT CENTER PHONE (A/C, No. Ext): 888-333-4949 FAX (A/C, No): 507-446-4864 E-MAIL ADDRESS: CLIENTCONTACTCENTER@FEDINS.COM | |
| INSURED VAN GROL INC 84 MERRITTS ISLAND RD PINE ISLAND, NY 10969-1529 | | INSURER(S) AFFORDING COVERAGE INSURER A: FEDERATED MUTUAL INSURANCE COMPANY NAIC # 13935 INSURER B: FEDERATED RESERVE INSURANCE COMPANY 16024 INSURER C: INSURER D: INSURER E: INSURER F: | |

COVERAGES CERTIFICATE NUMBER: 138 REVISION NUMBER: 0

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 | <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER: | Y | N | 6048279 | 05/13/2021 | 05/13/2022 | EACH OCCURRENCE \$1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$100,000 MED EXP (Any one person) EXCLUDED PERSONAL & ADV INJURY \$1,000,000 GENERAL AGGREGATE \$2,000,000 PRODUCTS - COM/OP AGG \$2,000,000 |
| A | AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY | N | N | 6048279 | 05/13/2021 | 05/13/2022 | 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 <input type="checkbox"/> DED <input checked="" type="checkbox"/> RETENTION | N | N | 6048282 | 05/13/2021 | 05/13/2022 | EACH OCCURRENCE \$1,000,000 AGGREGATE \$1,000,000 |
| B | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory In NH) If yes, describe under DESCRIPTION OF OPERATIONS below | Y/N | N/A | 6048283 | 05/13/2021 | 05/13/2022 | <input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTHER E.L. EACH ACCIDENT \$1,000,000 E.L. DISEASE - EA EMPLOYEE \$1,000,000 E.L. DISEASE - POLICY LIMIT \$1,000,000 |

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
 THE CERTIFICATE HOLDER IS AN ADDITIONAL INSURED SUBJECT TO THE CONDITIONS OF THE ADDITIONAL INSURED - OWNERS, LESSEES OR CONTRACTORS - AUTOMATIC STATUS WHEN REQUIRED IN CONSTRUCTION AGREEMENT WITH YOU ENDORSEMENT FOR GENERAL LIABILITY.

CERTIFICATE HOLDER
 151-280-7
 ORANGE COUNTY IDA
 4 CROTTY LN STE 100
 NEW WINDSOR, NY 12553-4778

138 0

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

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**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

| | |
|---|---|
| <p>1a. Legal Name & Address of Insured (use street address only) VAN GROL INC 84 MERRITS ROAD PINE ISLAND, NY 10969</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 914-564-2940</p> <p>1c. Federal Employer Identification Number of Insured or Social Security Number 141740758</p> |
| <p>2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) ORANGE COUNTY IDA 4 CROTTY LANE, SUITE 100 NEW WINDSOR NY 12553</p> | <p>3a. Name of Insurance Carrier ShelterPoint Life Insurance Company</p> <p>3b. Policy Number of Entity Listed in Box "1a" DBL66478</p> <p>3c. Policy effective period 11/30/2020 to 11/29/2022</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 7/21/2021 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.

