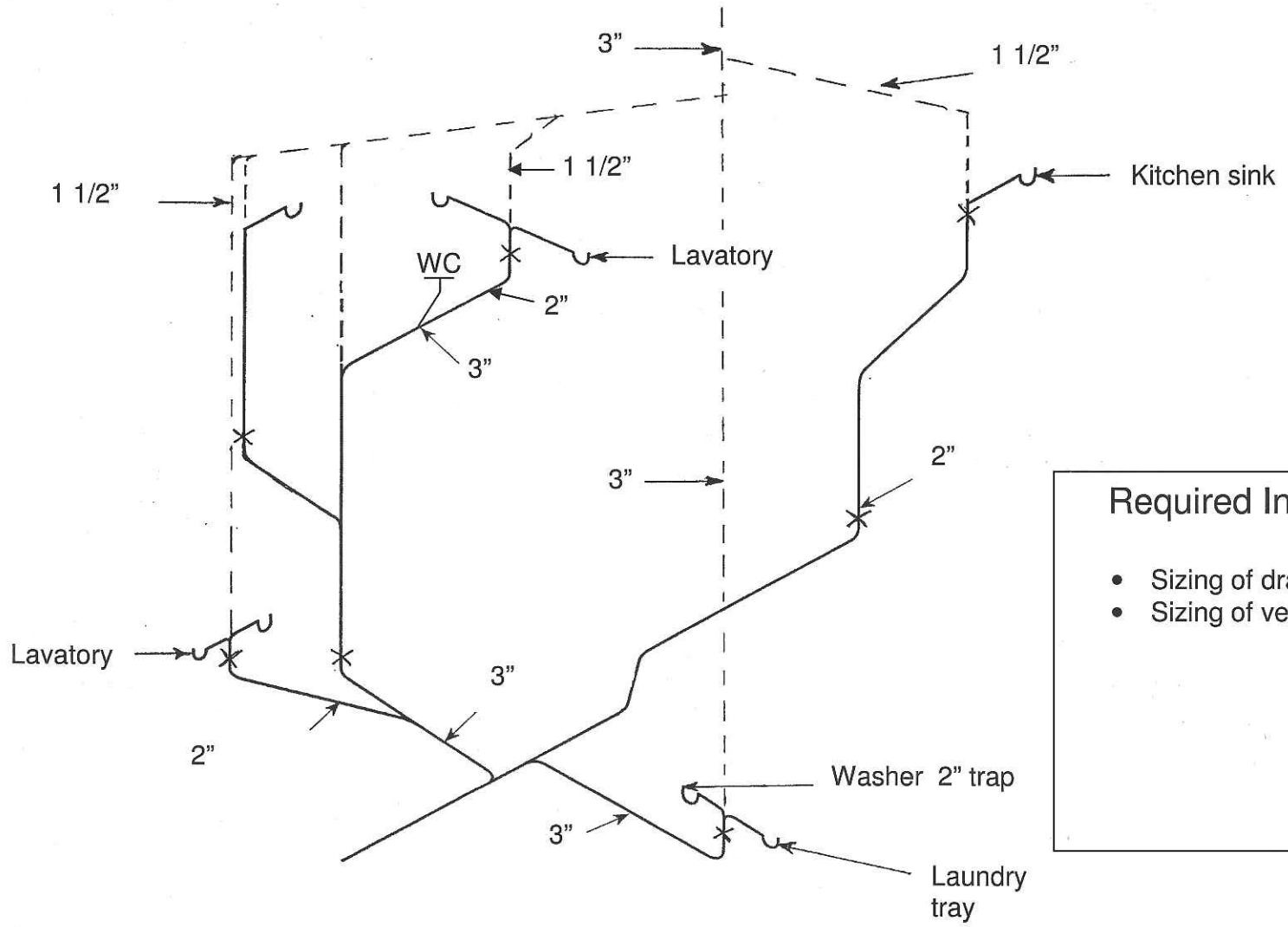
Example Drainage System – Isometric View



Required Information

- Sizing of drains
- Sizing of vents

Westchester County Electrical Licensing Board
Westchester County Consumer Protection
Master Electrician License 2021

Michael P Kerins
D.O.B: 11/24/1971
Company:
Kerins Electric Company Inc
276 Route Us 202
Somers , NY 10598

License No. 1290
Expires on 12/31/2021

Peter Borducci

KERIELE-01 HFUSCO

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 8/11/2021

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 Emery & Webb, Inc. 989 Main Street Fishkill, NY 12524	CONTACT NAME: PHONE (A/C, No, Ext): (845) 896-6727 FAX (A/C, No): (845) 896-6877 E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Merchants Mutual Insurance Company	23329
INSURER B : Merchants Preferred Insurance Company	12901
INSURER C : Hartford Underwriters Insurance Company	30104
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Kerins Electric Co., Inc.
8 Griffen Place
Yorktown Heights, NY 10598-6620

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY [X] PRO-JECT [ ] LOC OTHER:	X		BOPI047291	4/1/2021	4/1/2022	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 500,000 $ 15,000 $ Included $ 2,000,000 $ 2,000,000
B	AUTOMOBILE LIABILITY X ANY AUTO OWNED AUTOS ONLY / SCHEDULED AUTOS HIRED AUTOS ONLY / NON-OWNED AUTOS ONLY			CAPI051408	4/1/2021	4/1/2022	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
A	X UMBRELLA LIAB [X] OCCUR EXCESS LIAB [ ] CLAIMS-MADE DED [X] RETENTION $ 10,000			CUP9142092	4/1/2021	4/1/2022	EACH OCCURRENCE AGGREGATE	$ 1,000,000 $ 1,000,000
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N [N] If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		16WECVV9635	4/1/2021	4/1/2022	X PER STATUTE [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 100,000 $ 100,000 $ 500,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Certificate Holder is included as Additional Insured as required by written contract or written agreement, subject to the language of the policy.

CERTIFICATE HOLDER

Town of North Castle
17 Bedford Road
Armonk, NY 10504

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

1a. Legal Name & Address of Insured (Use street address only) Kerins Electric Co., Inc. 8 Griffen Place Yorktown Heights, NY 10598-6620 **Work Location of Insured** ***(Only required if coverage is specifically limited to certain locations in New York State, i.e, a Wrap-Up Policy)***	**1b. Business Telephone Number of Insured** (914) 248-5616 **1c. NYS Unemployment Insurance Employer Registration Number of Insured** **1d. Federal Employer Identification Number of Insured or Social Security Number** 06-1661185
2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) **Town of North Castle** **17 Bedford Road** **Armonk, NY 10501**	**3a. Name of Insurance Carrier** Hartford Underwriters Insurance Company **3b. Policy Number of entity listed in box "1a"** 16WECVV9635 **3c. Policy effective period** 4/1/2021 **to** 4/1/2022 **3d. The Proprietor, Partners or Executive Officers are:** ☒ **included. (Only check box if all partners/officers included)** ☐ **all excluded or certain partners/officers Excluded.**

This certifies that the insurance carrier indicated above in box "3" insures the business referenced above in box "1a" for workers' compensation under the New York State Workers' Compensation Law. **(To use this form, New York (NY) must be listed under Item 3A on the INFORMATION PAGE of the workers' compensation insurance policy).** The Insurance Carrier or its licensed agent will send this Certificate of Insurance to the entity listed above as the certificate holder in box "2".

The insurance carrier must notify the above certificate holder and the Workers' Compensation Board within 10 days IF a policy is canceled due to nonpayment of premium or within 30 days IF there are reasons other than nonpayment of premiums that cancel the policy or eliminate the insured from the coverage indicated on this Certificate. (These notices may be sent by regular mail.) **Otherwise, this Certificate is valid for one year after this form is approved by the insurance carrier or its licensed agent, or until the policy expiration date listed in box "3c", whichever is earlier.**

This certificate is issued as a matter of information only and confers no rights upon the certificate holder. This certificate does not amend, extend or alter the coverage afforded by the policy listed, nor does it confer any rights or responsibilities beyond those contained in the referenced policy.

This certificate may be used as evidence of a Workers' Compensation contract of insurance only while the underlying policy is in effect.

Please Note: Upon the 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: John C. Webb III
(Print name of authorized representative or licensed agent of insurance carrier)

Approved by: J. C. Webb III 8/11/2021
(Signature) (Date)

Title: President & Chief Operating Officer

Telephone Number of authorized representative or licensed agent of insurance carrier: (845) 896-6727

NEW YORK STATE | Workers' Compensation Board

CERTIFICATE OF INSURANCE COVERAGE
DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

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

1a. Legal Name & Address of Insured (use street address only)
KERINS ELECTRIC CO., INC.

8 GRIFFIN PLACE
YORKTOWN HEIGHTS, NY 10598

Work Location of Insured *(Only required if coverage is specifically limited to certain locations in New York State, i.e., Wrap-Up Policy)*

1b. Business Telephone Number of Insured
914-248-5616

1c. Federal Employer Identification Number of Insured or Social Security Number
061661185

2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)
Town of North Castle
17 Bedford Road
Armonk, NY 10504

3a. Name of Insurance Carrier
ShelterPoint Life Insurance Company

3b. Policy Number of Entity Listed in Box "1a"
DBL196266

3c. Policy effective period
03/21/2021 to 03/20/2022

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 8/11/2021 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.***

DB-120.1 (10-17)

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

C-105.2 (9-17) www.wcb.state.ny.us

Workers' Compensation Law

Section57. Restriction on issue of permits and the entering into contracts unless compensation is secured.

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

2. The head of a state or municipal department, board, commission or office authorized or required by law to enter into any contract for or in connection with any work involving the employment of employees in a hazardous employment defined by this chapter, notwithstanding any general or special statute requiring or authorizing any such contract, shall not enter into any such contract unless proof duly subscribed by an insurance carrier is produced in a form satisfactory to the chair, that compensation for all employees has been secured as provided by this chapter.