



May 7, 2014

City of Saratoga Springs
Attn: Purchasing Agent
474 Braodway
Saratoga Springs, NY 12866

**Re: Martin Environmental Services, Inc.
Fire Department**

Gentlemen:

Enclosed please find a Certificate of Insurance, issued in your behalf, to show the various provisions of insurance coverages provided in connection with the above captioned subject.

We trust the enclosed will meet with your requirements and that you will contact this office should you have any questions with regard to this matter.

Very truly yours,

A handwritten signature in black ink, appearing to read 'Lisa M. Angerami'.

Lisa M. Angerami, CIC
Account Executive

LMA/cja
Enclosures

cc: Martin Environmental Services, Inc.- **Via Email**



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
05/07/2014

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 Arthur J Gallagher Risk Management Services, Inc. 677 Broadway 4th Floor Albany, NY 12207	1-518-463-3181	CONTACT NAME: PHONE (A/C, No, Ext): (518) 463-3181 FAX (A/C, No): (518) 463-5048 E-MAIL ADDRESS:
INSURED Martin Environmental Services, Inc. 1710 Erie Blvd. Schenectady, NY 12308		INSURER(S) AFFORDING COVERAGE INSURER A: GREAT DIVIDE INS CO INSURER B: INSURER C: INSURER D: INSURER E: INSURER F:
		NAIC # 25224

COVERAGES

CERTIFICATE NUMBER: 39610598

REVISION NUMBER:

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

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR <input checked="" type="checkbox"/> Ded. \$5,000 BI/PD GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PROJECT <input type="checkbox"/> LOC	X		ECP01530068-13	04/30/14	04/30/15	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
								\$
A	AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS			BAP1530070-13	04/30/14	04/30/15	COMBINED SINGLE LIMIT (Ea accident)	\$ 1,000,000
							BODILY INJURY (Per person)	\$
							BODILY INJURY (Per accident)	\$
							PROPERTY DAMAGE (Per accident)	\$
								\$
A	UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR <input checked="" type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$			FFX1530071-13	04/30/14	04/30/15	EACH OCCURRENCE	\$ 5,000,000
							AGGREGATE	\$ 5,000,000
								\$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below			WCA1530069-13	04/30/14	04/30/15	<input checked="" type="checkbox"/> WC STATUTORY LIMITS	OTHER
							E.L. EACH ACCIDENT	\$ 1,000,000
							E.L. DISEASE - EA EMPLOYEE	\$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	\$ 1,000,000
A	Pollution Liability			ECP01530068-13	04/30/14	04/30/15	Per Claim	1,000,000
A	Liability						Per Project Agg.	2,000,000
A							Deductible	10,000

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

Saratoga Springs Fire Department
Certificate Holder is a Primary/Non-Contributory Additional Insured as Required by Written Contract for General Liability.

CERTIFICATE HOLDER**CANCELLATION**

City of Saratoga Springs Purchasing Agent 474 Braodway Saratoga Springs, NY 12866 USA	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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ENDORSEMENT

This endorsement forms a part of the policy to which it is attached. Please read it carefully.

ADDITIONAL INSURED – BLANKET

This endorsement modifies insurance provided under the following:

ENVIRONMENTAL COMBINED POLICY

In consideration of the premium charged and notwithstanding anything contained in this policy to the contrary, it is hereby agreed and understood that this endorsement shall apply only to the Coverage Part(s) corresponding with the box or boxes marked below.

- COVERAGES A AND B – GENERAL LIABILITY
- COVERAGE D – CONTRACTORS POLLUTION LIABILITY

SECTION III – WHO IS AN INSURED is amended to include as an insured, with respect to Coverage A, B and D, any person(s) or organization(s) when you and such person(s) or organization(s) have agreed in a written contract or written agreement that such person(s) or organization(s) be added as an additional insured on your policy. Such written contract or written agreement must be in effect prior to the performance of **your work** which is the subject of such written contract or written agreement.

Such additional insured status applies only:

1. Under **COVERAGE A BODILY INJURY AND PROPERTY DAMAGE LIABILITY** and **COVERAGE B PERSONAL AND ADVERTISING INJURY LIABILITY** for claims or suits resulting from:
 - a. Your work performed for such person(s) or organization(s) in the performance of your ongoing operations for the additional insured; or
 - b. Your work performed for such person(s) or organizations(s) and included in the products-completed operations hazard.
2. Under **COVERAGE D CONTRACTORS POLLUTION LIABILITY** for claims or suits arising out of pollution conditions that are the result of:
 - a. Your work performed for such person(s) or organization(s) in the performance of your ongoing operations for the additional insured; or
 - b. Your work performed for such person(s) or organizations(s) and included in the products-completed operations hazard.

With respect to damages caused by **your work**, as described above, the coverage provided hereunder shall be primary and not contributing with any other insurance available to those person(s) or organization(s) with which you have so agreed in a written contract or written agreement.

ALL OTHER TERMS AND CONDITIONS OF THE POLICY SHALL APPLY AND REMAIN UNCHANGED.

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
CERTIFICATE OF INSURANCE COVERAGE UNDER THE NYS DISABILITY 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>MARTIN ENVIRONMENTAL SERVICE INC 1710ERIE BLVD SCHENECTADY, NY 12308</p>	<p>1b. Business Telephone Number of Insured (518) 346 - 5800</p> <p>1c. NYS Unemployment Insurance Employer Registration Number of Insured 5622721</p> <p>1d. Federal Employer Identification Number of Insured or Social Security Number 141784580</p>
<p>2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)</p> <p>CITY OF SARATOGA SPRINGS, NY PURCHASING AGENT 474 BROADWAY SARATOGA SPRINGS, NY 12866</p>	<p>3a. Name of Insurance Carrier NATIONAL BENEFIT LIFE INSURANCE COMPANY</p> <p>3b. Policy Number of entity listed in box "1a": 8-910-0179196C</p> <p>3c. Policy effective period: 04/23/2014 to 04/23/2016</p>

4. Policy covers:

- a. All of the employer's employees eligible under the New York Disability Benefits Law
- b. Only the following class or classes of the 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 04/23/2014 By *Kathleen P. [Signature]*
(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number 800-535-2711 Title Vice President

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" is checked, this certificate is NOT COMPLETE for purposes of Section 220, Subd. 8 of the Disability 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.

Additional Instructions for Form DB-120.1

By signing this form, the insurance carrier identified in box "3" on this form is certifying that it is insuring the business referenced in box "1a" for disability benefits under the New York State Disability Benefits Law. The Insurance Carrier or its licensed agent will send this Certificate of Insurance to the entity listed as the certificate holder in box "2". *This Certificate is valid for the earlier of one year after this form is approved by the insurance carrier or its licensed agent, or the policy expiration date listed in box "3c".*

Please Note: Upon the cancellation of the disability benefits 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 NYS Disability Benefits Coverage or other authorized proof that the business is complying with the mandatory coverage requirements of the New York State Disability Benefits Law.

DISABILITY BENEFITS LAW

§220. Subd. 8

(a) 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 employment as defined in this article, 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 the payment of disability benefits for all employees has been secured as provided by this article. 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 disability benefits to any such employee if so employed.

(b) 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 employment as defined in this article, and 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 the payment of disability benefits for all employees has been secured as provided by this article.

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

<p>1a. Legal Name & Address of Insured (Use street address only)</p> <p>Martin Environmental Services, Inc. 1710 Erie Blvd. Schenectady, NY 12308</p> <p>Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e., a Wrap-Up Policy)</p>	<p>1b. Business Telephone Number of Insured (518) 346-5800</p> <p>1c. NYS Unemployment Insurance Employer Registration Number of Insured</p> <p>1d. Federal Employer Identification Number of Insured or Social Security Number 14-1784580</p>
<p>2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)</p> <p>City of Saratoga Springs Purchasing Agent 474 Braodway Saratoga Springs, NY 12866</p>	<p>3a. Name of Insurance Carrier Great Divide Insurance Company</p> <p>3b. Policy Number of entity listed in box "1a" WCA1530069-13</p> <p>3c. Policy effective period 04/30/2014 to 04/30/2015</p> <p>3d. The Proprietor, Partners or Executive Officers are <input checked="" type="checkbox"/> included. (Only check box if all partners/officers included) <input type="checkbox"/> all excluded or certain partners/officers excluded.</p>

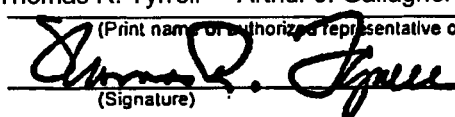
This certifies that the insurance carrier indicated above in box "3" insures the business referenced above in box "1a" for workers' compensation under the New York State Workers' Compensation Law. (To use this form, New York (NY) must be listed under Item 3A on the INFORMATION PAGE of the workers' compensation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

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

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

Approved by:  5/6/2014
(Signature) (Date)

Title: Area Chairman

Telephone Number of authorized representative or licensed agent of insurance carrier: (518) 463-3181

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.

Workers' Compensation Law

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

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