



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
5/29/2015

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).

<b>PRODUCER</b> Shoff Darby Companies 488 Main Avenue 3rd Floor Norwalk CT 06851		<b>CONTACT NAME:</b> Gina Mallone <b>PHONE (A/C, No, Ext):</b> (203) 354-6200 <b>FAX (A/C, No):</b> (203) 354-6480 <b>E-MAIL ADDRESS:</b> malloneg@shoffdarby.com	
<b>INSURED</b> Green Mountain Pipeline Services, Inc. 244 Waterman Road South Royalton VT 05068		<b>INSURER(S) AFFORDING COVERAGE</b>	
		<b>INSURER A:</b> Charter Oak Fire Insurance Co.	<b>NAIC #</b> 25615
		<b>INSURER B:</b> Travelers Property Casualty Co	<b>36161</b>
		<b>INSURER C:</b>	
		<b>INSURER D:</b>	
		<b>INSURER E:</b>	
		<b>INSURER F:</b>	

**COVERAGES**                      **CERTIFICATE NUMBER:** 15-16 Master Liability                      **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 <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR	X Y	CO567M8492	1/12/2015	1/12/2016	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Per occurrence) \$ 300,000 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
GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PROJECT <input type="checkbox"/> LOC OTHER:						
A	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" 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	X Y	810567M8492	1/12/2015	1/12/2016	COMBINED SINGLE LIMIT (Per accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ Non-owned \$
B	<input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE	X Y	CUP567M8492	1/12/2015	1/12/2016	EACH OCCURRENCE \$ 5,000,000 AGGREGATE \$ 5,000,000
	<input checked="" type="checkbox"/> DED <input checked="" type="checkbox"/> RETENTION \$ 10,000	X Y				
	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 Y				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)  
Certificate holder is additional insured with respects to all noted policies except Workers Compensation.  
Waiver of Subrogation applies. Insurance is primary and non-contributory.

<b>CERTIFICATE HOLDER</b> City of Saratoga Springs 474 Broadway Saratoga Springs, NY 12866	<b>CANCELLATION</b> 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 Gina Mallone/GINA <i>Gina Mallone</i>
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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>GREEN MOUNTAIN PIPELINE SERVICES CORP 244 WATERMAN ROAD ROYALTON, VT 05068</p>	<p>1b. Business Telephone Number of Insured 802-763-7022</p> <p>1c. NYS Unemployment Insurance Employer Registration Number of Insured PENDING</p> <p>1d. Federal Employer Identification Number of Insured or Social Security Number 900113105</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 474 BROADWAY SARATOGA SPRINGS NY 12866</p>	<p>3a. Name of Insurance Carrier HARTFORD LIFE AND ACCIDENT</p> <p>3b. Policy Number of entity listed in box "1a": LNY618290</p> <p>3c. Policy effective period: 01-01-2015 to 12-31-2015</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 05-29-2015 By   
(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number (800) 454-7020 Title Manager

**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><b>1a. Legal Name &amp; Address of Insured (Use street address only)</b> Green Mountain Pipeline Services, Inc. 244 Waterman Road Royalton, VT 05068</p> <p><i>Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e., a Wrap-Up Policy)</i></p>	<p><b>1b. Business Telephone Number of Insured</b> 802-763-7022</p> <p><b>1c. NYS Unemployment Insurance Employer Registration Number of Insured</b> 2409358</p> <p><b>1d. Federal Employer Identification Number of Insured or Social Security Number</b> 90-0113105</p>
<p><b>2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)</b></p> <p>City of Saratoga Springs 474 Broadway  Saratoga Springs, NY 12866</p>	<p><b>3a. Name of Insurance Carrier</b> Travelers Insurance</p> <p><b>3b. Policy Number of entity listed in box "1a"</b> UB 567M8492</p> <p><b>3c. Policy effective period</b> 1-12-2015 to 1-12-2016</p> <p><b>3d. The Proprietor, Partners or Executive Officers are</b>  <input checked="" type="checkbox"/> included. (Only check box if all partners/officers included)  <input type="checkbox"/> all excluded or certain partners/officers excluded.</p>

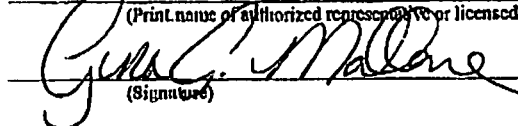
This certifies that the insurance carrier indicated above in box "3" insures the business referenced above in box "1a" for workers' compensation under the New York State Workers' Compensation Law. (To use this form, New York (NY) must be listed under Item 3A on the **INFORMATION PAGE** of the workers' 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: Gina G. Mallone  
(Print name of authorized representative or licensed agent of insurance carrier)

Approved by:  5/29/15  
(Signature) (Date)

Title: Commercial Lines Account Manager

Telephone Number of authorized representative or licensed agent of insurance carrier: 203-445-2100

**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.

**PRECISION**  
Industrial Maintenance, Inc

5/19/15

Albert Flick  
City of Saratoga Springs  
474 Broadway  
Saratoga Springs, NY 12866  
(518) 587-3550 x-2573

Dear Albert,

I would like to take this opportunity to thank you for choosing Precision Industrial Maintenance Inc. (PIM) for your environmental needs. The following quotation is based on our conversation regarding the sanitary pipe cleaning and CCTV inspection in Saratoga Springs.

Scope of Work

PIM will provide a combination jetting/vacuum truck w/ operator and an IBAK CCTV inspection trailer w/ operator for the cleaning and CCTV inspection of 3,650 LF of 8" pipe and 200 LF of 10" pipe. PIM will vacuum and dispose of solids at a permitted facility. PIM will use cones and men at work signs around work area/equipment. Two digital copies w/ reports will be supplied following inspection/cleaning. Quote assumes the city will provide access to a hydrant for water.

Cost

\$13,167.00 lump sum for labor and equipment---\$3.42/ LF—3,850 LF total

Other Terms and Conditions

- All work will be performed in a legal manner according to all local, state, and federal regulations.
- All local, state, and federal taxes apply unless a tax-exempt document is presented to PIM.
- Payment terms are net 30 days
- Quote contains prevailing wages for on-site time
- This quotation is valid for 30 days and subject to verification thereafter.

If you have any questions or comments, please feel free to contact me at (518) 346-5800.

Sincerely,

Scott Kramer  
Project Manager

\_\_\_\_\_  
Authorizing Signature

# KENYON PIPELINE INSPECTION, LLC

22 Helen Drive  
Queensbury, NY 12804  
518-926-9843 ph  
518-348-3040 fx



Albert Flick  
Sr. Engineering Technician  
City of Saratoga Springs  
Ph: 518-587-3550 ext. 2573

Project: Clean & CCTV Approx. 3650 LF of 8" pipe and 200 LF of 10" Pipe Around  
Adams Street Lift Station

Proposal	
Date:	May 13, 2015
Project Manager:	Josh Kenyon
Phone:	518-932-2510
Email:	<a href="mailto:joshk@kpisewer.com">joshk@kpisewer.com</a>

KPI, LLC is pleased to provide the following proposal for the above mentioned project. KPI will provide all labor, materials, and equipment to perform the work as directed for the following items unless otherwise stated in this quotation. The hours provided in this quote are estimates only based on the limited information provided for pipe size and quantity.

Item	Description	Unit Price	Quantity	Units	Total
1	Cleaning & CCTV 3850 LF of Pipe	\$ 310.00	24	HR	\$ 7,440.00
2	Traffic Control if applicable	\$ 1,500.00	3	day	\$ 4,500.00
3	Debris Disposal; Transport Offsite	\$ 500.00	1	Lump Sum	\$ 500.00
4	Debris Disposal; Per Ton	\$ 120.00	unknown	Per Ton	\$ 720.00
Total:					\$ 13,160.00

Debris is Estimated at 6 ton

**DOES NOT INCLUDE ADDITIONAL DAYS IF MECHANICAL CLEANING (Root Removal)  
IS REQUIRED THAT TAKES MORE THAN (3) DAYS**

**Quote Includes:**

- Labor, materials, and equipment to perform the work above as specified
- Mobilization and demobilization
- UP TO (3) Days of Cleaning and CCTV Inspections
  - If additional time is needed, ex. Heavy Root Removal Required, that will require City Approval before performed
- Traffic Control including Cones and Flaggers

**GC/Owner to provide:**

- Taxes, Fees, Bonds, and Permitting
- Bypass pumping
- Truck access to all structures and access points
- Restoration of lawns and sidewalks if necessary
- Water source for cleaning process at NO CHARGE to KPI LLC

Sincerely,

*Josh Kenyon*

Josh Kenyon  
President  
KPI LLC