

POLICY NUMBER CS02463707	POLICY PERIOD 12/28/2014 - 12/28/2015 <i>12:01 A.M. Standard Time at the address of the insured stated herein.</i>	AGENCY/PRODUCER CODE 04806
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NAMED INSURED AND ADDRESS John Welliver LFK 188A State St Portland, ME 04101-3704	AGENCY/PRODUCER EA Kelley Co RI, Inc. 450 Veterans Memorial Pkwy Ste 501 East Providence RI 02914-5300
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SCHEDULE

Name of Person or Organization:	City of Portland
Address:	389 Congress St Portland ME 04101-3566 Cumberland
Insured Item:	Location 1 - 188A State St Portland ME 04101-3704
Interest:	CG 20 12 - Additional Insured State or Governmental Agency of Subdivision or Political Subdivision Permits or Authorizations
Interest Type:	Additional Insured State or Governmental Agency of Subdivision or Political Subdivision Permits or Authorizations
Description:	

Countersigned 12/23/2014 By _____
Authorized Representative



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
04/24/2015

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).

PRODUCER E A Kelley 450 Veterans Memorial Parkway Building 5 East Providence RI 02914		CONTACT Betty DiBlase NAME A/C No. (800) 235-7451 FAX (800) 370-2924 EMAIL ADDRESS bettyd@eakelley.com															
INSURED LFK 188 A State Street Portland ME 04101		PRODUCER CUSTOMER ID: 141318 <table border="1"> <tr> <th>INSURER(S) AFFORDING COVERAGE</th> <th>NAIC #</th> </tr> <tr> <td>INSURER A: Capitol Specialty Ins Corp</td> <td>110328</td> </tr> <tr> <td>INSURER B:</td> <td></td> </tr> <tr> <td>INSURER C:</td> <td></td> </tr> <tr> <td>INSURER D:</td> <td></td> </tr> <tr> <td>INSURER E:</td> <td></td> </tr> <tr> <td>INSURER F:</td> <td></td> </tr> </table>		INSURER(S) AFFORDING COVERAGE	NAIC #	INSURER A: Capitol Specialty Ins Corp	110328	INSURER B:		INSURER C:		INSURER D:		INSURER E:		INSURER F:	
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COVERAGES	CERTIFICATE NUMBER:	NUMBER:
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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 TR	TYPE OF INSURANCE	ADDL INSR	SUBR WVB	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	Y		CS02463707-01	12/28/2014	12/28/2015	EACH OCCURRENCE \$ 1,000,000
	<input type="checkbox"/> DAMAGE TO RENTED PREMISES (Ea Occurrence) \$ 100,000 <input type="checkbox"/> MED EXP (Any one person) \$ 5,000						
	<input type="checkbox"/> PERSONAL & ADV INJURY \$ 1,000,000 <input type="checkbox"/> GENERAL AGGREGATE \$ 2,000,000 <input type="checkbox"/> PRODUCTS - COMP/OP AGG \$ 2,000,000						
	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						
	<input type="checkbox"/> UMBRELLA LIAB <input type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> DEDUCTIBLE <input type="checkbox"/> RETENTION \$						
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N <input type="checkbox"/> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) N If yes, describe under DESCRIPTION OF OPERATIONS below N/A						<input type="checkbox"/> WC STATUTORY LIMITS <input type="checkbox"/> OTHER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$

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

It is understood and agreed that the certificate holder is listed as an Additional Insured.

CERTIFICATE HOLDER**CANCELLATION**

City of Portland 389 Congress Street Portland ME 04101	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>David A. Thomas</i>
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