

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
Month/Date/Year

PRODUCER Insurce Agent/Broker Name Insurce Agent/Broker Street Address or P.O. Box Insurce Agent/Broker City, State & Zip Code Contact & Phone Number	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 Company Name: Address: Email Address:	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:80%;">INSURERS AFFORDING COVERAGE</th> <th style="width:20%;">NAIC #</th> </tr> <tr><td>INSURER A:</td><td></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> </table>	INSURERS AFFORDING COVERAGE	NAIC #	INSURER A:		INSURER B:		INSURER C:		INSURER D:		INSURER E:	
INSURERS AFFORDING COVERAGE	NAIC #												
INSURER A:													
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. ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE PERTAINS, 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.

Must not be expired

INSR LTR	ADD'L INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS
A	<input checked="" type="checkbox"/>	GENERAL LIABILITY <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS MADE <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> _____ <input type="checkbox"/> _____ GEN'L AGGREGATE LIMIT A _____ <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PROJECT	POLICY #	BEGIN EFFECTIVE DATE	END EFFECTIVE DATE	EACH OCCURENCE \$1,000,000 #1 DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY \$1,000,000 #2 GENERAL AGGREGATE PRODUCTS - COMP/OP AGG
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 <input type="checkbox"/> _____ <input type="checkbox"/> _____	POLICY #	BEGIN EFFECTIVE DATE	END EFFECTIVE DATE	COMBINED SINGLE LIMIT (Each Occurrence) \$1,000,000 #3 BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)
A	<input checked="" type="checkbox"/>	GARAGE LIABILITY <input checked="" type="checkbox"/> ANY AUTO <input type="checkbox"/> _____ <input type="checkbox"/> _____	POLICY #	BEGIN EFFECTIVE DATE	END EFFECTIVE DATE	AUTO ONLY - EA ACCIDENT OTHER THAN AUTO ONLY: EA ACC AGG
A	<input checked="" type="checkbox"/>	EXCESS/UMBRELLA LIABILITY <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> DEDUCTIBLE <input checked="" type="checkbox"/> RETENTION	POLICY #	BEGIN EFFECTIVE DATE	END EFFECTIVE DATE	EACH OCCURENCE \$4,000,000 #4 AGGREGATE
A	<input checked="" type="checkbox"/>	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below	POLICY #	BEGIN EFFECTIVE DATE	END EFFECTIVE DATE	<input checked="" type="checkbox"/> WC STATUTORY LIMITS <input type="checkbox"/> OTHER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT
	<input type="checkbox"/>	OTHER				

Boxes must be checked

#1, #2, #3 must be at least \$1 mil each
#1 + #4 must = \$5 mil combined
#2 + #4 must = \$5 mil combined

Not required

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS

Required Language:

LEVY PREMIUM FOODSERVICE LIMITED PARTNERSHIP AND ITS OFFICERS, DIRECTORS, EMPLOYEES, AND AGENTS ARE NAMED AS ADDITIONAL INSURED UNDER GENERAL LIABILITY.

CERTIFICATE HOLDER LEVY PREMIUM FOODSERVICE LIMITED PARTNERSHIP 5001 GREAT AMERICA PARKWAY, SANTA CLARA, CA 95054 FAX: (408) 748-7047	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
--	--