

Application for Ambulance Certification

Fee Must Accompany Application.

The license period is from January 1 to December 31.

\$1,100.00 - New Applicants and Renewals

Make check payable to the City of Milwaukee Health Department

RECEIVED

2015 SEP -8 A 10: 23

Check(✓) one: ☐ Individual
☐ Partnership
☒ Corporation

1. NAME OF APPLICANT (If individual): _____

Business Name: BELL AMBULANCE, INC.

Phone: 414-486-2000

Business Address: 549 E WILSON ST

City: MILWAUKEE

State: WI

Zip: 53207-1635

Have any people on this application been convicted of violating any federal or state laws, or local ordinances? ☐ Yes ☒ No

If 'yes', name of person(s), date, charge and penalty: _____

2. PARTNERSHIP (If applicable):

Name: _____

Home Address: _____

City: _____

State: _____

Zip: _____

Phone: _____

Date of Birth: _____

Name _____

Home Address: _____

City: _____

State: _____

Zip: _____

Phone: _____

Date of Birth: _____

3. NAME OF CORPORATION BELL AMBULANCE, INC.

Address: 549 E WILSON ST, MILWAUKEE, WI 53207-1635

Date and Place of Incorporation: OCTOBER 1, 1978, WISCONSIN

President: R A ZEHETNER

Home Address: 212 E RAVINE DR

City: MEQUON

State: WI

Zip: 53092

Phone 262-241-1990

Date of Birth 06/15/1948

Vice President: JAMES P LOMBARDO

Home Address: 549 E WILSON ST

City: MILWAUKEE

State: WI

Zip: 53207

Phone 414-486-4013

Date of Birth: 12/24/1952

continued on other side

Secretary: VALERIE A ZEHETNER
Home Address: 11811 N LAKE SHORE DR
City: MEQUON State: WI Zip: 53092
Phone: 414-406-0567 Date of Birth: 02/06/1978
Treasurer: WAYNE A JURECKI
Home Address: 1111 N MARSHALL ST, UNIT 1002
City: MILWAUKEE State: WI Zip: 53202
Agent: WAYNE A JURECKI
Home Address: 1111 N MARSHALL ST, UNIT 1002
City: MILWAUKEE State: WI Zip: 53202

4. OTHER REQUIREMENTS:

Do you have on file with the Health Department, a valid and current certificate of insurance for this license period? ☒ Yes ☐ No
Do you have a valid State of Wisconsin Inspection Certificate? ☒ Yes ☐ No
Do you participate in the Emergency Medical Services System? ☒ Yes ☐ No

If yes, list service area number: 4
Do you wish to participate in the Emergency Medical Services System? ☒ Yes ☐ No

Total number of vehicles in service: 48
Please attach a separate page listing all vehicles including city assigned number, and description (year, make and vin number).

5. The undersigned agrees to inform the Health Department within ten days of any substantial changes in the information supplied in this application. The undersigned shall not willfully refuse to provide those services offered under this license, permit, or franchise, or refuse to employ, or discharge any person otherwise qualified because of race, color, creed, sex, national origin or ancestry; and not seek such information as a condition of employment, or penalize any employee or discriminate in the selection of personnel for training or promotion on the basis of such information.
6. The undersigned understand that this application does not entitle the applicants to a license and that the granting of licenses is solely in the discretion of the Common Council.
7. I have a knowledge of the City Ordinances currently regulating the license applied for herein, and being duly sworn under oath, depose and say that I am the person named above and that all statements made in the foregoing application are true and correct.

SUBSCRIBED AND SWORN TO BEFORE ME THIS 3RD day of September, 2015

Individual/Corporate President/Partner: [Signature]

Additional Partner/Corporate Vice President: James P. Lombardo

Notary Public, State of Wisconsin: Kathleen M. McKeown

My commission expires: 11/16/2018

Corporate Secretary: Valerie A. Zehetner

Corporate Treasurer: Wayne A. Jurecki

Do Not Write Below This Line

Clerk

License #

New

Renewal

Date Filed

Date Granted

| Unit number | In service since | Make | VIN | Location |
|-------------|------------------|-----------|-------------------|-----------|
| 401 | 2011 | CHEVROLET | 1GB6G2B64A1100458 | Milwaukee |
| 402 | 2011 | CHEVROLET | 1GB6G2B64A1101965 | Milwaukee |
| 403 | 2011 | CHEVROLET | 1GB6G2B65A1101120 | Milwaukee |
| 404 | 2012 | CHEVROLET | 1GB6G2B65A1101621 | Milwaukee |
| 405 | 2012 | CHEVROLET | 1GB6G2B67A1100731 | Milwaukee |
| 406 | 2012 | CHEVROLET | 1GB6G2B67A1101247 | Milwaukee |
| 407 | 2012 | CHEVROLET | 1GB6G2B67A1101894 | Milwaukee |
| 408 | 2013 | CHEVROLET | 1GB3G2CLXD1130463 | Milwaukee |
| 409 | 2014 | CHEVROLET | 1GB3G2CL0E1108523 | Milwaukee |
| 410 | 2014 | CHEVROLET | 1GB3G2CL8E1108544 | Milwaukee |
| 411 | 2014 | CHEVROLET | 1GB3G2CL9E1108908 | Milwaukee |
| 412 | 2014 | CHEVROLET | 1GB3G2CL5E1107772 | Milwaukee |
| 413 | 2014 | CHEVROLET | 1GB3G2CL6D1182382 | Milwaukee |
| 414 | 2014 | CHEVROLET | 1GB3G2CL4D1182459 | Milwaukee |
| 415 | 2015 | CHEVROLET | 1GB3G2CL4E1186335 | Milwaukee |
| 416 | 2015 | CHEVROLET | 1GB3G2CL8E1186435 | Milwaukee |
| 417 | 2015 | CHEVROLET | 1GB3G2CL5E1187266 | Milwaukee |
| 418 | 2015 | CHEVROLET | 1GB3G2CL3E1187363 | Waukesha* |
| 440 | 2015 | CHEVROLET | 1GBZGUCLXE1205718 | Milwaukee |
| 441 | 2015 | CHEVROLET | 1GBZGUCL7E1207426 | Milwaukee |
| 444 | 2008 | FORD | 1FDXE45P98DA77060 | Milwaukee |
| 445 | 2008 | FORD | 1FDWE35P48DA42271 | Milwaukee |
| 446 | 2008 | FORD | 1FDWE35P28DA35920 | Milwaukee |
| 448 | 2009 | CHEVROLET | 1GBHG316191155798 | Milwaukee |
| 449 | 2009 | CHEVROLET | 1GBJG316191148724 | Milwaukee |
| 450 | 2009 | CHEVROLET | 1GBJG316X91152299 | Milwaukee |
| 451 | 2009 | CHEVROLET | 1GBJG316391152550 | Milwaukee |
| 452 | 2009 | CHEVROLET | 1GBJG316491152685 | Milwaukee |
| 453 | 2009 | CHEVROLET | 1GBJG316791154415 | Milwaukee |
| 454 | 2010 | CHEVROLET | 1GB6G2B6XA1101582 | Milwaukee |
| 455 | 2010 | CHEVROLET | 1GB6G2B69A1100181 | Milwaukee |
| 456 | 2010 | CHEVROLET | 1GB6G2B69A1100410 | Milwaukee |
| 457 | 2010 | CHEVROLET | 1GB6G2B60A1101347 | Milwaukee |
| 459 | 2009 | CHEVROLET | 1GBKG316791152653 | Milwaukee |
| 460 | 2012 | CHEVROLET | 1GB9G5B6XA1113567 | Milwaukee |
| 461 | 2012 | CHEVROLET | 1GB9G5B61A1114395 | Milwaukee |
| 470 | 2011 | CHEVROLET | 1GB9G5B61A1124831 | Milwaukee |
| 471 | 2011 | CHEVROLET | 1GB9G5B67A1124932 | Milwaukee |
| 472 | 2012 | CHEVROLET | 1GB9G5B68A1113647 | Milwaukee |
| 473 | 2015 | CHEVROLET | 1GB6G5CL7E1198039 | Milwaukee |
| 474 | 2015 | CHEVROLET | 1GB6G5CL1E1198649 | Waukesha* |
| 491 | 2008 | FORD | 1FDXE45P78DA55025 | Milwaukee |
| 492 | 2009 | CHEVROLET | 1GBKG316091100135 | Milwaukee |
| 493 | 2009 | CHEVROLET | 1GBKG316291100136 | Milwaukee |
| 494 | 2009 | CHEVROLET | 1GBKG316X91123650 | Milwaukee |
| 496 | 2010 | CHEVROLET | 1GB9G5B64A1112379 | Milwaukee |
| 497 | 2010 | CHEVROLET | 1GB9G5B63A1112714 | Milwaukee |
| 498 | 2010 | CHEVROLET | 1GB9G5B66A1113713 | Milwaukee |

48 UNITS IN SERVICE

*these units are assigned to Waukesha county,
but can be moved to Milwaukee if needed



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
8/19/2015

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 Cottingham & Butler Jeff K. Bair 800 Main St. Dubuque IA 52001 | | CONTACT NAME: PHONE (A/C, No, Ext): 563-587-5000 FAX (A/C, No): 563-583-7339 E-MAIL ADDRESS: | |
| INSURED Bell Ambulance, Inc. PO Box 070550 Milwaukee WI 53207-0550 | | INSURER(S) AFFORDING COVERAGE INSURER A: Homeland Insurance Company of New Y INSURER B: Old Republic Insurance Company INSURER C: Lloyd's INSURER D: INSURER E: INSURER F: | |
| BELAMB1 | | NAIC # 34452 24147 | |

COVERAGES

CERTIFICATE NUMBER: 683589504

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 VVD | 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 GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER: | | | MFL-004692-0615 | 6/1/2015 | 6/1/2016 | EACH OCCURRENCE \$1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$100,000 MED EXP (Any one person) \$10,000 PERSONAL & ADV INJURY \$2,000,000 GENERAL AGGREGATE \$2,000,000 PRODUCTS - COMP/OP AGG \$2,000,000 Employee Benefits \$5M/\$2M |
| B | <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 | | | MWTB 305159 | 6/1/2015 | 6/1/2016 | COMBINED SINGLE LIMIT (Ea accident) \$1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$ |
| C | <input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> DED <input checked="" type="checkbox"/> RETENTION \$5,000 | | | UM100011 | 6/1/2015 | 6/1/2016 | EACH OCCURRENCE \$4,000,000 AGGREGATE \$4,000,000 \$ |
| B | 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 <input type="checkbox"/> N/A | | MWC 305158 00 | 6/1/2015 | 6/1/2016 | <input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$1,000,000 E.L. DISEASE - EA EMPLOYEE \$1,000,000 E.L. DISEASE - POLICY LIMIT \$1,000,000 |
| A | Professional | | | MFL-004692-0615 | 6/1/2015 | 6/1/2016 | Aggregate Incident 2,000,000 1,000,000 |

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

The City of Milwaukee is additional insured on the general liability policy subject to all terms and conditions of the policy forms. A 30 day notice of cancellation is provided by the insurance company to the certificate holder as outlined by the endorsement attached to the General Liability policy.

CERTIFICATE HOLDER

CANCELLATION

| | |
|---|---|
| City of Milwaukee; Health Department 841 N. Broadway, Room 315 Milwaukee WI 53202 | 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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SERVICE CONTRACT (BID, CONTRACT OR PURCHASE ORDER #)

AFFIDAVIT OF NO INTEREST

AFFIDAVIT MUST ACCOMPANY EACH CERTIFICATE OF INSURANCE
ISSUED, INCLUDING NEW AND RENEWALS

Jeffrey K. Bair

_____, being first duly sworn, on oath deposes and
(Insurance Agent that signed the insurance certificate submitted)¹

says that he/she is the agent of the
Homeland Insurance Company of New York

_____, insurer, on the attached certificate issued
(Insurance Company(s) Named on Insurance Certificate that apply
-listed under Insurers Affording Coverage)

to Bell Ambulance, Inc.

(Name of Insured/Contractor listed on insurance certificate)

Affiant further deposes and says that no officer, official or employee of the City of Milwaukee
has any interest, directly or indirectly, or is receiving any premium, commission, fee or other
thing of value in connection with the furnishing of said insurance certificate.

Jeffrey K. Bair

(Agent's Signature)

STATE OF Iowa

SS

Dubuque

COUNTY



Subscribed and sworn to before me this 20th day of August,
2015.

Stacey Abbitt

_____, Notary Public

My Commission expires: 2/3/18.

**NOTE: THIS "AFFIDAVIT OF NO INTEREST" MUST BE COMPLETED AND
SIGNED BY THE PERSON WHO EXECUTED THE CERTIFICATE OF
INSURANCE, NOTARIZED, AND SUBMITTED WITH YOUR CERTIFICATE OF
INSURANCE.**

¹ The name of the insurance agent signing this affidavit – not the name of the insurance company. The same agent
whose name/signature is on the insurance certificate must complete this affidavit, and their signature must be
notarized.

Application for Ambulance Certification

Fee Must Accompany Application.

The license period is from January 1 to December 31.

\$1,100.00 - New Applicants and Renewals

Make check payable to the City of Milwaukee Health Department

Check(✓) one: ☐ Individual
☐ Partnership
☒ Corporation

1. NAME OF APPLICANT (If individual):

Business Name: MEDA-CARE AMBULANCE, INC Phone: (414) 344-4444

Business Address: 2515 W. VLIET ST

City: Milwaukee State: WI Zip: 53205

Have any people on this application been convicted of violating any federal or state laws, or local ordinances? ☐ Yes ☒ No

If 'yes', name of person(s), date, charge and penalty: _____

2. PARTNERSHIP (If applicable):

Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date of Birth: _____

Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date of Birth: _____

3. NAME OF CORPORATION MEDA-CARE AMBULANCE, INC

Address: 2515 W VLIET ST, MILWAUKEE WI 53205

Date and Place of Incorporation: 1/10/72 Milwaukee WI

President: YVONNE LARSEN

Home Address: 568 W18118 ISLAND DR

City: MUSKEGO State: WI Zip: 53150

Phone: (262) 679-0290 Date of Birth: 9/24/57

Vice President: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date of Birth: _____

continued on other side

Secretary: TED LARSEN
Home Address: 20905 VILLA CT
City: BROOKFIELD State: WI Zip: 53186
Phone: (262) 798-0654 Date of Birth: 11/12/65
Treasurer: SAME AS SECRETARY
Home Address: _____
City: _____ State: _____ Zip: _____
Agent: Chris Mahoy
Home Address: 2103 GARLAND AVE
City: Waukesha State: WI Zip: 53188

4. OTHER REQUIREMENTS:

Do you have on file with the Health Department, a valid and current certificate of insurance for this license period? ☒ Yes ☐ No
Do you have a valid State of Wisconsin Inspection Certificate? ☒ Yes ☐ No
Do you participate in the Emergency Medical Services System? ☒ Yes ☐ No
If yes, list service area number: 2
Do you wish to participate in the Emergency Medical Services System? ☒ Yes ☐ No
Total number of vehicles in service: 16
Please attach a separate page listing all vehicles including city assigned number, and description (year, make and vin number).

5. The undersigned agrees to inform the Health Department within ten days of any substantial changes in the information supplied in this application. The undersigned shall not willfully refuse to provide those services offered under this license, permit, or franchise, or refuse to employ, or discharge any person otherwise qualified because of race, color, creed, sex, national origin or ancestry; and not seek such information as a condition of employment, or penalize any employee or discriminate in the selection of personnel for training or promotion on the basis of such information.
6. The undersigned understand that this application does not entitle the applicants to a license and that the granting of licenses is solely in the discretion of the Common Council.
7. I have a knowledge of the City Ordinances currently regulating the license applied for herein, and being duly sworn under oath, depose and say that I am the person named above and that all statements made in the foregoing application are true and correct.

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____ day of _____, 20____
Individual/Corporate President/Partner: Gloria Larsen
Additional Partner/Corporate Vice President: _____
Notary Public, State of Wisconsin: C. Mahoy
My commission expires: 6/8/19
Corporate Secretary: [Signature]
Corporate Treasurer: _____

Do Not Write Below This Line

| Clerk | License # | New | Renewal | Date Filed | Date Granted |
|-------|-----------|-----|---------|------------|--------------|
|-------|-----------|-----|---------|------------|--------------|

| | Ambulance Number | VIN Number | License Number | Year manufactured | Year Purchased |
|----|------------------|-------------------|----------------|-------------------|----------------|
| 1 | 201 Fly Car | 2FMDK46CX7BA53698 | 873-SRS | | 2010 |
| 2 | 202 | 1FDSS34P26DA92043 | 158-VEV | 2006 | 2013 |
| 3 | 204 | 1FDSS34P16DB15523 | 345-XGH | 2006 | 2014 |
| 4 | 205 | 1FDSS34P07DA91524 | 342-XGH | 2007 | 2014 |
| 5 | 206 | 1FDSS34P86HA97319 | 344-XGH | 2006 | 2014 |
| 6 | 207 | 1FDSS34P65HB44572 | 278-TPV | 2005 | 2012 |
| 7 | 208 | 1FDSS34P46DA88818 | 500-VAT | 2006 | 2013 |
| 8 | 209 | 1FDSS34P26DA88820 | 163-VEV | 2006 | 2013 |
| 9 | 210 | 1FDSS34P54HA96657 | 291-STP | 2004 | 2010 |
| 10 | 224 | 1FDSS34P84HB04962 | 660-SUF | 2004 | 2010 |
| 11 | 228 | 1FDXE45P56HA37726 | 119-VEW | 2006 | 2013 |
| 12 | 229 | 1FDXE45P35HB39573 | 126-VEW | 2005 | 2013 |
| 13 | 231 | 1FDWE35P08DB40519 | 102-YBA | 2008 | 2015 |
| 14 | 232 | 1FDWE35P08DB11778 | 101-YBA | 2008 | 2015 |
| 15 | 233 | 1FDXE45P97DA27533 | 135-PWA | 2007 | 2007 |
| 16 | 234 | 1FDXE45P97DA38063 | 136-PWA | 2007 | 2007 |



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

1/27/2015

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 R&R Insurance Services Inc 1581 E Racine Avenue PO Box 1610 Waukesha WI 53186 | | CONTACT NAME: Julie Liebelt PHONE (A/C, No, Ext): (262) 574-7219 E-MAIL ADDRESS: julie.liebelt@rrins.com FAX (A/C, No): (262) 953-1353 | |
| INSURED Meda-Care Ambulance Service Inc 2515 W Vliet St Milwaukee WI 53205-1835 | | INSURER(S) AFFORDING COVERAGE INSURER A: Arch Insurance Company INSURER B: INSURER C: INSURER D: INSURER E: INSURER F: | |

COVERAGES **CERTIFICATE NUMBER:** 2015 Liability - No WC **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 type="checkbox"/> Professional Liability GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC | | | MAPK07855601 | 2/1/2015 | 2/1/2016 | 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 \$ 3,000,000 PRODUCTS - COMP/OP AGG \$ 3,000,000 |
| | AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input checked="" type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS | | | MAPK07855601 | 2/1/2015 | 2/1/2016 | COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ |
| | <input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED <input checked="" type="checkbox"/> RETENTION \$ 0 | | | MAUM06385201 | 2/1/2015 | 2/1/2016 | EACH OCCURRENCE \$ 1,000,000 AGGREGATE \$ 1,000,000 |
| | 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 <input type="checkbox"/> N/A | | | | | | WC STATUTORY LIMITS <input type="checkbox"/> OTHER <input type="checkbox"/> 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)
The City of Milwaukee is additional insured per CG 20 10 (07-04) concerning work performed by the Insured.

CERTIFICATE HOLDER**CANCELLATION**

City of Milwaukee
Health Department
841 N Broadway
Milwaukee, WI 53202

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

William Katzfey/C172