

# INSURANCE



## Checklist

### Commercial General Liability Insurance

1

- Must be an ACORD Form
- Policy number clearly stated
- Effective start and end dates
- Coverage limits meet, at minimum, \$1,000,000 per occurrence and \$2,000,000 in general aggregate
- City of Santa Clarita is clearly stated as the certificate holder, with address: 23920 Valencia Boulevard Santa Clarita, Ca 91355

### Additional Insured Endorsement

2

- Must accompany Commercial General Liability insurance certificate
- City of Santa Clarita is clearly stated as the certificate holder
- Policy number must match certificate

**Additional Insured Endorsement**

This Endorsement Changes The Policy. Please Read It Carefully.

**ADDITIONAL INSURED—OWNERS, LESSEES OR CONTRACTORS—PRIMARY AND NONCONTRIBUTORY**

Name of Person or Organization:  
**City of Santa Clarita  
 23920 Valencia Blvd., Suite 300  
 Santa Clarita, CA 91355**

2

### Worker's Compensation

3

- Statutory requirement

**WAIVER OF SUBROGATION SAMPLE (REQUIRED WITH WORKERS COMP POLICY)**

**WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY**

**WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS ENDORSEMENT—CALIFORNIA**

We have the right to recover our payments from anyone liable for an injury covered by this policy. We will not enforce our right against the person or organization named in the Schedule. (This agreement applies only to the extent that you perform work under a written contract that requires you to obtain this agreement from us.)

You must maintain payroll records accurately segregating the remuneration of your employees while engaged in the work described in the Schedule.

The additional premium for this endorsement shall be \_\_\_ % of the California workers' compensation premium otherwise due on such remuneration.

Person or Organization \_\_\_\_\_ Schedule \_\_\_\_\_ Job Description \_\_\_\_\_

4

### Waiver of Subrogation

4

- Must accompany Worker's Compensation certificate

**WHERE YOU ARE REQUIRED BY WRITTEN CONTRACT TO OBTAIN THIS AGREEMENT FROM US, PROVIDED THE CONTRACT IS SIGNED AND DATED PRIOR TO THE DATE OF THE LOSS TO WHICH THE WAIVER APPLIES. IN NO INSTANCE SHALL THE PROVISIONS AFFORDED BY THIS ENDORSEMENT BENEFIT ANY COMPANY OPERATING AIRCRAFT FOR HIRE.**

(661) 250-3715

ContractClasses@santaclarita.gov

SantaClarita.gov/ContractClass

\*The premium charge for this endorsement shall be 1% of the premium developed in the State of California, but not less than \$, policy minimum premium.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated. (The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: 02/01/2020 Policy No: 121456789 Endorsement No: 20  
 Insured: CONTACTOR OR NAME Policy Effective Date: 02/01/2020  
 Insurance Company: NAME OF INSURANCE COMPANY

WC 04 03 05 (EG 4-04)

POLICY NUMBER MUST MATCH WORKERS COMP POLICY NUMBER



# Commercial General Liability Insurance

DATE (MM/YY)

1

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 have **ADDITIONAL INSURED** provisions or 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	<b>SAMPLE</b>	CONTACT NAME:	
		PHONE (A/C, No. Ext):	FAX (A/C, No):
		E-MAIL ADDRESS:	
		INSURER(S) AFFORDING COVERAGE	NAIC #
INSURED	<b>SAMPLE</b>	INSURER A :	
		INSURER B :	
		INSURER C :	
		INSURER D :	
		INSURER E :	
		INSURER F :	

**COVERAGES**                      **CERTIFICATE NUMBER:**                      **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 WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b>			<b>"Policy Number"</b>	<b>Policy Start/ Expiration Date</b>		EACH OCCURRENCE \$ <b>1,000,000</b>
	<input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR					DAMAGE TO RENTED PREMISES (Ea occurrence) \$ <b>100,000</b>	
	GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:						MED EXP (Any one person) \$ <b>10,000</b>
	<b>AUTOMOBILE LIABILITY</b>						PERSONAL & ADV INJURY \$ <b>1,000,000</b>
	<input type="checkbox"/> ANY AUTO						GENERAL AGGREGATE \$ <b>2,000,000</b>
	<input type="checkbox"/> OWNED AUTOS ONLY	<input type="checkbox"/> SCHEDULED AUTOS					PRODUCTS - COMP/OP AGG \$ <b>2,000,000</b>
	<input type="checkbox"/> HIRED AUTOS ONLY	<input type="checkbox"/> NON-OWNED AUTOS ONLY					\$
	<b>UMBRELLA LIAB</b>						COMBINED SINGLE LIMIT (Ea accident) \$
	<input type="checkbox"/> OCCUR						BODILY INJURY (Per person) \$
	<b>EXCESS LIAB</b>						BODILY INJURY (Per accident) \$
	<input type="checkbox"/> CLAIMS-MADE						PROPERTY DAMAGE (Per accident) \$
	DED						\$
	RETENTION \$						\$
	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b>						PER STATUTE
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)						OTHER
	If yes, describe under DESCRIPTION OF OPERATIONS below	<input type="checkbox"/> Y / <input type="checkbox"/> N	N / A				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)

<b>CERTIFICATE HOLDER</b>	<b>CANCELLATION</b>
City of Santa Clarita 23920 Valencia Boulevard Santa Clarita, CA 91355	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

# Additional Insured Endorsement



Policy Number:

This Endorsement Changes The Policy. Please Read It Carefully.

## ADDITIONAL INSURED –OWNERS, LESSEES OR CONTRACTORS –PRIMARY AND NONCONTRIBUTORY

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART

### SCHEDULE

<p>Name of Person or Organization:</p> <p><b>City of Santa Clarita</b> <b>23920 Valencia Boulevard</b> <b>Santa Clarita, CA 91355</b></p>	
---	--

(If no entry appears above, information required to complete this endorsement will be shown in the Declarations as applicable to this endorsement.)

A. Section II –Who Is An Insured is amended to include as an insured the person or organization shown in the Schedule, but only with respect to liability arising out of your ongoing operations performed for that insured.

B. With respect to the insurance afforded to these additional insureds, the following exclusion is added:

#### 2. Exclusions

This insurance does not apply to “bodily injury” or “property damage” occurring after:

- (1) All work, including materials, parts or equipment furnished in connection with such work, on the project (other than service, maintenance or repairs) to be performed by or on behalf of the additional insured(s) at the site of the covered operations has been completed; or
- (2) That portion of “your work” out of which the injury or damage arises has been put to its intended use by any person or organization other than another contractor or subcontractor engaged in performing operations for a principal as a part of the same project.

If the contract between the additional insured and you requires that the insurance afforded by this policy be primary and noncontributory, this insurance shall be primary and noncontributory but only as to the general liability policy(ies) where that additional insured is listed as the named insured on the declaration page(s) of such policy(ies).

All other terms and conditions of this policy remain unchanged.



# Worker's Compensation Certificate

DATE (MM/

3

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 have ADDITIONAL INSURED provisions or 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	<b>SAMPLE</b>	CONTACT NAME:	
		PHONE (A/C, No. Ext):	FAX (A/C, No):
		E-MAIL ADDRESS:	
		INSURER(S) AFFORDING COVERAGE	NAIC #
INSURED	<b>SAMPLE</b>	INSURER A :	
		INSURER B :	
		INSURER C :	
		INSURER D :	
		INSURER E :	
		INSURER F :	

**COVERAGES**                      **CERTIFICATE NUMBER:**                      **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 WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
	<b>COMMERCIAL GENERAL LIABILITY</b> <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR  GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:						EACH OCCURRENCE \$ DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS - COMP/OP AGG \$ \$
	<b>AUTOMOBILE LIABILITY</b> <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY						COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
	<b>UMBRELLA LIAB</b> <input type="checkbox"/> OCCUR <b>EXCESS LIAB</b> <input type="checkbox"/> CLAIMS-MADE DED    RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$ \$
	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) <input type="checkbox"/> Y / N If yes, describe under DESCRIPTION OF OPERATIONS below		N/A	"Policy Number"		Policy Start/ Expiration Date	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTHER E.L. EACH ACCIDENT \$ 1,000,000 E.L. DISEASE - EA EMPLOYEE \$ 1,000,000 E.L. DISEASE - POLICY LIMIT \$ 1,000,000

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

<b>CERTIFICATE HOLDER</b>  <b>City of Santa Clarita</b> <b>23920 Valencia Boulevard</b> <b>Santa Clarita, CA 91355</b>	<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



**WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS ENDORSEMENT—CALIFORNIA**

We have the right to recover our payments from anyone liable for an injury covered by this policy. We will not enforce our right against the person or organization named in the Schedule. (This agreement applies only to the extent that you perform work under a written contract that requires you to obtain this agreement from US.)

You must maintain payroll records accurately segregating the remuneration of your employees while engaged in the work described in the Schedule.

The additional premium for this endorsement shall be   \*  % of the California workers' compensation premium otherwise due on such remuneration.

Schedule

**Person or Organization**

**Job Description**

WHERE YOU ARE REQUIRED BY WRITTEN   
CONTRACT TO OBTAIN THIS AGREEMENT FROM  
US, PROVIDED THE CONTRACT IS SIGNED AND  
> DATED PRIOR TO THE DATE OF THE LOSS TO <  
WHICH THE WAIVER APPLIES. IN NO INSTANCE  
SHALL THE PROVISIONS AFFORDED BY THIS  
ENDORSEMENT BENEFIT ANY COMPANY  
OPERATING AIRCRAFT FOR HIRE.

\*The premium charge for this endorsement shall be X% of the premium developed in the State of California, but not less than X policy minimum premium.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.  
(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective 02/01/2020 (Policy No.) 123456789 Endorsement No. 20  
Insured CONTRACTOR NAME Policy Effective Date  
Insurance Company NAME OF INSURANCE COMPANY 02/01/2020

Countersigned By \_\_\_\_\_

POLICY NUMBER MUST MATCH WORKER'S  
COMPENSATION POLICY NUMBER