

# CERTIFICATE OF LIABILITY INSURANCE

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

<b>PRODUCER</b>  Insurance Agent/Broker Name Insurance Agent/Broker Street Address or P.O. Box Insurance Agent/Broker City, State & Zip Code Contact & Phone Number	<p style="text-align: center;"><b>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.</b></p> <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: Name of Insurance Company</td> <td>Enter NAIC#</td> </tr> <tr> <td>INSURER B: Name of Insurance Company (if applicable)</td> <td>Enter NAIC#</td> </tr> <tr> <td>INSURER C: Name of Insurance Company (if applicable)</td> <td>Enter NAIC#</td> </tr> <tr> <td>INSURER D: Name of Insurance Company (if applicable)</td> <td>Enter NAIC#</td> </tr> <tr> <td>INSURER E: Name of Insurance Company (if applicable)</td> <td>Enter NAIC#</td> </tr> </table>	INSURERS AFFORDING COVERAGE	NAIC #	INSURER A: Name of Insurance Company	Enter NAIC#	INSURER B: Name of Insurance Company (if applicable)	Enter NAIC#	INSURER C: Name of Insurance Company (if applicable)	Enter NAIC#	INSURER D: Name of Insurance Company (if applicable)	Enter NAIC#	INSURER E: Name of Insurance Company (if applicable)	Enter NAIC#
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<b>INSURED</b>  Vendor Name Vendor Street Address or P.O. Box Vendor City, State & Zip Code													

**COVERAGES**  
 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. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

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"/>	<b>GENERAL LIABILITY</b> <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> OCCUR <input type="checkbox"/> _____ <input type="checkbox"/> _____ GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC	Enter Policy #	Enter Effective Date	Enter Expiration Date	EACH OCCURENCE	\$1,000,000
						DAMAGE TO RENTED PREMISES (Ea occurrence)	
						MED EXP (Any one person)	
						PERSONAL & ADV INJURY	
						GENERAL AGGREGATE	
						PRODUCTS - COMP/OP AGG	
							\$
A	<input type="checkbox"/>	<b>AUTOMOBILE LIABILITY</b> <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"/> _____ <input type="checkbox"/> _____				COMBINED SINGLE LIMIT (Each Occurrence)	
						BODILY INJURY (Per person)	\$
						BODILY INJURY (Per accident)	\$
						PROPERTY DAMAGE (Per accident)	\$
A	<input type="checkbox"/>	<b>GARAGE LIABILITY</b> <input type="checkbox"/> ANY AUTO <input type="checkbox"/> _____				AUTO ONLY - EA ACCIDENT	
						OTHER THAN EA ACC	\$
						AUTO ONLY: AGG	\$
A	<input type="checkbox"/>	<b>EXCESS/UMBRELLA LIABILITY</b> <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> DEDUCTIBLE <input type="checkbox"/> RETENTION \$Enter Amount				EACH OCCURENCE	\$Enter Limit
						AGGREGATE	\$Enter Limit
							\$
							\$
							\$
A	<input type="checkbox"/>	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below				<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"/>	<b>OTHER</b>					

**DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS**  
 The State of Ohio is listed as the additional insured as required by written contract.

<b>CERTIFICATE HOLDER</b>  The State of Ohio ATTN: Rhonda Lawson 717 East 17th Avenue Columbus, Ohio 43211-2698 r.lawson@expo.ohio.gov	<b>CANCELLATION</b>  SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE INSURER AFFORDING COVERAGE WILL ENDEAVOR TO MAIL 30 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.  AUTHORIZED REPRESENTATIVE
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## **IMPORTANT**

If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

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).

## **DISCLAIMER**

The Certificate of Insurance on the reverse side of this form does not constitute a contract between the issuing insurer(s), authorized representative or producer, and the certificate holder, nor does it affirmatively or negatively amend, extend or alter the coverage afforded by the policies listed thereon.