

Class Code	Description	7/1/2021-6/30/2022			7/1/2020-6/30/2021			7/1/2019-6/30/2020			Wag
		Wages	Rate	Premium	Wages	Rate	Premium	Wages	Rate	Premium	
7380	Chauffeurs				3,333	5.60	187	-	5.60	-	
7720	Police	508,959	5.19	26,415	537,445	5.19	27,893	530,572	5.46	28,969	50
8810	Library		0.14	-	56,615	0.14	79	55,388	0.16	89	
8810	Office	195,961	0.14	274	160,567	0.14	225	183,517	0.16	294	19
9015	Janitorial	-	3.79	-	7,308	3.79	277	-	4.10	-	
9102	Park Municipal	114,811	3.08	3,536	106,345	3.08	3,275	109,616	3.69	4,045	11
9220	Cemetery	-	5.08	-		5.08	-		5.43	-	
9410	Municipal, Twp, State or County	66,788	1.42	948	83,327	1.42	1,183	45,000	1.52	684	5
				-							
		886,519		31,174	954,940		33,120	924,093		34,080	85
				-							
0900	Expense Constant			250			250			250	
9740	Terrorism	886,519	0.02	177	954,940	0.02	191	924,093	0.02	185	88
9741	Catastrophe	886,519	0.01	89	954,940	0.01	95	924,093	0.01	92	88
9880	1-800 claims	22,743	0.99	(227)	25,069	0.01	(251)	25,487	0.01	(255)	2
9880	Managed care	22,743	0.99	(227)	25,069	0.01	(251)	25,487	0.01	(255)	2
9034	Renewal credit	23,691	0.96	(948)	26,114	0.04	(1,045)	26,549	0.04	(1,062)	2
9887	Schedule credit	22,743	0.94	(1,365)	25,069	0.10	(2,507)	25,487	0.10	(2,549)	2
0063	Premium Discount	20,924	0.07	(1,449)	22,060	0.07	(1,540)	22,428	0.07	(1,569)	2
9037	Group/Assoc credit	31,173	0.95	(1,559)	33,119	0.05	(1,656)	34,081	0.05	(1,704)	3
9898	Experience modification	29,614	0.80	(5,923)	31,463	0.83	(5,349)	32,377	0.82	(5,828)	3
	Estimated Premium			19,992			21,058			21,386	
9757	Non compliance charge			9,996							
	Total Earned Premium			29,988			21,058			21,386	



AccidentFund UnitedHeartland CompWest ThirdCoast Underwriters

## Determination of Worker Status

**Purpose:** Policyholders submit this form to request the determination of the status of a worker for the purpose of completing his or her worker's compensation audit. This form will only be used to determine whether or not remuneration paid to a worker will be included on the policyholder's audit. All factors will be considered, however, no one factor is determinative of the worker's status.

Answer all questions as completely as possible. **Attach additional sheets if you need more space.** Provide information for the worker and policy period stated below. Determinations are based on the entire relationship between the policyholder and worker. **In order to make a determination as to whether an Employer/Employee status exists, please complete this analysis and provide as much of the following documentation as possible. This information must be provided and updated on an annual basis.**

Policyholder  
Worker's Name: Jason Bunker Policy Period  
Worker's DBA (applicable): Bunker Services  
7859 White Rd Indian River MI 49749  
Worker's Place of Business Address (Include street address, city, state, and zip code) Worker's FEIN number

Worker is a: ☐ Sole Proprietor ☐ Partnership ☐ Corporation ☒ Limited Liability Company

How is the worker paid? ☐ per agreed upon price ☒ per hour ☐ salary ☐ commission ☐ piece work ☐ lump sum

Does the worker hire any employees, casual laborers, or subcontractors? ☐ Yes ☒ No If yes who pays them? \_\_\_\_\_

If the work is done under a written agreement between the policyholder and the worker, **attach a copy** (preferably signed by both parties).

Describe the term and conditions of the work arrangement. Time & material

The worker was contracted to perform: Misc Service work on HVAC equipment

What specific training or instruction is the worker given by the policyholder? \_\_\_\_\_

What expenses are incurred by the worker in the performance of services for the policyholder? \_\_\_\_\_

List the supplies, equipment, materials and property provided by the worker. Please provide a copy of an invoice from the contractor: \_\_\_\_\_

During the above policy period, the approximate percentage of payments to the subcontractor in relation to their total income for the year. \_\_\_\_\_ %

Can the relationship be terminated by either party without incurring liability or penalty? If "No" explain your answer ☐ Yes ☐ No

Does the worker perform similar service for others? ☐ Yes ☐ No. If "Yes" is the worker required to get approval from the policy holder? ☐ Yes ☐ No

Below is a list of other individuals and business entities that the worker has performed services for over the past year. \_\_\_\_\_

Does the worker carry insurance? (e.g. workers compensation, general liability, professional liability, etc.) ☐ Yes ☒ No If "Yes" please attach copies

What type of advertising, if any, does the worker have (e.g. business listing in a directory or trade journal, newspaper advertisement, business card, etc.)? Provide copies, if applicable. Does the worker advertise their business on T.V. or radio? ☐ Yes ☐ No

### Signature

I declare that I have examined this request, including accompanying documents, and to the best of my knowledge and belief, the facts presented are true, correct and complete. This form must be signed by the policyholder (i.e., Owner, Partner, Corporate Officer, Member/Manager) who has personal knowledge of the facts.

Signature Jason Bunker Title Owner Date 3-18-23



TEMPCON-08

SVELD1

## CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

2/28/2022

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 License # 0019304-1 Hub International Midwest East 1591 Galbraith Ave SE Grand Rapids, MI 49546	CONTACT NAME: Sarah Veld	
	PHONE (A/C, No, Ext):	FAX (A/C, No):
INSURED  Temperature Control Inc. 1623 Northern Star Dr Traverse City, MI 49686	E-MAIL ADDRESS: sarah.veld@hubinternational.com	
	INSURER(S) AFFORDING COVERAGE	
	INSURER A : National Fire Insurance Company of Hartford 20478	
	INSURER B : Continental Insurance Company of New Jersey 42625	
	INSURER C : Valley Forge Insurance Company 20508	
	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
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 checked="" type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:			6076462195	3/1/2022	3/1/2023	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000 MED EXP (Any one person) \$ 15,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000 EMPLOYEE BENEFIT \$ 1,000,000
A	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY			BUA 6076462181	3/1/2022	3/1/2023	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
B	<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 \$ 10,000			CUE6076462231	3/1/2022	3/1/2023	EACH OCCURRENCE \$ 7,000,000 AGGREGATE \$ 7,000,000 \$
C	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 N	N/A	WC6 76462214	3/1/2022	3/1/2023	<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

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

## CERTIFICATE HOLDER

## CANCELLATION

Tuscarora Township  
3546 S Straits Highway  
PO Box 220  
Indian River, MI 49749

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

*Neil R. Hughes*



WHITPIN-01

JSTEPHENS

## CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
2/9/2023

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 General Agency Company 525 E. Broadway Mount Pleasant, MI 48858	CONTACT NAME: Julie Stephens		
	PHONE (A/C, No, Ext): (989) 817-4245	FAX (A/C, No): (989) 772-1855	
	E-MAIL ADDRESS: jstephens@ga-ins.com		
INSURED  White Pines Electric Inc, J & J Northern Properties LLC PO Box 177 Alanson, MI 49706	INSURER(S) AFFORDING COVERAGE		NAIC #
	INSURER A: Fremont Insurance Co		13994
	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
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 checked="" type="checkbox"/> POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC <input type="checkbox"/> OTHER:	X		CPP007871706	10/24/2022	10/24/2023	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000 MED EXP (Any one person) \$ 10,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000
A	AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY			CAP002716405	10/24/2022	10/24/2023	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
A	UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR <input checked="" type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> DED <input checked="" type="checkbox"/> RETENTION \$ 10,000			CUP003273308	10/24/2022	10/24/2023	EACH OCCURRENCE \$ 1,000,000 AGGREGATE \$ 1,000,000
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY 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	WCP002084306	10/24/2022	10/24/2023	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ 500,000 E.L. DISEASE - EA EMPLOYEE \$ 500,000 E.L. DISEASE - POLICY LIMIT \$ 500,000
A	Contractors E & O			CPP007871706	10/24/2022	10/24/2023	Each Occurrence 1,000,000

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

## CERTIFICATE HOLDER

## CANCELLATION

Tuscarora Township  
3546 S Straits Hwy  
Indian River, MI 49749

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



## Determination of Worker Status

**Purpose:** Policyholders submit this form to request the determination of the status of a worker for the purpose of completing his or her workers compensation audit. This form will only be used to determine whether or not remuneration paid to a worker will be included on the policyholder's audit. This form is only valid for the worker and policy period listed below. This determination is for the audit period in question and does not affect the payment of claims.

**Completing the form:** Answer all questions as completely as possible. **Attach additional sheets if you need more space.** Provide information for the worker and policy period stated below. Determinations are based on the entire relationship between the policyholder and worker.

Tuscarora Township

WCV 0215291 16 01

Accident Fund Policyholder

Policy Period

Policy Number

In order to make a determination as to whether an Employer/Employee status exists, please complete this analysis and provide as much of the following documentation as possible. This information must be provided on an annual basis.

Worker's Name <b>Bruce Thompson</b>		Worker's DBA (applicable)	
Worker's Address (Include street address, city, state and Zip code.) <b>2063 Miller Road, Alanson, MI 49706</b>		Worker's Tax ID <b>38-6549319</b>	
Worker is a:	<input type="checkbox"/> Sole Proprietorship  Did the sole proprietor use any employees, casual labor, or uninsured subcontractors to complete the work? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Partnership	<input type="checkbox"/> Corporation
<input type="checkbox"/> Limited Liability Company			

- A. How did the worker obtain the job?   ☐ Application   ☒ Bid   ☐ Employment Agency   ☐ Other (specify)  
 Type of pay the worker receives:   ☐ Salary   ☐ Commission   ☐ Hourly Wage   ☒ Piece Work   ☐ Lump sum   ☐ Other (specify)
- B. If the work is done under a written agreement between the policyholder and the worker, **attach a copy** (preferably signed by both parties). Describe the terms and conditions of the work arrangement.
- C. What specific training or instruction is the worker given by the policyholder? None
- D. How does the worker receive work assignments? And who determines how and when the assignments are performed?  
By phone call when a burial is scheduled
- E. Is the worker required to provide the services personally? No
- F. If substitutes or helpers are needed, who hires them? Self   Who pays them? Thompson
- G. List the supplies, equipment, materials and property provided by each party:  
 The policyholder: None  
 The worker: Shovels and loader  
 Other party: None
- H. What expenses are incurred by the worker in the performance of services for the policyholder? None
- I. Does the worker carry insurance (e.g., workers compensation, general liability, etc.)? If "Yes", please attach copies. Yes
- J. List the benefits available to the worker (e.g., paid vacations, sick pay, pensions, bonuses). None
- K. Can the relationship be terminated by either party without incurring liability or penalty? If "No," explain your answer. Yes
- L. Does the worker perform similar services for others? If "Yes," is the worker required to get approval from the policyholder? Yes
- M. What type of advertising, if any, does the worker do (e.g., business listing in a directory, business cards, etc.)? Provide copies, if applicable. Yes

**Signature**

I declare that I have examined this request, including accompanying documents, and to the best of my knowledge and belief, the facts presented are true, correct and complete. This form must be signed by the policyholder (i.e., Owner, Partner, Corporate Officer, Member/Manager) who has personal knowledge of the facts.

Signature Bruce Thompson

Title Owner

Date 8-30-2021



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
02/20/2023

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<b>PRODUCER</b> TCA Insurance 1118 W Lake St Tawas City, MI 48763	<b>CONTACT NAME:</b> Lindsey Martin	
	<b>PHONE (A/C, No, Ext):</b> 989-362-3003 <b>FAX (A/C, No):</b>	
<b>INSURED</b> Bunker Services LLC 7859 White Road Indian River, MI 49749	<b>E-MAIL ADDRESS:</b> lindsey@tcains.biz	
	<b>INSURER(S) AFFORDING COVERAGE</b>	
	<b>INSURER A:</b> Pioneer State Mutual	<b>NAIC #</b> 18309
	<b>INSURER B:</b> Accident Fund Co of America	12305
	<b>INSURER C:</b>	
	<b>INSURER D:</b>	
<b>INSURER E:</b>		
<b>INSURER F:</b>		

**COVERAGES****CERTIFICATE NUMBER:****REVISION NUMBER:**

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INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	<input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b> <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:			CB00000995	07/01/2021	07/01/2022	EACH OCCURRENCE \$ 2,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ 5,000 PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ 4,000,000 PRODUCTS - COMP/OP AGG \$ 4,000,000 \$
A	<b>AUTOMOBILE LIABILITY</b> ANY AUTO OWNED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY  UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED <input type="checkbox"/> RETENTION \$			CA00302812	07/01/2021	07/01/2022	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$ EACH OCCURRENCE \$ AGGREGATE \$ \$
B	<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	100032726	06/01/2021	06/01/2022	<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

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

**CERTIFICATE HOLDER****CANCELLATION**

Tuscarora Township 3546 S Straits Hwy Indian River, MI 49749	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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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
07/08/2022

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<b>PRODUCER</b> BKC Insurance Services 220 Water Street  Cheboygan MI 49721		<b>CONTACT NAME:</b> Rose Waite <b>PHONE (A/C, No, Ext):</b> (231) 627-4381 <b>E-MAIL ADDRESS:</b> rwaite@bkcinurance.com <b>FAX (A/C, No):</b> (231) 627-5171	
<b>INSURED</b> Chaskey Septic Service Inc PO Box 135  Onaway MI 49765-0135		<b>INSURER(S) AFFORDING COVERAGE</b> <b>INSURER A:</b> Home Owners Insurance Company <b>INSURER B:</b> Auto Owners Ins Co <b>INSURER C:</b> <b>INSURER D:</b> <b>INSURER E:</b> <b>INSURER F:</b>	
		<b>NAIC #</b> 26638 18988	

## COVERAGES

CERTIFICATE NUMBER: CL227819107

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
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"/> PROJECT <input type="checkbox"/> LOC OTHER:			33643888	12/20/2021	12/20/2022	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 300,000 MED EXP (Any one person) \$ 10,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMPI/OP AGG \$ 2,000,000
	<b>AUTOMOBILE LIABILITY</b> <input type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY			9679925501	12/20/2021	12/20/2022	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
	<b>UMBRELLA LIAB</b> <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> OCCUR <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) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N <input checked="" type="checkbox"/> Y	N/A	33178139	12/20/2021	12/20/2022	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ 100,000 E.L. DISEASE - EA EMPLOYEE \$ 100,000 E.L. DISEASE - POLICY LIMIT \$ 500,000

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

## CERTIFICATE HOLDER

## CANCELLATION

Indian River Contractors, Inc.  
PO Box 280

Indian River

MI 49749

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

*Rose M Waite*

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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
09/27/2021

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).

<b>PRODUCER</b> BKC Insurance Services 220 Water Street  Cheboygan MI 49721		<b>CONTACT NAME:</b> Kimberly Valot <b>PHONE (A/C, No, Ext):</b> <b>FAX (A/C, No):</b> <b>E-MAIL ADDRESS:</b> kvalot@bkcsinsurance.com	
		<b>INSURER(S) AFFORDING COVERAGE</b>	
		<b>INSURER A:</b> Michigan Millers Mut Ins Co	<b>NAIC #</b> 14508
		<b>INSURER B:</b> Accident Fund Ins Co of America	10166
		<b>INSURER C:</b>	
		<b>INSURER D:</b>	
		<b>INSURER E:</b>	
		<b>INSURER F:</b>	

**COVERAGES** **CERTIFICATE NUMBER:** CL2142266523 **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
A	<input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b> <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:			C0530511	03/25/2021	03/25/2022	EACH OCCURRENCE \$ 500,000
			DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000				
			MED EXP (Any one person) \$ 5,000				
			PERSONAL & ADV INJURY \$ 500,000				
						GENERAL AGGREGATE \$ 1,000,000	
						PRODUCTS - COMP/OP AGG \$ 1,000,000	
						TOT \$	
	<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	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N <input checked="" type="checkbox"/> Y	N/A	ARP12002736900	08/01/2021	08/01/2022	<input type="checkbox"/> PER STATUTE <input type="checkbox"/> OTHER
			E.L. EACH ACCIDENT \$ 100,000				
			E.L. DISEASE - EA EMPLOYEE \$ 100,000				
			E.L. DISEASE - POLICY LIMIT \$ 500,000				

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

<b>CERTIFICATE HOLDER</b>  Dodd's Tree Removal, LLC C&H Tree Removal, LLC 1110 Lahaie Rd  Cheboygan MI 49721	<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 
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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
06/13/2022

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.

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<b>PRODUCER</b> BKC Insurance Services 220 Water Street  Cheboygan MI 49721		<b>CONTACT NAME:</b> Kimberly Valot <b>PHONE (A/C, No, Ext):</b> <b>FAX (A/C, No):</b> <b>E-MAIL ADDRESS:</b> kvalot@bkinsurance.com	
<b>INSURED</b> C&H Tree Removal, LLC Patrick Dodd 1110 Lahaie Rd  Cheboygan MI 49721		<b>INSURER(S) AFFORDING COVERAGE</b> <b>INSURER A:</b> Michigan Millers Mut Ins Co <b>INSURER B:</b> Accident Fund Ins Co of America <b>INSURER C:</b> <b>INSURER D:</b> <b>INSURER E:</b> <b>INSURER F:</b>	
		<b>NAIC #</b> 14508 10166	

## COVERAGES

CERTIFICATE NUMBER: CL2261315140

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
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:			C0530511	03/25/2022	03/25/2023	EACH OCCURRENCE \$ 500,000
			DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000				
			MED EXP (Any one person) \$ 5,000				
			PERSONAL & ADV INJURY \$ 500,000				
						GENERAL AGGREGATE \$ 1,000,000	
						PRODUCTS - COMP/OP AGG \$ 1,000,000	
							\$
	<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 <input type="checkbox"/> RETENTION \$						EACH OCCURRENCE \$
							AGGREGATE \$
							\$
B	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N Y	N/A	ARP12002736900	08/01/2021	08/01/2022	<input type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER
			E.L. EACH ACCIDENT \$ 100,000				
			E.L. DISEASE - EA EMPLOYEE \$ 100,000				
			E.L. DISEASE - POLICY LIMIT \$ 500,000				

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

## CERTIFICATE HOLDER

## CANCELLATION

Dodd's Tree Removal, LLC C&H Tree Removal, LLC 1110 Lahaie Rd  Cheboygan MI 49721	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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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
03/15/2023

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.

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<b>PRODUCER</b> Larkin Group of Traverse City 13900 S West Bay Shore Drive  Traverse City MI 49684		<b>CONTACT NAME:</b> Beth McCardel <b>PHONE (A/C, No, Ext):</b> (231) 947-8800 <b>FAX (A/C, No):</b> (231) 346-6111 <b>E-MAIL ADDRESS:</b> bmccardel@larkingrp.com	
<b>INSURED</b> DROST LANDSCAPE, INC. PO BOX 696 2010 CEDAR VALLEY ROAD PETOSKEY MI 49770-0696		<b>INSURER(S) AFFORDING COVERAGE</b> <b>INSURER A:</b> Selective Insurance Co of America <b>INSURER B:</b> Accident Fund Natl. Ins. Co. <b>INSURER C:</b> <b>INSURER D:</b> <b>INSURER E:</b> <b>INSURER F:</b>	
		<b>NAIC #</b> 12305	

**COVERAGES** **CERTIFICATE NUMBER:** 2021/22 **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
A	<input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b> <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR  GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PROJECT <input type="checkbox"/> LOC OTHER:			S 2417572	02/24/2021	02/24/2022	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 500,000 MED EXP (Any one person) \$ 15,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000
	<input checked="" type="checkbox"/> <b>AUTOMOBILE LIABILITY</b> <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY			S 2417572	02/24/2021	02/24/2022	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
	<input checked="" type="checkbox"/> <b>UMBRELLA LIAB</b> <input type="checkbox"/> EXCESS LIAB DED <input checked="" type="checkbox"/> RETENTION \$ 0			S 2417572	02/24/2021	02/24/2022	EACH OCCURRENCE \$ 5,000,000 AGGREGATE \$ 5,000,000
	<input checked="" type="checkbox"/> <b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N N	N/A	WCV6125268	03/28/2021	03/28/2022	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTHER E.L. EACH ACCIDENT \$ 500,000 E.L. DISEASE - EA EMPLOYEE \$ 500,000 E.L. DISEASE - POLICY LIMIT \$ 500,000

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

<b>CERTIFICATE HOLDER</b> Tuscarora Township	<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 
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## Determination of Worker Status

**Purpose:** Policyholders submit this form to request the determination of the status of a worker for the purpose of completing his or her workers compensation audit. This form will only be used to determine whether or not remuneration paid to a worker will be included on the policyholder's audit. This form is only valid for the worker and policy period listed below. This determination is for the audit period in question and does not affect the payment of claims.

**Completing the form:** Answer all questions as completely as possible. **Attach additional sheets if you need more space.** Provide information for the worker and policy period stated below. Determinations are based on the entire relationship between the policyholder and worker.

TUSCARORA TOWNSHIP

WCV 0215291 16 01

Accident Fund Policyholder

Policy Period

Policy Number

In order to make a determination as to whether an Employer/Employee status exists, please complete this analysis and provide as much of the following documentation as possible. This information must be provided on an annual basis.

Worker's Name <b>Ellen August</b>		Worker's DBA (applicable) <b>Classic Cleaning</b>	
Worker's Address (Include street address, city, state and Zip code.) <b>10701 Parke Rd., Alanson, MI 49706</b>		Worker's Tax ID <b>38-3086106</b>	
Worker is a:	<input checked="" type="checkbox"/> Sole Proprietorship  Did the sole proprietor use any employees, casual labor, or uninsured subcontractors to complete the work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Partnership	<input type="checkbox"/> Corporation
<input type="checkbox"/> Limited Liability Company			

- A. How did the worker obtain the job?   ☐ Application   ☒ Bid   ☐ Employment Agency   ☐ Other (specify)  
 Type of pay the worker receives:   ☐ Salary   ☐ Commission   ☒ Hourly Wage   ☐ Piece Work   ☐ Lump sum   ☐ Other (specify)
- B. If the work is done under a written agreement between the policyholder and the worker, **attach a copy** (preferably signed by both parties). Describe the terms and conditions of the work arrangement.
- C. What specific training or instruction is the worker given by the policyholder?   **None**
- D. How does the worker receive work assignments? And who determines how and when the assignments are performed?   **Per attached copy**
- E. Is the worker required to provide the services personally?   **No**
- F. If substitutes or helpers are needed, who hires them?   **Self**   Who pays them?   **Classic Cleaning**
- G. List the supplies, equipment, materials and property provided by each party:  
 The policyholder:   **All**  
 The worker:   **None**  
 Other party:   **None**
- H. What expenses are incurred by the worker in the performance of services for the policyholder?   **None**
- I. Does the worker carry insurance (e.g., workers compensation, general liability, etc.)? If "Yes", please attach copies.   **Yes**
- J. List the benefits available to the worker (e.g., paid vacations, sick pay, pensions, bonuses).   **None**
- K. Can the relationship be terminated by either party without incurring liability or penalty? If "No," explain your answer.   **Yes**
- L. Does the worker perform similar services for others? If "Yes," is the worker required to get approval from the policyholder?   **Yes/No**
- M. What type of advertising, if any, does the worker do (e.g., business listing in a directory, business cards, etc.)? Provide copies, if applicable.   **None**

**Signature**

I declare that I have examined this request, including accompanying documents, and to the best of my knowledge and belief, the facts presented are true, correct and complete. This form must be signed by the policyholder (i.e., Owner, Partner, Corporate Officer, Member/Manager) who has personal knowledge of the facts.

Signature **Ellen August**   Title **Owner**   Date **9/2/21**



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
12/28/2021

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.

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<b>PRODUCER</b> North Country Insurance Agency, Inc PO Box 518  Indian River MI 49749		<b>CONTACT NAME:</b> Terry Baxler <b>PHONE (A/C, No, Ext):</b> 231-238-9882 <b>E-MAIL ADDRESS:</b> Generalmail@northcountryins.com <b>FAX (A/C, No):</b> 231-238-4321													
<b>INSURED</b> Fullford Surveying & Mapping, PC. Brian Fullford P.O. Box 969 Indian River MI 49749		<b>INSURER(S) AFFORDING COVERAGE</b> <table border="1"><tr><td><b>INSURER A:</b> Property-Owners Insurance Company</td><td><b>NAIC #</b> 01063100</td></tr><tr><td><b>INSURER B:</b> Progressive Insurance Company</td><td>46271</td></tr><tr><td><b>INSURER C:</b> Auto-Owners Insurance Company</td><td>01063100</td></tr><tr><td><b>INSURER D:</b> Home-Owners Insurance Company</td><td>01063100</td></tr><tr><td><b>INSURER E:</b></td><td></td></tr><tr><td><b>INSURER F:</b></td><td></td></tr></table>		<b>INSURER A:</b> Property-Owners Insurance Company	<b>NAIC #</b> 01063100	<b>INSURER B:</b> Progressive Insurance Company	46271	<b>INSURER C:</b> Auto-Owners Insurance Company	01063100	<b>INSURER D:</b> Home-Owners Insurance Company	01063100	<b>INSURER E:</b>		<b>INSURER F:</b>	
<b>INSURER A:</b> Property-Owners Insurance Company	<b>NAIC #</b> 01063100														
<b>INSURER B:</b> Progressive Insurance Company	46271														
<b>INSURER C:</b> Auto-Owners Insurance Company	01063100														
<b>INSURER D:</b> Home-Owners Insurance Company	01063100														
<b>INSURER E:</b>															
<b>INSURER F:</b>															

## COVERAGES

CERTIFICATE NUMBER: 20211228170757751

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
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 checked="" type="checkbox"/> PROJECT <input type="checkbox"/> LOC  OTHER:			33023720	12/05/2021	12/05/2022	EACH OCCURRENCE \$ 2,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 300,000 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 \$
	<b>AUTOMOBILE LIABILITY</b> <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY			02797191-6	12/05/2021	12/05/2022	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 type="checkbox"/> EXCESS LIAB <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS-MADE  DED <input type="checkbox"/> RETENTION \$			49-023-420-01	12/05/2021	12/05/2022	EACH OCCURRENCE \$ 2,000,000 AGGREGATE \$ 2,000,000 \$
	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N		33037255	12/05/2021	12/05/2022	PER STATUTE <input type="checkbox"/> OTH-ER <input type="checkbox"/> E.L. EACH ACCIDENT \$ 500,000 E.L. DISEASE - EA EMPLOYEE \$ 500,000 E.L. DISEASE - POLICY LIMIT \$ 500,000

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

## CERTIFICATE HOLDER

For Informational Purposes Only

## 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

*Terry Baxler*

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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
03/15/2023

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.

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<b>PRODUCER</b> BKC Insurance Services 220 Water Street  Cheboygan MI 49721	<b>CONTACT NAME:</b> Rose Waite <b>PHONE (A/C, No, Ext):</b> (231) 627-4381 <b>FAX (A/C, No):</b> (231) 627-5171 <b>E-MAIL ADDRESS:</b> rwaite@bkcsinsurance.com
<b>INSURED</b> K & J Septic Service, LLC 2360 River Rd  Potoskey MI 49770	<b>INSURER(S) AFFORDING COVERAGE</b> <b>INSURER A:</b> Michigan Ins Co <b>INSURER B:</b> Atlantic States Ins Co <b>INSURER C:</b> <b>INSURER D:</b> <b>INSURER E:</b> <b>INSURER F:</b>

**COVERAGES** **CERTIFICATE NUMBER:** CL2182079906 **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
A	<input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b> <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:			CPJ9356718	09/01/2021	09/01/2022	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 \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000 \$
A	<b>AUTOMOBILE LIABILITY</b> <input checked="" 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			CCJ9356718	09/01/2021	09/01/2022	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
A	<input checked="" type="checkbox"/> <b>UMBRELLA LIAB</b> <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$			CXJ9356718	09/01/2021	09/01/2022	EACH OCCURRENCE \$ 5,000,000 AGGREGATE \$ 5,000,000 \$
B	<b>WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N Y	N/A	1000015062	09/01/2021	09/01/2022	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ 500,000 E.L. DISEASE - EA EMPLOYEE \$ 500,000 E.L. DISEASE - POLICY LIMIT \$ 500,000

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

<b>CERTIFICATE HOLDER</b>  Tuscarora Township 3545 S Straits Hwy  Indian River MI 49749	<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.  <b>AUTHORIZED REPRESENTATIVE</b>  Ron M Waite
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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

11/24/2021

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.

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<b>PRODUCER</b> Holmes Murphy Associates/CSDZ,LLC 225 South Sixth Street STE 1900 Minneapolis MN 55402	<b>CONTACT NAME:</b> Allie Darling <b>PHONE (A/C, No, Ext):</b> 612-322-6041 <b>FAX (A/C, No):</b> <b>E-MAIL ADDRESS:</b> adarling@csdz.com
<b>INSURED</b> Mead & Hunt, Inc. 2440 Deming Way Middleton, WI 53562	<b>INSURER(S) AFFORDING COVERAGE</b> <b>INSURER A:</b> Travelers Indemnity Company <b>INSURER B:</b> Charter Oak Fire Insurance Company <b>INSURER C:</b> Travelers Property Casualty Co. America <b>INSURER D:</b> XL Specialty Insurance <b>INSURER E:</b> <b>INSURER F:</b>

**COVERAGES****CERTIFICATE NUMBER:** 1794631004**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 SUBR INSD WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	<input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b> <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR <input checked="" type="checkbox"/> Cont Liab Per <input checked="" type="checkbox"/> Policy Form/XCU GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PRO-JECT <input checked="" type="checkbox"/> LOC OTHER:		6308S701301	12/1/2021	12/1/2022	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 300,000 MED EXP (Any one person) \$ 10,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMPI/OP AGG \$ 2,000,000 \$
B	<input checked="" type="checkbox"/> <b>AUTOMOBILE LIABILITY</b> <input checked="" type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY		8108S688704	12/1/2021	12/1/2022	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"/> <b>UMBRELLA LIAB</b> <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED <input checked="" type="checkbox"/> RETENTION \$ 0		CUP8S887858	12/1/2021	12/1/2022	EACH OCCURRENCE \$ 10,000,000 AGGREGATE \$ 10,000,000 \$
A C A	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N N	UB8696243 UB8S698039 UB8S699509	12/1/2021 12/1/2021 12/1/2021	12/1/2022 12/1/2022 12/1/2022	<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 D	Property Professional/Pollution Liability		6308S701301 DPR9984620	12/1/2021 10/25/2021	12/1/2022 10/25/2022	Bldg/BPP: \$12,825,012 Per Claim: \$5,000,000 Per Aggregate: \$10,000,000

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

**CERTIFICATE HOLDER****CANCELLATION**Tuscarora Township  
3546 South Straits Hwy  
Indian River MI 49749

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

Paula A. Dixon

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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

8/10/2022

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.

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PRODUCER		CONTACT NAME: Megan Reilly	
Wilson Insurance		PHONE (A/C, No, Ext): 2313474464	FAX (A/C, No): 2313481190
2073 US 31 N		E-MAIL ADDRESS: mreilly@wilsoninsurance.us	
Petoskey MI 49770		INSURER(S) AFFORDING COVERAGE	
INSURED		INSURER A: HASTINGS MUT INS CO	
MICHIGAN LAKE PRODUCTS INC		INSURER B:	
PO BOX 880		INSURER C:	
INDIAN RIVER MI 49749-0880		INSURER D:	
		INSURER E:	
		INSURER F:	

## COVERAGES

## CERTIFICATE NUMBER:

## REVISION NUMBER:

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INSR LTR	TYPE OF INSURANCE	ADDL INSD	WVD	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 checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:			CPP6093822	12/27/2021	12/27/2022	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 500,000 MED EXP (Any one person) \$ 5,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000
A	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY			ACV6093814	12/27/2021	12/27/2022	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ UMCSL \$ 1,000,000
A	<input checked="" type="checkbox"/> UMBRELLA LIAB <input type="checkbox"/> EXCESS LIAB DED RETENTION \$ <input type="checkbox"/> CLAIMS-MADE			ULC6093817	12/27/2021	12/27/2022	EACH OCCURRENCE \$ 1,000,000 AGGREGATE \$ 1,000,000
A	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 Y	N/A	6093816	12/27/2021	12/27/2022	<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)

## CERTIFICATE HOLDER

## 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

Phillip Goldsmith

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NORTTAN-01

FDEN1

## CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

3/14/2023

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PRODUCER  
General Agency Company  
525 E. Broadway  
Mount Pleasant, MI 48858

CONTACT NAME: Jennifer Robinson

PHONE (A/C, No, Ext): (989) 817-4265

FAX (A/C, No): (989) 772-1855

E-MAIL ADDRESS: jrobinson@ga-ins.com

INSURED  
  
Northern Tank Truck Service  
PO Box 8  
Waters, MI 49797

INSURER(S) AFFORDING COVERAGE

NAIC #

INSURER A : HDI Global Insurance Company

41343

INSURER B : Accident Fund Ins Co of America

10166

INSURER C : Kinsale Insurance Company

48920

INSURER D :

INSURER E :

INSURER F :

## COVERAGES

## CERTIFICATE NUMBER:

## REVISION NUMBER:

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INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	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 checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:			GG09C00017802	1/1/2021	1/1/2022	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000 MED EXP (Any one person) \$ 10,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000
A	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY			GA09C00044000	1/1/2021	1/1/2022	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
A	<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 \$ 10,000			GU09C00017802	1/1/2021	1/1/2022	EACH OCCURRENCE \$ 1,000,000 AGGREGATE \$ 1,000,000
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY 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	WCV6179703	1/1/2021	1/1/2022	<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
C	Commercial Umbrella			01001351710	1/1/2021	1/1/2022	Occurrence/Aggregate 3,000,000

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

## CERTIFICATE HOLDER

## CANCELLATION

Tuscarora Township  
3546 S Straits Highway  
PO Box 220  
Indian River, MI 49749

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AUTHORIZED REPRESENTATIVE



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

04/01/2021

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<b>PRODUCER</b>  <b>Loyalty Insurance Agency Inc.</b> <b>41575 Joy Road Ste 100</b> <b>Canton, MI 48187</b>	<b>CONTACT NAME:</b> Sandra Canedo
	<b>PHONE (A/C, No, Ext):</b> 734-454-5450 <b>FAX (A/C, No):</b> 734-454-5457
	<b>E-MAIL ADDRESS:</b> sandra@loyaltyinsurance.com
	<b>INSURER(S) AFFORDING COVERAGE</b>
	<b>INSURER A:</b> Secura Insurance Companies
	<b>INSURER B:</b> Secura Insurance Company
	<b>INSURER C:</b> Retailers Mutual Insurance Company
	<b>INSURER D:</b>
	<b>INSURER E:</b>
	<b>INSURER F:</b>

**COVERAGES**

CERTIFICATE NUMBER: 00019035-442525

REVISION NUMBER: 13


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.

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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 checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:			20-CP-3265743	04/01/2021	04/01/2022	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 300,000 MED EXP (Any one person) \$ 10,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COM/OP AGG \$ 2,000,000
B	<input type="checkbox"/> AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY			A3326601	04/01/2021	04/01/2022	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
	<input type="checkbox"/> UMBRELLA LIAB <input type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> DED <input type="checkbox"/> RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$
C	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 Y	N/A	WCP 0010818	04/05/2021	04/05/2022	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ 2,000,000 E.L. DISEASE - EA EMPLOYEE \$ 2,000,000 E.L. DISEASE - POLICY LIMIT \$ 2,000,000

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

Workers Comp: Marie Burfiend

**CERTIFICATE HOLDER****CANCELLATION**

<b>Ostlund Pest Control North Inc</b> <b>PO Box 700</b> <b>Indian River, MI 49749</b>	<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.</b>
	<b>AUTHORIZED REPRESENTATIVE</b>  (SCA)

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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

3/14/2023

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<b>PRODUCER</b> Peterson McGregor & Associates 1368 Business Park Dr Traverse City MI 49686	<b>CONTACT NAME:</b> Janet Douglas	
	<b>PHONE (A/C, No, Ext):</b> 231-944-7027	<b>FAX (A/C, No):</b> 231-922-7275
	<b>E-MAIL ADDRESS:</b> jdouglas@team-pma.com	
	<b>INSURER(S) AFFORDING COVERAGE</b>	<b>NAIC #</b>
	INSURER A : Hastings Mutual Insurance Co.	14176
<b>INSURED</b> Ramsby Drilling, Inc. 1865 S Straits Hwy Indian River MI 49749	RAMDR-1	
	INSURER B :	
	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

**COVERAGES**

CERTIFICATE NUMBER: 2083919976

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 CERTIFICATION 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
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 checked="" type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:			CPP9702127	1/1/2021	1/1/2022	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 \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000 \$
A	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" 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			ACV9700030	1/1/2021	1/1/2022	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
A	<input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> EXCESS LIAB <input type="checkbox"/> DED <input checked="" type="checkbox"/> RETENTION \$ 0			ULC9700032	1/1/2021	1/1/2022	EACH OCCURRENCE \$ 5,000,000 AGGREGATE \$ 5,000,000 \$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below		N/A	A0009700031	1/1/2021	1/1/2022	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ 500,000 E.L. DISEASE - EA EMPLOYEE \$ 500,000 E.L. DISEASE - POLICY LIMIT \$ 500,000

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

**CERTIFICATE HOLDER****CANCELLATION**Tuscarora Township  
PO Box 220  
Indian River MI 49749

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

© 1988-2015 ACORD CORPORATION. All rights reserved.



TEMPCON-08

MKINGMAN

## CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

3/14/2023

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 License # 0019304-1 Hub International Midwest East 1591 Galbraith Ave SE Grand Rapids, MI 49546	CONTACT NAME: Sarah Veld	
	PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL ADDRESS: sarah.veld@hubinternational.com	
INSURED  Temperature Control Inc. 1623 Northern Star Dr Traverse City, MI 49686	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : National Fire Insurance Company of Hartford	20478
	INSURER B : Continental Insurance Company of New Jersey	42625
	INSURER C : Valley Forge Insurance Company	20508
	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
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 checked="" type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:			6076462195	3/1/2021	3/1/2022	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000 MED EXP (Any one person) \$ 15,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000 EMPLOYEE BENEFIT \$ 1,000,000
A	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" 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			BUA 6076462181	3/1/2021	3/1/2022	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
B	<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 \$ 10,000			CUE6076462231	3/1/2021	3/1/2022	EACH OCCURRENCE \$ 7,000,000 AGGREGATE \$ 7,000,000 \$
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N If yes, describe under DESCRIPTION OF OPERATIONS below N		N/A	WC6 76462214	3/1/2021	3/1/2022	<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

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

## CERTIFICATE HOLDER

## CANCELLATION

Tuscarora Township 3546 S Straits Highway PO Box 220 Indian River, MI 49749	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 



ZIMM&amp;SO-01

KDOWNEY1

## CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
3/14/2023

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).

<b>PRODUCER</b> License # 0019304-1 Hub International Midwest East 1591 Galbraith Ave SE Grand Rapids, MI 49546	<b>CONTACT NAME:</b> Carrie Sizemore <b>PHONE (A/C, No, Ext):</b> (269) 441-5078 <b>FAX (A/C, No):</b> <b>E-MAIL ADDRESS:</b> Carrie.Sizemore@hubinternational.com																					
<b>INSURED</b> Zimmerman & Sons Electric LLC LSP Electric LLC P.O. Box 467 Port Austin, MI 48467-0467	<table border="1"><tr><th colspan="2">INSURER(S) AFFORDING COVERAGE</th><th>NAIC #</th></tr><tr><td>INSURER A:</td><td>AMCO Insurance Company</td><td>19100</td></tr><tr><td>INSURER B:</td><td>Accident Fund National Insurance Company</td><td>12305</td></tr><tr><td>INSURER C:</td><td>Allied Property and Casualty Insurance Company</td><td>42579</td></tr><tr><td>INSURER D:</td><td></td><td></td></tr><tr><td>INSURER E:</td><td></td><td></td></tr><tr><td>INSURER F:</td><td></td><td></td></tr></table>	INSURER(S) AFFORDING COVERAGE		NAIC #	INSURER A:	AMCO Insurance Company	19100	INSURER B:	Accident Fund National Insurance Company	12305	INSURER C:	Allied Property and Casualty Insurance Company	42579	INSURER D:			INSURER E:			INSURER F:		
INSURER(S) AFFORDING COVERAGE		NAIC #																				
INSURER A:	AMCO Insurance Company	19100																				
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INSURER D:																						
INSURER E:																						
INSURER F:																						

**COVERAGES** **CERTIFICATE NUMBER:** **REVISION NUMBER:**

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INSR LTR	TYPE OF INSURANCE	ADDL SUBR INSD WVD	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 checked="" type="checkbox"/> PRO-JECT <input checked="" type="checkbox"/> LOC OTHER:		ACP GLAO 3019788532	6/11/2021	6/11/2022	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 300,000 MED EXP (Any one person) \$ 10,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000
A	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" 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		ACP BAA 3019788532	6/11/2021	6/11/2022	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
A	<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		ACP CAA 3019788532	6/11/2021	6/11/2022	EACH OCCURRENCE \$ 3,000,000 AGGREGATE \$ 3,000,000
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY 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	WCV6216250	1/1/2022	1/1/2023	<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
C	Leased/Rented Equip		ACP CIMP 3019788532	6/11/2021	6/11/2022	\$500 Deductible 100,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)  
Blanket Additional Insured applies to General Liability, including completed operations, and Automobile Liability, on a primary and non-contributory basis, including Waiver of Subrogation, if required by written contract. Blanket Waiver of Subrogation applies to Workers Compensation, if required by written contract. Umbrella policy is a follow form policy over General Liability, Automobile Liability and Workers Compensation.

<b>CERTIFICATE HOLDER</b> Tuscarora Township 3546 S Straits Highway PO Box 220 Indian River, MI 49749	<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 
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# CERTIFICATE OF LIABILITY INSURANCE

1/1/2022

DATE (MM/DD/YYYY)  
12/14/2020

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.

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PRODUCER	LOCKTON COMPANIES 3657 BRIARPARK DRIVE, SUITE 700 HOUSTON TX 77042 866-260-3538	CONTACT NAME: PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL ADDRESS:
INSURED	WASTE MANAGEMENT HOLDINGS, INC. & ALL AFFILIATED 1300299 RELATED & SUBSIDIARY COMPANIES INCLUDING: WASTE MANAGEMENT OF NORTHERN MICHIGAN 2294 CASS ROAD TRAVERSE CITY MI 49685	INSURER(S) AFFORDING COVERAGE INSURER A: ACE American Insurance Company INSURER B: Indemnity Insurance Co of North America INSURER C: ACE Fire Underwriters Insurance Company INSURER D: ACE Property & Casualty Insurance Co INSURER E: INSURER F:

**COVERAGES**

CERTIFICATE NUMBER: 3491037

REVISION NUMBER: XXXXXXXX

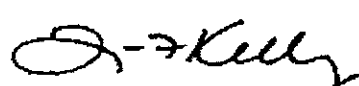
THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE 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
A	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR <input checked="" type="checkbox"/> XCU INCLUDED <input checked="" type="checkbox"/> ISO FORM CG00010413 GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PRO-JECT <input checked="" type="checkbox"/> LOC OTHER:	Y	Y	HDO G71572985	01/01/2021	01/01/2022	EACH OCCURRENCE \$ 5,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 5,000,000 MED EXP (Any one person) \$ XXXXXXXX PERSONAL & ADV INJURY \$ 5,000,000 GENERAL AGGREGATE \$ 6,000,000 PRODUCTS - COMP/OP AGG \$
A	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO <input checked="" type="checkbox"/> OWNED AUTOS ONLY <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> MCS-90 <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY	Y	Y	MMT H25308645	01/01/2021	01/01/2022	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ XXXXXXXX BODILY INJURY (Per accident) \$ XXXXXXXX PROPERTY DAMAGE (Per accident) \$ XXXXXXXX
D	<input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> EXCESS LIAB DED RETENTION \$	Y	Y	XOOG27929242 006	01/01/2021	01/01/2022	EACH OCCURRENCE \$ 15,000,000 AGGREGATE \$ 15,000,000
B A C	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 N	N/A	WLR C6781180A (AOS) WLR C67811768 (AZ, CA & MA) SCF C67811847 (WI)	01/01/2021 01/01/2021 01/01/2021	01/01/2022 01/01/2022 01/01/2022	<input checked="" type="checkbox"/> PER STATUTE E.L. EACH ACCIDENT \$ 3,000,000 E.L. DISEASE - EA EMPLOYEE \$ 3,000,000 E.L. DISEASE - POLICY LIMIT \$ 3,000,000
A	EXCESS AUTO LIABILITY	Y	Y	XSA H25308608	01/01/2021	01/01/2022	COMBINED SINGLE LIMIT \$9,000,000 (EACH ACCIDENT)

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

BLANKET WAIVER OF SUBROGATION IS GRANTED IN FAVOR OF CERTIFICATE HOLDER ON ALL POLICIES WHERE AND TO THE EXTENT REQUIRED BY WRITTEN CONTRACT WHERE PERMISSIBLE BY LAW. CERTIFICATE HOLDER IS NAMED AS AN ADDITIONAL INSURED (EXCEPT FOR WORKERS' COMP/EL) WHERE AND TO THE EXTENT REQUIRED BY WRITTEN CONTRACT.

**CERTIFICATE HOLDER****CANCELLATION**

3491037 TUSCARORA TOWNSHIP PO BOX 220 INDIAN RIVER MI 49749	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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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
03/14/2023

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.

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<b>PRODUCER</b> TCA Insurance 1118 W Lake St Tawas City, MI 48763	<b>CONTACT NAME:</b>	
	<b>PHONE (A/C No, Ext):</b>	<b>FAX (A/C, No):</b>
<b>INSURED</b> Bunker Services LLC 7859 White Road Indian River, MI 49749	<b>E-MAIL ADDRESS:</b>	
	<b>INSURER(S) AFFORDING COVERAGE</b>	
	<b>INSURER A:</b> Pioneer State Mutual	
	<b>INSURER B:</b> Accident Fund	
	<b>INSURER C:</b>	
	<b>INSURER D:</b>	
<b>INSURER E:</b>		
<b>INSURER F:</b>		

**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
A	<input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b> <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:			CB00000995	07/01/2020	07/01/2021	EACH OCCURRENCE \$ 2,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ 5,000 PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ 4,000,000 PRODUCTS - COMP/OP AGG \$ 4,000,000
A	<b>AUTOMOBILE LIABILITY</b> ANY AUTO OWNED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS HIRED AUTOS ONLY <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY  <b>UMBRELLA LIAB</b> <input type="checkbox"/> OCCUR <b>EXCESS LIAB</b> <input type="checkbox"/> CLAIMS-MADE DED <input type="checkbox"/> RETENTION \$			CA00302812	07/01/2020	07/01/2021	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ EACH OCCURRENCE \$ AGGREGATE \$
B	<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	WCV6189732	06/01/2020	06/01/2021	<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>  Tuscarora Township 3546 S Straits Hwy Indian River, MI 49749	<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
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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
03/15/2023

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.

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<b>PRODUCER</b> Larkin Group of Traverse City 13900 S West Bay Shore Drive  Traverse City MI 49684		<b>CONTACT NAME:</b> Beth McCardel <b>PHONE (A/C, No, Ext):</b> (231) 947-8800 <b>FAX (A/C, No):</b> (231) 346-6111 <b>E-MAIL ADDRESS:</b> bmccardel@larkingrp.com	
<b>INSURED</b> DROST LANDSCAPE, INC. PO BOX 696 2010 CEDAR VALLEY ROAD PETOSKEY MI 49770-0696		<b>INSURER(S) AFFORDING COVERAGE</b> <b>INSURER A:</b> Selective Insurance Co of America <b>INSURER B:</b> Accident Fund Natl. Ins. Co. <b>INSURER C:</b> <b>INSURER D:</b> <b>INSURER E:</b> <b>INSURER F:</b>	
		<b>NAIC #</b> 12305	

## COVERAGES

CERTIFICATE NUMBER: 2020/21 Master

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
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 checked="" type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:			S 2417572	02/24/2020	02/24/2021	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 500,000 MED EXP (Any one person) \$ 15,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000
	<input type="checkbox"/> AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY			S 2417572	02/24/2020	02/24/2021	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 \$			S 2417572	02/24/2020	02/24/2021	EACH OCCURRENCE \$ 5,000,000 AGGREGATE \$ 5,000,000
	<input checked="" type="checkbox"/> 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 checked="" type="checkbox"/> N	N/A	WCV6125268	03/28/2020	03/28/2021	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTHER E.L. EACH ACCIDENT \$ 500,000 E.L. DISEASE - EA EMPLOYEE \$ 500,000 E.L. DISEASE - POLICY LIMIT \$ 500,000

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

## CERTIFICATE HOLDER

## CANCELLATION

Tuscarora Township	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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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

12/10/2020

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).

<b>PRODUCER</b> North Country Insurance Agency, Inc PO Box 518  Indian River MI 49749		<b>CONTACT NAME:</b> Terry Baxter <b>PHONE (A/C, No, Ext):</b> 231-238-9882 <b>E-MAIL ADDRESS:</b> Generalmail@northcountryins.com <b>FAX (A/C, No):</b> 231-238-4321															
<b>INSURED</b> Fullford Surveying & Mapping, PC. P.O. Box 969 Indian River MI 49749		<b>INSURER(S) AFFORDING COVERAGE</b> <table border="1"><thead><tr><th>INSURER</th><th>NAIC #</th></tr></thead><tbody><tr><td>INSURER A: Property-Owners Insurance Company</td><td>01063100</td></tr><tr><td>INSURER B: Progressive Insurance Company</td><td>46271</td></tr><tr><td>INSURER C: Auto-Owners Insurance Company</td><td>01063100</td></tr><tr><td>INSURER D: Home-Owners Insurance Company</td><td>01063100</td></tr><tr><td>INSURER E:</td><td></td></tr><tr><td>INSURER F:</td><td></td></tr></tbody></table>		INSURER	NAIC #	INSURER A: Property-Owners Insurance Company	01063100	INSURER B: Progressive Insurance Company	46271	INSURER C: Auto-Owners Insurance Company	01063100	INSURER D: Home-Owners Insurance Company	01063100	INSURER E:		INSURER F:	
INSURER	NAIC #																
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INSURER C: Auto-Owners Insurance Company	01063100																
INSURER D: Home-Owners Insurance Company	01063100																
INSURER E:																	
INSURER F:																	

**COVERAGES****CERTIFICATE NUMBER:****REVISION NUMBER:**

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INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS														
A	<input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b> <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR  GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:			33023720	12/05/2020	12/05/2021	<table border="1"><tr><td>EACH OCCURRENCE</td><td>\$ 2,000,000</td></tr><tr><td>DAMAGE TO RENTED PREMISES (Ea occurrence)</td><td>\$ 300,000</td></tr><tr><td>MED EXP (Any one person)</td><td>\$ 10,000</td></tr><tr><td>PERSONAL &amp; ADV INJURY</td><td>\$ 2,000,000</td></tr><tr><td>GENERAL AGGREGATE</td><td>\$ 2,000,000</td></tr><tr><td>PRODUCTS - COM/OP AGG</td><td>\$ 2,000,000</td></tr><tr><td></td><td>\$</td></tr></table>	EACH OCCURRENCE	\$ 2,000,000	DAMAGE TO RENTED PREMISES (Ea occurrence)	\$ 300,000	MED EXP (Any one person)	\$ 10,000	PERSONAL & ADV INJURY	\$ 2,000,000	GENERAL AGGREGATE	\$ 2,000,000	PRODUCTS - COM/OP AGG	\$ 2,000,000		\$
EACH OCCURRENCE	\$ 2,000,000																				
DAMAGE TO RENTED PREMISES (Ea occurrence)	\$ 300,000																				
MED EXP (Any one person)	\$ 10,000																				
PERSONAL & ADV INJURY	\$ 2,000,000																				
GENERAL AGGREGATE	\$ 2,000,000																				
PRODUCTS - COM/OP AGG	\$ 2,000,000																				
	\$																				
B	<b>AUTOMOBILE LIABILITY</b> <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> NON-OWNED AUTOS ONLY			02797191-4	12/05/2020	12/05/2021	<table border="1"><tr><td>COMBINED SINGLE LIMIT (Ea accident)</td><td>\$ 1,000,000</td></tr><tr><td>BODILY INJURY (Per person)</td><td>\$ /</td></tr><tr><td>BODILY INJURY (Per accident)</td><td>\$</td></tr><tr><td>PROPERTY DAMAGE (Per accident)</td><td>\$</td></tr><tr><td></td><td>\$</td></tr></table>	COMBINED SINGLE LIMIT (Ea accident)	\$ 1,000,000	BODILY INJURY (Per person)	\$ /	BODILY INJURY (Per accident)	\$	PROPERTY DAMAGE (Per accident)	\$		\$				
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"/> <b>UMBRELLA LIAB</b> <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> DED <input type="checkbox"/> RETENTION \$			49-023-420-01	12/05/2020	12/05/2021	<table border="1"><tr><td>EACH OCCURRENCE</td><td>\$ 2,000,000</td></tr><tr><td>AGGREGATE</td><td>\$ 2,000,000</td></tr><tr><td></td><td>\$</td></tr></table>	EACH OCCURRENCE	\$ 2,000,000	AGGREGATE	\$ 2,000,000		\$								
EACH OCCURRENCE	\$ 2,000,000																				
AGGREGATE	\$ 2,000,000																				
	\$																				
D	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N	N/A	33037255	12/05/2020	12/05/2021	<table border="1"><tr><td>PER STATUTE</td><td>OTH-ER</td></tr><tr><td>E.L. EACH ACCIDENT</td><td>\$ 500,000</td></tr><tr><td>E.L. DISEASE - EA EMPLOYEE</td><td>\$ 500,000</td></tr><tr><td>E.L. DISEASE - POLICY LIMIT</td><td>\$ 500,000</td></tr></table>	PER STATUTE	OTH-ER	E.L. EACH ACCIDENT	\$ 500,000	E.L. DISEASE - EA EMPLOYEE	\$ 500,000	E.L. DISEASE - POLICY LIMIT	\$ 500,000						
PER STATUTE	OTH-ER																				
E.L. EACH ACCIDENT	\$ 500,000																				
E.L. DISEASE - EA EMPLOYEE	\$ 500,000																				
E.L. DISEASE - POLICY LIMIT	\$ 500,000																				

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

**CERTIFICATE HOLDER****CANCELLATION**

For Informational Purposes Only

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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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
8/30/2021

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.

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<b>PRODUCER</b> Holmes Murphy Associates/CSDZ, LLC 225 South Sixth Street STE 1900 Minneapolis MN 55402	<b>CONTACT NAME:</b> Allie Darling	
	<b>PHONE (A/C, No, Ext):</b> 612-322-6041 <b>FAX (A/C, No):</b>	
	<b>E-MAIL:</b> adarling@csdz.com	
	<b>ADDRESS:</b>	
	<b>INSURER(S) AFFORDING COVERAGE</b>	<b>NAIC #</b>
	INSURER A : Travelers Indemnity Company	25658
	INSURER B : Charter Oak Fire Insurance Company	25615
	INSURER C : Travelers Property Casualty Co. America	25674
	INSURER D : XL Specialty Insurance	37885
	INSURER E :	
	INSURER F :	

**COVERAGES** **CERTIFICATE NUMBER:** 511274809 **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
A	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR <input checked="" type="checkbox"/> Cont Liab Per <input checked="" type="checkbox"/> Policy Form/XCU GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PROJECT <input checked="" type="checkbox"/> LOC OTHER:			P6305C656013TIA20	12/1/2020	12/1/2021	EACH OCCURRENCE \$1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$300,000 MED EXP (Any one person) \$10,000 PERSONAL & ADV INJURY \$1,000,000 GENERAL AGGREGATE \$2,000,000 PRODUCTS - COMP/OP AGG \$2,000,000 \$
B	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" 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			8101L2755752043G	12/1/2020	12/1/2021	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 DED <input checked="" type="checkbox"/> RETENTION \$0			CUP0K3011012043	12/1/2020	12/1/2021	EACH OCCURRENCE \$9,000,000 AGGREGATE \$9,000,000 \$
C A A	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 N	N/A	B8J3002332043G UB8J2154322043E UB8J3173932043V	12/1/2020 12/1/2020 12/1/2020	12/1/2021 12/1/2021 12/1/2021	<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 D	Property Professional/Pollution Liability			P6305C656013TIA20 DPR9967599	12/1/2020 10/25/2020	12/1/2021 10/25/2021	Bldg/BPP: \$12,825,012 Per Claim: \$5,000,000 Per Aggregate: \$10,000,000

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

## CERTIFICATE HOLDER

## CANCELLATION

Tuscarora Township 3546 South Straits Highway Indian River MI 49749	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>Paula A. Dixon</i>

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MEAD&amp;HU-01

MHORSFALL

## CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
11/9/2020

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.

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<b>PRODUCER</b> Hausmann-Johnson Insurance, Inc. 740 Regent Street 4th Floor PO Box 259408 Madison, WI 53725-9408	<b>CONTACT NAME:</b> Melissa Horsfall	
	<b>PHONE (A/C, No, Ext):</b> (608) 252-9617 <b>FAX (A/C, No):</b>	
	<b>E-MAIL ADDRESS:</b> melissa.horsfall@hausmann-johnson.com	
<b>INSURED</b>  Mead & Hunt, Inc. 2440 Deming Way Middleton, WI 53562-1562	<b>INSURER(S) AFFORDING COVERAGE</b>	<b>NAIC #</b>
	<b>INSURER A:</b> The Travelers Indemnity Company of Connecticut	25682
	<b>INSURER B:</b> Charter Oak Fire Insurance Co	25615
	<b>INSURER C:</b> Travelers Property Casualty Company of America	25674
	<b>INSURER D:</b>	
	<b>INSURER E:</b>	
	<b>INSURER F:</b>	

## 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
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 checked="" type="checkbox"/> PRO-JECT <input checked="" type="checkbox"/> LOC <input type="checkbox"/> OTHER:			6305C656013	12/1/2020	12/1/2021	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 300,000 MED EXP (Any one person) \$ 10,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000
B	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY			8101L275575	12/1/2020	12/1/2021	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 checked="" type="checkbox"/> DED <input checked="" type="checkbox"/> RETENTION \$ 0			CUP0K301101	12/1/2020	12/1/2021	EACH OCCURRENCE \$ 9,000,000 AGGREGATE \$ 9,000,000
A	<input checked="" type="checkbox"/> 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 N	N/A	UB8J2154321943E -OTH STAT	12/1/2020	12/1/2021	<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

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

## CERTIFICATE HOLDER

## CANCELLATION

Tuscarora Township  
3546 South Straits Hwy  
Indian River, MI 49749

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



NORTTAN-01

FDENI

## CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

3/14/2023

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.

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PRODUCER General Agency Company 525 E. Broadway Mount Pleasant, MI 48858	CONTACT NAME: Jennifer Robinson	
	PHONE (A/C, No, Ext): (989) 817-4265	FAX (A/C, No): (989) 772-1855
INSURED  Northern Tank Truck Service PO Box 8 Waters, MI 49797	E-MAIL ADDRESS: jrobinson@ga-ins.com	
	INSURER(S) AFFORDING COVERAGE	
	INSURER A: HDI Global Insurance Company	NAIC #: 41343
	INSURER B: Accident Fund Ins Co of America	10166
	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
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 checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:			GG09C00017801	1/1/2020	1/1/2021	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000 MED EXP (Any one person) \$ 10,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COM/OP AGG \$ 2,000,000
A	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" 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			GA09C00017801	1/1/2020	1/1/2021	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
A	<input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR EXCESS LIAB CLAIMS-MADE DED <input checked="" type="checkbox"/> RETENTION \$ 10,000			GU09C00017801	1/1/2020	1/1/2021	EACH OCCURRENCE \$ 1,000,000 AGGREGATE \$ 1,000,000
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY 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	WCV6179703	1/1/2020	1/1/2021	<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

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

## CERTIFICATE HOLDER

## CANCELLATION

Tuscarora Township  
3546 S Straits Highway  
PO Box 220  
Indian River, MI 49749

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



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

03/30/2020

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).

<b>PRODUCER</b>  Loyalty Insurance Agency Inc. 41575 Joy Road Ste 100 Canton, MI 48187	<b>CONTACT NAME:</b> Sandra Canedo	<b>FAX (A/C, No):</b> 734-454-5457	
	<b>PHONE (A/C, No, Ext):</b> 734-454-5450	<b>E-MAIL ADDRESS:</b> sandra@loyaltyinsurance.com	
<b>INSURED</b>  Ostlund Pest Control North Inc PO Box 700 Indian River, MI 49749	<b>INSURER(S) AFFORDING COVERAGE</b>		<b>NAIC #</b>
	<b>INSURER A:</b> Secura Insurance Companies		
	<b>INSURER B:</b> Secura Insurance Company		22543
	<b>INSURER C:</b> Retailers Mutual Insurance Company		
	<b>INSURER D:</b>		
	<b>INSURER E:</b>		
<b>INSURER F:</b>			

**COVERAGES****CERTIFICATE NUMBER:** 00019035-290644**REVISION NUMBER:** 12

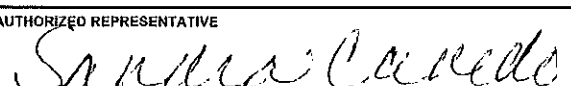
THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE 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
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 checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:			20-CP-3265743	04/01/2020	04/01/2021	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 300,000 MED EXP (Any one person) \$ 10,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000
B	<input type="checkbox"/> AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY			A3265744	04/01/2020	04/01/2021	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ EACH OCCURRENCE \$ AGGREGATE \$
	<input type="checkbox"/> UMBRELLA LIAB <input type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED <input type="checkbox"/> RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$
C	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 Y	N/A	WCP 0010818	04/05/2020	04/05/2021	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ 2,000,000 E.L. DISEASE - EA EMPLOYEE \$ 2,000,000 E.L. DISEASE - POLICY LIMIT \$ 2,000,000

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

Workers Comp: Marie Burfiend

**CERTIFICATE HOLDER****CANCELLATION**

Ostlund Pest Control North Inc PO Box 700 Indian River, MI 49749	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  (SCA)

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TEMPCON-08

JRITSEMA

## CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
2/20/2020

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).

<b>PRODUCER</b> License # 0019304-1 Hub International Midwest East 1591 Galbraith Ave SE Grand Rapids, MI 49546	<b>CONTACT NAME:</b> PHONE (A/C, No, Ext): (616) 233-4111 FAX (A/C, No): (616) 233-4110 E-MAIL ADDRESS:  <b>INSURER(S) AFFORDING COVERAGE</b> <b>INSURER A : National Fire Insurance Company of Hartford 20478</b> <b>INSURER B : Continental Insurance Company of New Jersey 42625</b> <b>INSURER C : Valley Forge Insurance Company 20508</b> <b>INSURER D :</b> <b>INSURER E :</b> <b>INSURER F :</b>
<b>INSURED</b>  Temperature Control Inc. 1623 Northern Star Dr Traverse City, MI 49686	<b>NAIC #</b>

## 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
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 checked="" type="checkbox"/> PROJECT <input type="checkbox"/> LOC OTHER:			6076462195	3/1/2020	3/1/2021	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 500,000 MED EXP (Any one person) \$ 15,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000 EMPLOYEE BENEFIT \$ 1,000,000
A	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY			BUA 6076462181	3/1/2020	3/1/2021	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
B	<input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR EXCESS LIAB CLAIMS-MADE DED <input checked="" type="checkbox"/> RETENTION \$ 10,000			CUE6076462231	3/1/2020	3/1/2021	EACH OCCURRENCE \$ 4,000,000 AGGREGATE \$ 4,000,000 \$
C	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	N/A	WC6 76462214	3/1/2020	3/1/2021	<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)

## CERTIFICATE HOLDER

## CANCELLATION

Tuscarora Township  
3546 S Stralts Highway  
PO Box 220  
Indian River, MI 49749

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



ZIMM&amp;SO-01

KDOWNEY1

## CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

3/14/2023

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.

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<b>PRODUCER</b> License # 0019304-1 Hub International Midwest East 1591 Galbraith Ave SE Grand Rapids, MI 49546	<b>CONTACT</b> Carrie Sizemore	
	<b>PHONE</b> (A/C, No, Ext): (269) 441-5078 <b>FAX</b> (A/C, No):	
	<b>E-MAIL ADDRESS:</b> Carrie.Sizemore@hubinternational.com	
<b>INSURED</b>  Zimmerman & Sons Electric LLC P.O. Box 467 Port Austin, MI 48467-0467	<b>INSURER(S) AFFORDING COVERAGE</b>	<b>NAIC #</b>
	<b>INSURER A:</b> AMCO Insurance Company	19100
	<b>INSURER B:</b> Accident Fund National Insurance Company	12305
	<b>INSURER C:</b> Depositors Insurance Company	42587
	<b>INSURER D:</b>	
	<b>INSURER E:</b>	
	<b>INSURER F:</b>	

## 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
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 checked="" type="checkbox"/> PRO-JECT <input checked="" type="checkbox"/> LOC OTHER:			ACPLAO3009788532	6/11/2020	6/11/2021	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 \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000
A	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY			ACPBAA3009788532	6/11/2020	6/11/2021	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
A	<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			ACPCAA3009788532	6/11/2020	6/11/2021	EACH OCCURRENCE \$ 3,000,000 AGGREGATE \$ 3,000,000
B	<input checked="" type="checkbox"/> 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	N/A	WCV6216250	1/1/2021	1/1/2022	<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
C	Leased/Rented Equip			ACPCIMP3009788532	6/11/2020	6/11/2021	\$500 Deductible 100,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)  
Revised 12/29/20 - to reflect Workers Compensation coverage effective 1/1/2021

Blanket Additional Insured applies to General Liability, including completed operations, and Automobile Liability, on a primary and non-contributory basis, including Waiver of Subrogation, if required by written contract. Umbrella policy is a follow form policy over General Liability, Automobile Liability and Workers Compensation.

## CERTIFICATE HOLDER

## CANCELLATION

<b>Tuscarora Township</b> 3546 S Straits Highway PO Box 220 Indian River, MI 49749	<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.</b>  <b>AUTHORIZED REPRESENTATIVE</b> 
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CUSTO-1

OP ID: RW

## CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

02/05/2019

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.

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<b>PRODUCER</b> BKC Insurance Services P.O. Box 326, 220 Water Street Cheboygan, MI 49721-0326 Rose Waite		231-627-4381	<b>CONTACT NAME:</b> Rose Waite <b>PHONE (A/C, No, Ext):</b> 231-627-4381 <b>FAX (A/C, No):</b> <b>E-MAIL ADDRESS:</b> rwaite@bkcinurance.com	
<b>INSURED</b> Custom Carpets & Furniture of Indian River Custom Carpets, Inc. dba P.O. Box 543, 5959 S. Straits Indian River, MI 49749		<b>INSURER(S) AFFORDING COVERAGE</b>		<b>NAIC #</b>
		<b>INSURER A:</b> Fremont Insurance Co.		13994
		<b>INSURER B:</b>		
		<b>INSURER C:</b>		
		<b>INSURER D:</b>		
		<b>INSURER E:</b>		
<b>INSURER F:</b>				

## 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
A	COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR <input checked="" type="checkbox"/> Business Owners GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:			B 0019735	02/07/2019	02/07/2020	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 \$ 2,000,000 PRODUCTS - COM/OP AGG \$ 2,000,000
A	AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY			CAP 0015353	09/01/2018	09/01/2019	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
A	<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 \$ 10,000			U 0017161	05/08/2018	05/08/2019	EACH OCCURRENCE \$ 2,000,000 AGGREGATE \$ 2,000,000
A	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	N/A	WCP 0004991	02/07/2019	02/07/2020	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ 500,000 E.L. DISEASE - EA EMPLOYEE \$ 500,000 E.L. DISEASE - POLICY LIMIT \$ 500,000

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

## CERTIFICATE HOLDER

## CANCELLATION

INDIA-9  Indian River Area Library 3546 S. Straits Hwy. Indian River, MI 49749	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 Rose Waite
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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
12/20/2019

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.

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PRODUCER	North Country Insurance Agency, Inc PO Box 518 Indian River MI 49749	CONTACT NAME: Terry Baxter		
		PHONE (A/C, No, Ext): 231-238-9882	FAX (A/C, No): 231-238-4321	
		E-MAIL ADDRESS: Generalmail@northcountryins.com		
INSURED	Fullford Surveying & Mapping, PC. Brian Fullford P.O. Box 969 Indian River MI 49749	INSURER(S) AFFORDING COVERAGE		NAIC #
		INSURER A: Property-Owners Insurance Company		01063100
		INSURER B: Progressive Insurance Company		46271
		INSURER C: Auto-Owners Insurance Company		01063100
		INSURER D: Home-Owners Insurance Company		01063100
		INSURER E:		
INSURER F:				

## COVERAGES

CERTIFICATE NUMBER:

REVISION NUMBER:

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INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	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			33023720	12/05/2019	12/05/2020	EACH OCCURRENCE \$ 2,000,000
			DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 300,000				
			MED EXP (Any one person) \$ 10,000				
			PERSONAL & ADV INJURY \$ 2,000,000				
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE \$ 2,000,000
	<input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC						PRODUCTS - COMP/OP AGG \$ 2,000,000
	OTHER:						\$
B	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> HIRED AUTOS ONLY			02797191-4	12/05/2019	12/05/2020	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000
			<input checked="" type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> NON-OWNED AUTOS ONLY				BODILY INJURY (Per person) \$
							BODILY INJURY (Per accident) \$
							PROPERTY DAMAGE (Per accident) \$
C	<input checked="" type="checkbox"/> UMBRELLA LIAB <input type="checkbox"/> EXCESS LIAB			49-023-420-01	12/05/2019	12/05/2020	EACH OCCURRENCE \$ 2,000,000
			<input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS-MADE				AGGREGATE \$ 2,000,000
	<input type="checkbox"/> DED	<input type="checkbox"/> RETENTION \$					\$
D	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	<input type="checkbox"/> Y <input type="checkbox"/> N	N/A	33037255	12/05/2019	12/05/2020	PER STATUTE <input type="checkbox"/> OTH-ER <input type="checkbox"/>
			E.L. EACH ACCIDENT \$ 500,000				
			E.L. DISEASE - EA EMPLOYEE \$ 500,000				
			E.L. DISEASE - POLICY LIMIT \$ 500,000				

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

## CERTIFICATE HOLDER

## CANCELLATION

For Informational Purposes Only

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

© 1988-2015 ACORD CORPORATION. All rights reserved.

**SOLE PROPRIETOR FORM**  
**For Sole Proprietors with No Employees**

For workers' compensation purposes, we are required to maintain verification regarding workers' compensation coverage for all of our independent contractors.

You must provide the following information if you:

- a) Are a sole proprietor with no employees, and
- b) Do not carry workers' compensation insurance.

1) Name of Sole Proprietor: JAMES HILL  
2) Federal Tax Identification Number or last 4 digits of Social Security No. 6562  
3) I am doing business as: PAINTER

Please attach one of the following:

- A copy of the assumed name certificate you filed with the county; or
- Your business card; or
- A copy of your advertisement (Yellow Pages, Newspaper, etc.); or
- List one other business or private homeowner that you have worked for during the period of July 1, through current date, including the name and address: \_\_\_\_\_

JEFF HAMAL  
7969 STURGEON VALLEY DR.  
INDIAN RIVER, 49749

Please complete the following statement:

I, JAMES HILL, a Sole Proprietor with no employees will provide PAINTING SERVICES services to INDIAN RIVER AREA LIBRARY on a periodic basis. I do understand that I am not entitled to workers' compensation benefits under Michigan's Law, therefore, I am personally responsible for any injuries/illnesses I may sustain while performing my services to said entity.

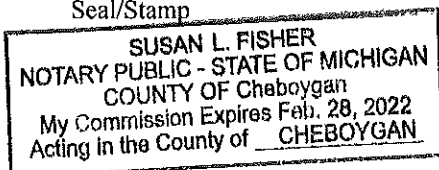
Dated at: 12/19/18, on this 19TH day of DECEMBER, 2018

Signed: James Hill  
Sole Proprietor

Notary Public, STATE OF MICHIGAN, COUNTY OF Cheboygan

On this 19th day of December, 2018 before me personally appeared James Hill, who being duly sworn did state that s/he is not entitled to workers' compensation benefits as indicated under Michigan's Law, and will not hold responsible the above named entity s/he may provide services to for any injury(ies) illness(es) s/he may sustain while performing such indicated services.

Seal/Stamp



[Signature]  
Notary Public,  
Acting in the County Of: Cheboygan  
County My Commission expires: 2022



# CERTIFICATE OF LIABILITY INSURANCE

K&amp;JSE-1

OP ID: SO

DATE (MM/DD/YYYY)

09/02/2020

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).

<b>PRODUCER</b> Madigan/Pingatore Ins Services 105 W. Water Street Sault Ste. Marie, MI 49783 Sonja J Reinhart	<b>CONTACT NAME:</b> Sonja J Reinhart <b>PHONE (A/C No, Ext):</b> 906-635-5233 <b>FAX (A/C, No):</b> 906-632-1612 <b>E-MAIL ADDRESS:</b>  <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 80%;">INSURER(S) AFFORDING COVERAGE</th> <th style="width: 20%;">NAIC #</th> </tr> <tr> <td>INSURER A : EMC Insurance Companies</td> <td>21415</td> </tr> <tr> <td>INSURER B : Accident Fund Company</td> <td>10166</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 : EMC Insurance Companies	21415	INSURER B : Accident Fund Company	10166	INSURER C :		INSURER D :		INSURER E :		INSURER F :	
INSURER(S) AFFORDING COVERAGE	NAIC #														
INSURER A : EMC Insurance Companies	21415														
INSURER B : Accident Fund Company	10166														
INSURER C :															
INSURER D :															
INSURER E :															
INSURER F :															
<b>INSURED</b> K & J Septic Service, LLC 2360 River Rd Petoskey, MI 49770															

<b>COVERAGES</b>	<b>CERTIFICATE NUMBER:</b>	<b>REVISION NUMBER:</b>
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
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:			6D10365	09/01/2019	09/01/2020	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 \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000
A	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			6E10365	09/01/2019	09/01/2020	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
A	<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			6J10365	09/01/2019	09/01/2020	EACH OCCURRENCE \$ 1,000,000 AGGREGATE \$ 1,000,000
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	N/A	WCV6195543	09/01/2019	09/01/2020	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTHER E.L. EACH ACCIDENT \$ 500,000 E.L. DISEASE - EA EMPLOYEE \$ 500,000 E.L. DISEASE - POLICY LIMIT \$ 500,000

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

<b>CERTIFICATE HOLDER</b>  Tuscarora Township	<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 Sonja J Reinhart
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MEADHU1

OP ID: MRH

## CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

11/21/2019

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.

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<b>PRODUCER</b> Hausmann-Johnson Insurance Inc 700 Regent St., PO Box 259408 Madison, WI 53725-9408 Phil Hausmann		<b>608-257-3795</b>		<b>CONTACT NAME:</b> Phil Hausmann, CIC	
				<b>PHONE (A/C, No, Ext):</b> 608-257-3795	<b>FAX (A/C, No):</b> 608-257-4324
				<b>E-MAIL ADDRESS:</b>	
				<b>INSURER(S) AFFORDING COVERAGE</b>	
				<b>INSURER A:</b> Travelers Casualty & Surety	
				<b>INSURER B:</b> Cincinnati Insurance Company	
				<b>INSURER C:</b>	
				<b>INSURER D:</b>	
				<b>INSURER E:</b>	
				<b>INSURER F:</b>	
<b>INSURED</b> Mead & Hunt, Inc. M&H Architecture, Inc. Mead & Hunt Companies, Inc. Mead & Hunt International, Inc 2440 Deming Way Middleton, WI 53562-1562				<b>NAIC #</b> 19038 10677	

## 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
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 checked="" type="checkbox"/> PRO-JECT <input checked="" type="checkbox"/> LOC OTHER:			6305C656013	12/01/2019	12/01/2020	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 300,000 MED EXP (Any one person) \$ 10,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000
A	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY			8101L275575	12/01/2019	12/01/2020	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
A	<input checked="" type="checkbox"/> UMBRELLA LIAB <input type="checkbox"/> EXCESS LIAB <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS-MADE DED <input checked="" type="checkbox"/> RETENTION \$ 0			CUP0K301101	12/01/2019	12/01/2020	EACH OCCURRENCE \$ 9,000,000 AGGREGATE \$ 9,000,000
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) <input checked="" type="checkbox"/> Y/N If yes, describe under DESCRIPTION OF OPERATIONS below		N/A	UB8J317393 - WI UB8J215432 - OTH STATE	12/01/2019 12/01/2019	12/01/2020 12/01/2020	<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

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

## CERTIFICATE HOLDER

TUSCARO

Tuscarora Township  
3546 South Straits Hwy  
Indian River, MI 49749

## 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



TEMPCON-08

MANDERSON3

## CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

02/28/2019

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.

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PRODUCER License # 0019304-1  
Hub International Midwest East  
625 Kenmoor Avenue SE, Suite 200  
Grand Rapids, MI 49546

CONTACT NAME:  
PHONE (A/C, No, Ext): (616) 233-4111 FAX (A/C, No): (616) 233-4110  
E-MAIL ADDRESS:

INSURED  
  
Temperature Control Inc.  
1623 Northern Star Dr  
Traverse City, MI 49686

INSURER(S) AFFORDING COVERAGE		NAIC #
INSURER A : National Fire Insurance of Hartford		20478
INSURER B : Continental Insurance Company of New Jersey		42625
INSURER C : Valley Forge Insurance Company		20508
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 SUBR INSD WVD	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 checked="" type="checkbox"/> PROJECT <input type="checkbox"/> LOC OTHER:		6076462195	03/01/2019	03/01/2020	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 500,000 MED EXP (Any one person) \$ 15,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000 EMPLOYEE BENEFIT \$ 1,000,000
A	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY		BUA 6076462181	03/01/2019	03/01/2020	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
B	<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 \$ 10,000		CUE6076462231	03/01/2019	03/01/2020	EACH OCCURRENCE \$ 4,000,000 AGGREGATE \$ 4,000,000 \$
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY 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	WC6 76462214	03/01/2019	03/01/2020	<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)

## CERTIFICATE HOLDER

Tuscarora Township  
3546 S Straits Highway  
PO Box 220  
Indian River, MI 49749

## 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





WHITPIN-01

JSTEPHENS

## CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

1/9/2020

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.

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PRODUCER General Agency Company 625 E. Broadway Mount Pleasant, MI 48858	CONTACT NAME: Julie Stephens	
	PHONE (A/C, No, Ext): (989) 817-4245 FAX (A/C, No): (989) 772-1855	
	E-MAIL ADDRESS: jstephens@ga-ins.com	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A: Fremont Insurance Co	13994
	INSURER B:	
	INSURER C:	
	INSURER D:	
	INSURER E:	
	INSURER F:	

INSURED  White Pines Electric Inc PO Box 177 Alanson, MI 49706
--

## 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	ADDITIONAL INSURED	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 checked="" type="checkbox"/> POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC <input type="checkbox"/> OTHER:		CPP007871703	10/24/2019	10/24/2020	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Per occurrence) \$ 100,000 MED EXP (Any one person) \$ 10,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMPROP AGG \$ 2,000,000
A	AUTOMOBILE LIABILITY <input checked="" 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		CAP002716403	10/24/2019	10/24/2020	COMBINED SINGLE LIMIT (Per accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
A	UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR <input checked="" type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED <input checked="" type="checkbox"/> RETENTION \$ 10,000		CUP003273303	10/24/2019	10/24/2020	EACH OCCURRENCE \$ 1,000,000 AGGREGATE \$ 1,000,000
A	WORKERS COMPENSATION AND EMPLOYERS LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in MI) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N Y N/A	WCP002084303	10/24/2019	10/24/2020	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTHER E.L. EACH ACCIDENT \$ 500,000 E.L. DISEASE - EA EMPLOYEE \$ 500,000 E.L. DISEASE - POLICY LIMIT \$ 500,000
A	Contractors E & O		CPP007871703	10/24/2019	10/24/2020	Each Occurrence \$ 1,000,000

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

## CERTIFICATE HOLDER

## CANCELLATION

Rhadigan & Sons Inc, Tuscarora Township  
Police Department  
3658 Sturgeon Ave  
Indian River, MI 49749

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

*Julie Stephens*



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

01/02/2020

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.

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<b>PRODUCER</b> Charlevoix Agency Inc. 112 Clinton Street PO Box 238 Charlevoix MI 49720-0238		<b>CONTACT NAME:</b> Noreen Aninos <b>PHONE (A/C, No, Ext):</b> (231) 547-4441 <b>E-MAIL:</b> noreen@charlevoixagency.com <b>ADDRESS:</b>		<b>FAX (A/C, No):</b> (231) 547-2771
		<b>INSURER(S) AFFORDING COVERAGE</b>		<b>NAIC #</b>
		<b>INSURER A:</b> Auto Owners Insurance Company		18888
		<b>INSURER B:</b> Home Owners Insurance Company		26638
		<b>INSURER C:</b>		
		<b>INSURER D:</b>		
		<b>INSURER E:</b>		
		<b>INSURER F:</b>		

**COVERAGES** **CERTIFICATE NUMBER:** 2019/2020 **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	ADDITIONAL INSURED	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	<input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b> <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR		33053272	10/01/2019	10/01/2020	EACH OCCURRENCE \$ 1,000,000
		DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 300,000				
		MED EXP (Any one person) \$ 10,000				
		PERSONAL & ADV INJURY \$ 1,000,000				
	GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC <input type="checkbox"/> OTHER					GENERAL AGGREGATE \$ 1,000,000
						PRODUCTS - COMP/OP AGG \$ 1,000,000
						\$
B	<input checked="" type="checkbox"/> <b>AUTOMOBILE LIABILITY</b> <input checked="" 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		4928285800	10/01/2019	10/01/2020	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000
		BODILY INJURY (Per person) \$				
		BODILY INJURY (Per accident) \$				
		PROPERTY DAMAGE (Per accident) \$				
						\$
B	<input checked="" type="checkbox"/> <b>UMBRELLA LIAB</b> <input type="checkbox"/> EXCESS LIAB	<input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS-MADE	4928285801	10/01/2019	10/01/2020	EACH OCCURRENCE \$ 1,000,000
						AGGREGATE \$ 1,000,000
						\$
						\$
	<input checked="" type="checkbox"/> DED <input checked="" type="checkbox"/> RETENTION \$ 10,000					
A	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N <input type="checkbox"/>	33053374	10/01/2019	10/01/2020	PER STATUTE <input type="checkbox"/> OTH-ER <input type="checkbox"/>
						E.L. EACH ACCIDENT \$ 500,000
						E.L. DISEASE - EA EMPLOYEE \$ 500,000
						E.L. DISEASE - POLICY LIMIT \$ 500,000

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

Plumbing and Heating Contractor

<b>CERTIFICATE HOLDER</b> Rhadian & Sons Inc. Attn: Eric PO Box 22 Indian River MI 49749	<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
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© 1988-2015 ACORD CORPORATION. All rights reserved.



CUSTO-1

OP ID: RW

## CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

01/03/2019

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).

<b>PRODUCER</b> BKC Insurance Services P.O. Box 326, 220 Water Street Cheboygan, MI 49721-0326 Rose Waite		231-627-4381	<b>CONTACT NAME:</b> Rose Waite <b>PHONE (A/C, No, Ext):</b> 231-627-4381 <b>E-MAIL ADDRESS:</b> rwaite@bkcsinsurance.com <b>FAX (A/C, No):</b>	
<b>INSURED</b> Custom Carpets & Furniture of Indian River Custom Carpets, Inc. dba P.O. Box 543, 5959 S. Straits Indian River, MI 49749		<b>INSURER(S) AFFORDING COVERAGE</b> <b>INSURER A:</b> Fremont Insurance Co. <b>INSURER B:</b> <b>INSURER C:</b> <b>INSURER D:</b> <b>INSURER E:</b> <b>INSURER F:</b>		<b>NAIC #</b> 13994

## 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
A	COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR <input checked="" type="checkbox"/> Business Owners GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:			B 0019735	02/07/2018	02/07/2019	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000 MED EXP (Any one person) \$ 5,000 PERSONAL & ADV INJURY \$ 2,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ \$
A	AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY			CAP 0015353	09/01/2018	09/01/2019	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
A	<input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED <input checked="" type="checkbox"/> RETENTION \$ 10,000			U 0017161	05/08/2018	05/08/2019	EACH OCCURRENCE \$ 2,000,000 AGGREGATE \$ 2,000,000 \$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY 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	WCP 0004991	02/07/2018	02/07/2019	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ 500,000 E.L. DISEASE - EA EMPLOYEE \$ 500,000 E.L. DISEASE - POLICY LIMIT \$ 500,000

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

## CERTIFICATE HOLDER

INDIA-9

Indian River Area Library  
Tuscarora Twp.  
3546 S. Straits Hwy.  
Indian River, MI 49749

## 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  
Rose Waite



JBSCONT-01

SDEWITT

## CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
2/18/2019

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 David Chapman Agency, Inc. P.O. Box 30109 Lansing, MI 48909	CONTACT NAME: Sue DeWitt	
	PHONE (A/C, No, Ext): (517) 319-8232 FAX (A/C, No): (517) 321-9443	
	E-MAIL ADDRESS: sdewitt@davidchapmanagency.com	
INSURED  JBS Contracting, Inc. P. O. Box 370 Mt. Pleasant, MI 48804-0370	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : National Trust Insurance Co	20141
	INSURER B : FCCI Insurance Group	10178
	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
A	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR <input checked="" type="checkbox"/> Contractual Liab <input checked="" type="checkbox"/> XCU Included GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:			CPP100031664	10/4/2018	10/4/2019	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 300,000 MED EXP (Any one person) \$ 5,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000
A	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY			CA100006759	10/4/2018	10/4/2019	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
A	<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			UMB100018571	10/4/2018	10/4/2019	EACH OCCURRENCE \$ 5,000,000 AGGREGATE \$ 5,000,000
B	<input checked="" type="checkbox"/> WORKERS COMPENSATION AND EMPLOYERS' LIABILITY 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	WC00002354	10/4/2018	10/4/2019	<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

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

## CERTIFICATE HOLDER

Tuscarora Townsuip  
PO Box 220  
Indian River, MI 49749

## 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



K&amp;JSE-1

OP ID: RW

## CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

09/17/2018

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.

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<b>PRODUCER</b> BKC Insurance Services P.O. Box 326, 220 Water Street Cheboygan, MI 49721-0326 Rose Waite	231-627-4381	<b>CONTACT NAME:</b> Rose Waite <b>PHONE (A/C, No, Ext):</b> 231-627-4381 <b>FAX (A/C, No):</b> <b>E-MAIL ADDRESS:</b> rwaite@bkcsinsurance.com
<b>INSURED</b> K & J Septic Service, LLC 2360 River Road Petoskey, MI 49770		<b>INSURER(S) AFFORDING COVERAGE</b> <b>INSURER A:</b> Hastings Mutual Insurance Co. <b>NAIC #</b> 14176 <b>INSURER B:</b> <b>INSURER C:</b> <b>INSURER D:</b> <b>INSURER E:</b> <b>INSURER F:</b>

**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
A	<input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b> <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:			CPP6122090	09/01/2018	09/01/2019	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 \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000
A	<input checked="" type="checkbox"/> <b>AUTOMOBILE LIABILITY</b> <input type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> NON-OWNED AUTOS ONLY			ACV6121601	09/01/2018	09/01/2019	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
A	<input checked="" type="checkbox"/> <b>UMBRELLA LIAB</b> <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED <input checked="" type="checkbox"/> RETENTION \$ 0			ULC6121603	09/01/2018	09/01/2019	EACH OCCURRENCE \$ 1,000,000 AGGREGATE \$ 1,000,000
A	<input checked="" type="checkbox"/> <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	WC 6121602	09/01/2018	09/01/2019	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ 500,000 E.L. DISEASE - EA EMPLOYEE \$ 500,000 E.L. DISEASE - POLICY LIMIT \$ 500,000

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

## CERTIFICATE HOLDER

TUSCA-1

Tuscarora Township  
PO Box 220  
Indian River, MI 49749

## 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  
Rose Waite



MEADHU1

OP ID: MRH

## CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

09/18/2019

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<b>PRODUCER</b> Hausmann-Johnson Insurance Inc 700 Regent St., PO Box 259408 Madison, WI 53725-9408 Phil Hausmann		<b>608-257-3795</b>	<b>CONTACT NAME:</b> Phil Hausmann, CIC <b>PHONE (A/C, No, Ext):</b> 608-257-3795 <b>FAX (A/C, No):</b> 608-257-4324 <b>E-MAIL ADDRESS:</b>
<b>INSURED</b> Mead & Hunt, Inc. M&H Architecture, Inc. Mead & Hunt Companies, Inc. Mead & Hunt International, Inc 2440 Deming Way Middleton, WI 53562-1562		<b>INSURER(S) AFFORDING COVERAGE</b> <b>INSURER A:</b> Travelers Casualty & Surety <b>INSURER B:</b> Cincinnati Insurance Company <b>INSURER C:</b> <b>INSURER D:</b> <b>INSURER E:</b> <b>INSURER F:</b>	
		<b>NAIC #</b> 19038 10677	

## 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
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 checked="" type="checkbox"/> PRO-JECT <input checked="" type="checkbox"/> LOC OTHER:			P6305C656013TIL18	12/01/2018	12/01/2019	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 300,000 MED EXP (Any one person) \$ 10,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000
A	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY			8101L2755751843G	12/01/2018	12/01/2019	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
A	<input checked="" type="checkbox"/> UMBRELLA LIAB EXCESS LIAB DED <input checked="" type="checkbox"/> RETENTION \$ 0			CUP0K3011011843	12/01/2018	12/01/2019	EACH OCCURRENCE \$ 9,000,000 AGGREGATE \$ 9,000,000
A	<input checked="" type="checkbox"/> 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 checked="" type="checkbox"/> N	N/A	UB8J3173931843V WI UB8J2154321843E-OTH STAT	12/01/2018 12/01/2018	12/01/2019 12/01/2019	<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

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

## CERTIFICATE HOLDER

## CANCELLATION

<b>TUSCARO</b>  Tuscarora Township 3546 South Straits Hwy Indian River, MI 49749	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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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

04/02/2018

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.

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<b>PRODUCER</b>  Loyalty Insurance Agency Inc. 41575 Joy Road Ste 100 Canton, MI 48187	<b>CONTACT NAME:</b> Sandra Canedo <b>PHONE (A/C, No, Ext):</b> 734-454-5450 <b>E-MAIL ADDRESS:</b> sandra@loyaltyinsurance.com <b>FAX (A/C, No):</b> 734-454-5457														
<b>INSURED</b>  Ostlund Pest Control North Inc PO Box 700 Indian River, MI 49749	<table><tr><td><b>INSURER(S) AFFORDING COVERAGE</b></td><td><b>NAIC #</b></td></tr><tr><td><b>INSURER A:</b> Secura Insurance Companies</td><td></td></tr><tr><td><b>INSURER B:</b> Secura Insurance Company</td><td>22543</td></tr><tr><td><b>INSURER C:</b> Retailers Mutual Insurance Company</td><td></td></tr><tr><td><b>INSURER D:</b></td><td></td></tr><tr><td><b>INSURER E:</b></td><td></td></tr><tr><td><b>INSURER F:</b></td><td></td></tr></table>	<b>INSURER(S) AFFORDING COVERAGE</b>	<b>NAIC #</b>	<b>INSURER A:</b> Secura Insurance Companies		<b>INSURER B:</b> Secura Insurance Company	22543	<b>INSURER C:</b> Retailers Mutual Insurance Company		<b>INSURER D:</b>		<b>INSURER E:</b>		<b>INSURER F:</b>	
<b>INSURER(S) AFFORDING COVERAGE</b>	<b>NAIC #</b>														
<b>INSURER A:</b> Secura Insurance Companies															
<b>INSURER B:</b> Secura Insurance Company	22543														
<b>INSURER C:</b> Retailers Mutual Insurance Company															
<b>INSURER D:</b>															
<b>INSURER E:</b>															
<b>INSURER F:</b>															

**COVERAGES**

CERTIFICATE NUMBER: 00000000-37537

REVISION NUMBER: 5

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
A	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR  GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC <input type="checkbox"/> OTHER:			20-CP-3265743	04/01/2018	04/01/2019	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 300,000 MED EXP (Any one person) \$ 10,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMPI/OP AGG \$ 2,000,000 \$
B	<input type="checkbox"/> AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY			A3265744	04/01/2018	04/01/2019	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
	<input type="checkbox"/> UMBRELLA LIAB <input type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> DED <input type="checkbox"/> RETENTION S						EACH OCCURRENCE \$ AGGREGATE \$ \$
C	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 Y	N/A	WCP 0010818	04/01/2018	04/01/2019	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ 2,000,000 E.L. DISEASE - EA EMPLOYEE \$ 2,000,000 E.L. DISEASE - POLICY LIMIT \$ 2,000,000

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

Workers Comp: Marie Burfiend

**CERTIFICATE HOLDER****CANCELLATION**

<b>CERTIFICATE HOLDER</b>  Ostlund Pest Control North Inc PO Box 700 Indian River, MI 49749	<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.  <b>AUTHORIZED REPRESENTATIVE</b>  Sandra Canedo (SCA)
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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

10/09/2018

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).

<b>PRODUCER</b> Larkin Group of Traverse City 13900 S West Bay Shore Drive  Traverse City MI 49684		<b>CONTACT NAME:</b> Beth McCardel <b>PHONE (A/C, No, Ext):</b> (231) 947-8800 <b>FAX (A/C, No):</b> (231) 346-6111 <b>E-MAIL ADDRESS:</b> bmccardel@larkingrp.com	
<b>INSURED</b> Temperature Control Inc 1623 Northern Star Dr  Traverse City MI 49696-9243		<b>INSURER(S) AFFORDING COVERAGE</b> <b>INSURER A:</b> Motorists Mutual Ins Co NAIC # 14621 <b>INSURER B:</b> Accident Fund General Ins Co 12304 <b>INSURER C:</b> <b>INSURER D:</b> <b>INSURER E:</b> <b>INSURER F:</b>	

## COVERAGES

CERTIFICATE NUMBER: 18/19

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
A	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY	Y		3330607810	03/01/2018	03/01/2019	EACH OCCURRENCE \$ 1,000,000
	<input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000
	<input checked="" type="checkbox"/> E & O - \$300,000						MED EXP (Any one person) \$ 5,000
	GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input checked="" type="checkbox"/> LOC						PERSONAL & ADV INJURY \$ 1,000,000
	OTHER:						GENERAL AGGREGATE \$ 2,000,000
A	<b>AUTOMOBILE LIABILITY</b>			3330607810	03/01/2018	03/01/2019	PRODUCTS - COMP/OP AGG \$ 2,000,000
	<input checked="" type="checkbox"/> ANY AUTO						Employee Benefits \$ 1,000,000
	<input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS NON-OWNED AUTOS ONLY						COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000
	<input checked="" type="checkbox"/> HIRED AUTOS ONLY						BODILY INJURY (Per person) \$
A	<input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR			3330607810	03/01/2018	03/01/2019	BODILY INJURY (Per accident) \$
	<input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE						PROPERTY DAMAGE (Per accident) \$
	DED RETENTION \$						Uninsured motorist \$ 1,000,000
							EACH OCCURRENCE \$ 4,000,000
B	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b>	N/A		WCV6098838	03/01/2018	03/01/2019	AGGREGATE \$ 4,000,000
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)						<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER
	If yes, describe under DESCRIPTION OF OPERATIONS below						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)

## CERTIFICATE HOLDER

## CANCELLATION

Tuscarora Township 3546 S. Straits Highway P.O. Box 220 Indian River MI 49749	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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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
04/07/2018

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).

<b>PRODUCER</b> FEDERATED MUTUAL INSURANCE COMPANY HOME OFFICE: P.O. BOX 328 OWATONNA, MN 55060		<b>CONTACT NAME:</b> CLIENT CONTACT CENTER <b>PHONE (A/C, No, Ext):</b> 888-333-4949 <b>FAX (A/C, No):</b> 507-446-4664 <b>E-MAIL ADDRESS:</b> CLIENTCONTACTCENTER@FEDINS.COM	
		<b>INSURER(S) AFFORDING COVERAGE</b>	
		<b>INSURER A:</b> FEDERATED MUTUAL INSURANCE COMPANY	
		<b>INSURER B:</b>	
		<b>INSURER C:</b>	
		<b>INSURER D:</b>	
		<b>INSURER E:</b>	
		<b>INSURER F:</b>	

**COVERAGES** **CERTIFICATE NUMBER: 73** **REVISION NUMBER: 0**

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	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR	N	N	9170642	06/01/2018	06/01/2019	EACH OCCURRENCE \$1,000,000		
	DAMAGE TO RENTED PREMISES (Ea occurrence) \$100,000								
	MED EXP (Any one person) EXCLUDED								
	PERSONAL & ADV INJURY \$1,000,000								
GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC						GENERAL AGGREGATE \$2,000,000			
OTHER:						PRODUCTS - COMP/OP AGG \$2,000,000			
A	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO	N	N	9170642	06/01/2018	06/01/2019	COMBINED SINGLE LIMIT (Ea accident) \$1,000,000		
	OWNED AUTOS ONLY						SCHEDULED AUTOS	BODILY INJURY (Per person)	
	HIRED AUTOS ONLY						NON-OWNED AUTOS ONLY	BODILY INJURY (Per accident)	
							PROPERTY DAMAGE (Per accident)		
A	<input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR	N	N	9170644	06/01/2018	06/01/2019	EACH OCCURRENCE \$5,000,000		
	EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE						AGGREGATE \$5,000,000		
	DED						RETENTION		
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETORS/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A	N	9170643	06/01/2018	06/01/2019	<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)  
THIS COPY IS NOT TO BE REPRODUCED FOR ISSUANCE OF CERTIFICATES.

## CERTIFICATE HOLDER

## CANCELLATION

73 0 THIS CERTIFICATE HAS BEEN FILED WITH EACH OF YOUR CERTIFICATE HOLDERS.	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>Michael G Kern</i>

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K&amp;JSE-1

OP ID: RW

## CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

09/17/2018

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<b>PRODUCER</b> BKC Insurance Services P.O. Box 326, 220 Water Street Cheboygan, MI 49721-0326 Rose Waite		231-627-4381	<b>CONTACT NAME:</b> Rose Waite <b>PHONE (A/C, No, Ext):</b> 231-627-4381 <b>FAX (A/C, No):</b> <b>E-MAIL ADDRESS:</b> rwaite@bkcininsurance.com	
<b>INSURED</b> K & J Septic Service, LLC 2360 River Road Petoskey, MI 49770		<b>INSURER(S) AFFORDING COVERAGE</b>		<b>NAIC #</b>
		INSURER A : Hastings Mutual Insurance Co.		14176
		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	
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:			CPP6122090	09/01/2017	09/01/2018	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence)	\$ 1,000,000 \$ 100,000
							MED EXP (Any one person)	\$ 5,000
							PERSONAL & ADV INJURY	\$ 1,000,000
							GENERAL AGGREGATE	\$ 2,000,000
							PRODUCTS - COMP/OP AGG	\$ 2,000,000
								\$
A	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" 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			ACV6121601	09/01/2017	09/01/2018	COMBINED SINGLE LIMIT (Ea accident)	\$ 1,000,000
							BODILY INJURY (Per person)	\$
							BODILY INJURY (Per accident)	\$
							PROPERTY DAMAGE (Per accident)	\$
								\$
A	<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			ULC6121603	09/01/2017	09/01/2018	EACH OCCURRENCE	\$ 1,000,000
							AGGREGATE	\$ 1,000,000
								\$
A	<input checked="" type="checkbox"/> 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 Y	N/A	WC 6121602	09/01/2017	09/01/2018	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER	\$ 500,000
							E.L. EACH ACCIDENT	\$ 500,000
							E.L. DISEASE - EA EMPLOYEE	\$ 500,000
							E.L. DISEASE - POLICY LIMIT	\$ 500,000

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

## CERTIFICATE HOLDER

TUSCA-1

Tuscarora Township  
PO Box 220  
Indian River, MI 49749

## 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  
Rose Waite



BENNKI1

OP ID: CW

# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

09/17/2018

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<b>PRODUCER</b> Dewey Ins. Agency, Inc. Dewey Oil & Gas Agency P.O. Box 640, 316 N. Cedar St Kalkaska, MI 49646		<b>CONTACT NAME:</b> PHONE (A/C, No, Ext): 231-258-2301 FAX (A/C, No): E-MAIL ADDRESS:																			
<b>INSURED</b> Matts, LLC dba Matts Underground Utility 8975 S. East Torch Lake Dr. Alden, MI 49612-9535		<b>INSURER(S) AFFORDING COVERAGE</b> <table border="1"> <tr> <td>INSURER A:</td> <td>Westchester Surplus Lines Ins</td> <td>NAIC #</td> </tr> <tr> <td>INSURER B:</td> <td>Hastings Mutual Insurance Co.</td> <td>14176</td> </tr> <tr> <td>INSURER C:</td> <td></td> <td></td> </tr> <tr> <td>INSURER D:</td> <td></td> <td></td> </tr> <tr> <td>INSURER E:</td> <td></td> <td></td> </tr> <tr> <td>INSURER F:</td> <td></td> <td></td> </tr> </table>		INSURER A:	Westchester Surplus Lines Ins	NAIC #	INSURER B:	Hastings Mutual Insurance Co.	14176	INSURER C:			INSURER D:			INSURER E:			INSURER F:		
INSURER A:	Westchester Surplus Lines Ins	NAIC #																			
INSURER B:	Hastings Mutual Insurance Co.	14176																			
INSURER C:																					
INSURER D:																					
INSURER E:																					
INSURER F:																					

## COVERAGES

## CERTIFICATE NUMBER:

## REVISION NUMBER:

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INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	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 POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC OTHER			CPP9746179	12/12/2017	12/12/2018	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 300,000 MED EXP (Any one person) \$ 5,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000
B	AUTOMOBILE LIABILITY <input checked="" 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			ACV9895613	12/12/2017	12/12/2018	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
B	UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED <input type="checkbox"/> RETENTION \$			ULC9893016	12/12/2017	12/12/2018	EACH OCCURRENCE \$ 5,000,000 AGGREGATE \$ 5,000,000
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/OWNER EXCLUDED? (Mandatory in NH) <input type="checkbox"/> Y/N If yes, describe under DESCRIPTION OF OPERATIONS below		N/A	WC9746180	12/12/2017	12/12/2018	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTHER E.L. EACH ACCIDENT \$ 1,000,000 E.L. D SEASE - EA EMPLOYEE \$ 1,000,000 E.L. D SEASE - POLICY LIMIT \$ 1,000,000
A	RENTED EQUIPMENT			CPP9746179	12/12/2017	12/12/2018	\$500 DED 200,000
B	CONTR POLLUTION			G27114714 004	09/17/2017	09/17/2018	200,000 2,000,000

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

CERTIFICATE DOES NOT REPRESENT THAT INSURANCE SATISFIES CONTRACTUAL REQUIREMENTS SIGNED BY INSURED.

## CERTIFICATE HOLDER

## CANCELLATION

<b>TUSCTO1</b>  TUSCARORA TOWNSHIP PO BOX 220 INDIAN RIVER, MI 49749	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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MEADHU1

OP ID: MRH

## CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

09/18/2019

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.

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<b>PRODUCER</b> Hausmann-Johnson Insurance Inc 700 Regent St., PO Box 259408 Madison, WI 53725-9408 Phil Hausmann		<b>608-257-3795</b>	<b>CONTACT NAME:</b> Phil Hausmann, CIC <b>PHONE (A/C, No, Ext):</b> 608-257-3795 <b>FAX (A/C, No):</b> 608-257-4324 <b>E-MAIL ADDRESS:</b>
<b>INSURED</b> Mead & Hunt, Inc. M&H Architecture, Inc. Mead & Hunt Companies, Inc. Mead & Hunt International, Inc 2440 Deming Way Middleton, WI 53562-1562		<b>INSURER(S) AFFORDING COVERAGE</b> <b>INSURER A:</b> Travelers Casualty & Surety <b>INSURER B:</b> <b>INSURER C:</b> <b>INSURER D:</b> <b>INSURER E:</b> <b>INSURER F:</b>	
		<b>NAIC #</b> 19038	

## 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 WYD	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 checked="" type="checkbox"/> PROJECT <input checked="" type="checkbox"/> LOC OTHER:			P6305C656013TIL17	12/01/2017	12/01/2018	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 300,000 MED EXP (Any one person) \$ 10,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000
A	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY			P8106C161444IND17	12/01/2017	12/01/2018	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
A	<input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR EXCESS LIAB CLAIMS-MADE DED <input checked="" type="checkbox"/> RETENTION \$ 0			CUP0K3011011743	12/01/2017	12/01/2018	EACH OCCURRENCE \$ 9,000,000 AGGREGATE \$ 9,000,000
A	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	N/A	UB8J3173931743V WI UB8J2154321743E-OTH STAT	12/01/2017 12/01/2017	12/01/2018 12/01/2018	<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)

## CERTIFICATE HOLDER

TUSCARO

Tuscarora Township  
3546 South Straits Hwy  
Indian River, MI 49749

## 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



AccidentFund UnitedHeartland CompWest ThirdCoast Underwriters

## Determination of Worker Status

**Purpose:** Policyholders submit this form to request the determination of the status of a worker for the purpose of completing his or her worker's compensation audit. This form will only be used to determine whether or not remuneration paid to a worker will be included on the policyholder's audit. All factors will be considered, however, no one factor is determinative of the worker's status.

Answer all questions as completely as possible. **Attach additional sheets if you need more space.** Provide information for the worker and policy period stated below. Determinations are based on the entire relationship between the policyholder and worker. **In order to make a determination as to whether an Employer/Employee status exists, please complete this analysis and provide as much of the following documentation as possible. This information must be provided and updated on an annual basis.**

Policyholder  
Worker's Name: Ellen August Policy Period  
10701 PRAIRIE ROAD Worker's DBA (applicable):  
Worker's Place of Business Address (Include street address, city, state, and zip code) Worker's FEIN number

Worker is a: ☒ Sole Proprietor ☐ Partnership ☐ Corporation ☐ Limited Liability Company

How is the worker paid? ☐ per agreed upon price ☒ per hour ☐ salary ☐ commission ☐ piece work ☐ lump sum

Does the worker hire any employees, casual laborers, or subcontractors? ☐ Yes ☒ No If yes who pays them?

If the work is done under a written agreement between the policyholder and the worker, **attach a copy** (preferably signed by both parties).

Describe the term and conditions of the work arrangement. 3 days a week, 2-3 hours per time

The worker was contracted to perform: Cleaning Services

What specific training or instruction is the worker given by the policyholder?

What expenses are incurred by the worker in the performance of services for the policyholder?

List the supplies, equipment, materials and property provided by the worker. Please provide a copy of an invoice from the contractor:

During the above policy period, the approximate percentage of payments to the subcontractor in relation to their total income for the year. %

Can the relationship be terminated by either party without incurring liability or penalty? If "No" explain your answer ☒ Yes ☐ No

Does the worker perform similar service for others? ☒ Yes ☐ No. If "Yes" is the worker required to get approval from the policy holder? ☐ Yes ☒ No

Below is a list of other individuals and business entities that the worker has performed services for over the past year.

TUSCARORA FIRE DEPT, Indian River Contractors, The Glen, UMC, Tap n Bee

Does the worker carry insurance? (e.g. workers compensation, general liability, professional liability, etc.) ☐ Yes ☒ No If "Yes" please attach copies

What type of advertising, if any, does the worker have (e.g. business listing in a directory or trade journal, newspaper advertisement, business card, etc.)? Provide copies, if applicable. Does the worker advertise their business on T.V. or radio? ☐ Yes ☐ No

### Signature

I declare that I have examined this request, including accompanying documents, and to the best of my knowledge and belief, the facts presented are true, correct and complete. This form must be signed by the policyholder (i.e., Owner, Partner, Corporate Officer, Member/Manager) who has personal knowledge of the facts.

Signature Ellen August Title Owner Date 4/11/23



# CERTIFICATE OF LIABILITY INSURANCE

DATE

9/13/2022

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.

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PRODUCER	CONTACT NAME: Robin Laskowski	PHONE (A/C, No, Ext): 231-34-7-4464	FAX (A/C, No): 231-348-1190
Wilson Insurance Agency LLC	E-MAIL ADDRESS: rlaskowski@wilsoninsurance.us		
2073 US 31 N	INSURER(S) AFFORDING COVERAGE		
Petoskey	MI 49770	INSURER A: HASTINGS MUT INS CO	NAIC # 14176
INSURED	24/7 SEWER AND DRAIN CLEANING LLC	INSURER B:	
	11541 PICKEREL LAKE RD	INSURER C:	
		INSURER D:	
		INSURER E:	
		INSURER F:	
PETOSKEY	MI 49770-9697		

## 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 SUBR INSD WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	8 COMMERCIAL GENERAL LIABILITY CLAIMS-MADE 8 OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY PROJECT LOC OTHER		CPP6183379	04/08/2022	04/08/2023	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 \$ 2,000,000 PRODUCTS - COMPROP AGG \$ 2,000,000
A	AUTOMOBILE LIABILITY ANY AUTO OWNED AUTOS ONLY 8 SCHEDULED AUTOS 8 NON-OWNED AUTOS ONLY 8 UMBRELLA LIAB - OCCUR EXCESS LIAB CLAIMS-MADE DED RETENTION \$		ACV6192319	05/16/2022	05/16/2023	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in MI) If yes, describe under DESCRIPTION OF OPERATIONS below	YIN Y N/A	0006193385	06/17/2022	06/17/2023	8 PER STATUTE OTH-ER E.L. EACH ACCIDENT \$ 500,000 E.L. DISEASE - EA EMPLOYEE \$ 500,000 E.L. DISEASE - POLICY LIMIT \$ 500,000

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

## CERTIFICATE HOLDER

## 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

Phillip Goldsmith



# CERTIFICATE OF LIABILITY INSURANCE

OP ID: JK

DATE (MM/DD/YYYY)

02/13/2023

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<b>PRODUCER</b> King Insurance Agency 308 State Street Petoskey, MI 49770 Julia E. Makela		<b>CONTACT NAME:</b> Julia Makela <b>PHONE (A/C, No, Ext):</b> 231-347-9062 <b>FAX (A/C, No):</b> 231-347-9063 <b>E-MAIL ADDRESS:</b> julia@kinginsagency.com <b>PRODUCER CUSTOMER ID #:</b> ACCESSL	
<b>INSURED</b> Access Locksmithing Inc Jared Urman 2795 Cemetery Road Petoskey, MI 49770		<b>INSURER(S) AFFORDING COVERAGE</b> <b>INSURER A:</b> Home Owners Insurance Co. <b>NAIC #</b> 26638 <b>INSURER B:</b> Auto Owners Insurance Co. <b>18988</b> <b>INSURER C:</b> <b>INSURER D:</b> <b>INSURER E:</b> <b>INSURER F:</b>	

**COVERAGES****CERTIFICATE NUMBER:****REVISION NUMBER:**

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INSR LTR	TYPE OF INSURANCE	ADDL SUBR INSR	WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	<input checked="" type="checkbox"/> GENERAL LIABILITY			33230875	02/24/2023	02/24/2024	EACH OCCURRENCE \$ 1,000,000
	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 300,000
	<input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR						MED EXP (Any one person) \$ 10,000
							PERSONAL & ADV INJURY \$ 1,000,000
					02/24/2022	02/24/2023	GENERAL AGGREGATE \$ 2,000,000
							PRODUCTS - COMP/OP AGG \$ 2,000,000
							\$
B	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY			4623087500	02/01/2023	02/01/2024	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000
	<input checked="" type="checkbox"/> ANY AUTO						BODILY INJURY (Per person) \$
	<input type="checkbox"/> ALL OWNED AUTOS						BODILY INJURY (Per accident) \$
	<input type="checkbox"/> SCHEDULED AUTOS						PROPERTY DAMAGE (PER ACCIDENT) \$
	<input checked="" type="checkbox"/> HIRED AUTOS						\$
	<input checked="" type="checkbox"/> NON-OWNED AUTOS						\$
B	<input checked="" type="checkbox"/> Garage Liability			4623087503	02/24/2023	02/24/2024	\$
	<input type="checkbox"/> UMBRELLA LIAB						EACH OCCURRENCE \$
	<input type="checkbox"/> EXCESS LIAB						AGGREGATE \$
	<input type="checkbox"/> DEDUCTIBLE						\$
	<input type="checkbox"/> RETENTION \$						\$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY			33211223	07/01/2022	07/01/2023	<input checked="" type="checkbox"/> WC STATUTORY LIMITS <input type="checkbox"/> OTHER
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)						E.L. EACH ACCIDENT \$ 1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE \$ 1,000,000
							E.L. DISEASE - POLICY LIMIT \$ 1,000,000

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

Service Provider

**CERTIFICATE HOLDER**

TUSCART

Tuscarora Township

**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

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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
02/20/2023

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<b>PRODUCER</b> TCA Insurance 1118 W Lake St Tawas City, MI 48763	<b>CONTACT NAME:</b> Lindsey Martin	
	<b>PHONE (A/C, No, Ext):</b> 989-362-3003 <b>FAX (A/C, No):</b>	
	<b>E-MAIL ADDRESS:</b> lindsey@tcains.biz	
	<b>INSURER(S) AFFORDING COVERAGE</b>	<b>NAIC #</b>
	<b>INSURER A:</b> Pioneer State Mutual	18309
	<b>INSURER B:</b> Accident Fund Co of America	12305
	<b>INSURER C:</b>	
	<b>INSURER D:</b>	
	<b>INSURER E:</b>	
	<b>INSURER F:</b>	

**COVERAGES** **CERTIFICATE NUMBER:** **REVISION NUMBER:**

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INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	<input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b> <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:			CB00000995	07/01/2022	07/01/2023	EACH OCCURRENCE \$ 2,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ 5,000 PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ 4,000,000 PRODUCTS - COMP/OP AGG \$ 4,000,000
A	<b>AUTOMOBILE LIABILITY</b> <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY			CA00302812	07/01/2022	07/01/2023	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
	<input type="checkbox"/> UMBRELLA LIAB <input type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$
B	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N	N/A	100032726	06/01/2022	06/01/2023	<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>  Tuscarora Township 3546 S Straits Hwy Indian River, MI 49749	<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
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BRBCGRO-01

SDEWITT

## CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

2/13/2023

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<b>PRODUCER</b> David Chapman Agency, Inc. P.O. Box 30109 Lansing, MI 48909	<b>CONTACT NAME:</b> Sue DeWitt	
	<b>PHONE (A/C, No, Ext):</b> (517) 319-8232 <b>FAX (A/C, No):</b> (517) 321-9443	
	<b>E-MAIL ADDRESS:</b> sdewitt@davidchapmanagency.com	
<b>INSURED</b>  BRBC Group, Inc. dba Blue Chip Window Cleaning 6800 Hillside Drive Harbor Springs, MI 49740	<b>INSURER(S) AFFORDING COVERAGE</b>	<b>NAIC #</b>
	<b>INSURER A:</b> Benchmark Insurance Company	41394
	<b>INSURER B:</b>	
	<b>INSURER C:</b>	
	<b>INSURER D:</b>	
	<b>INSURER E:</b>	
	<b>INSURER F:</b>	

**COVERAGES** **CERTIFICATE NUMBER:** **REVISION NUMBER:**

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INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	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 <input type="checkbox"/> OTHER:			CP5005338	1/3/2023	1/3/2024	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 \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000
A	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY			CA5002434	1/3/2023	1/3/2024	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
A	<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 \$ 10,000			UM5001230	1/3/2023	1/3/2024	EACH OCCURRENCE \$ 1,000,000 AGGREGATE \$ 1,000,000
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) <input type="checkbox"/> Y/N <input type="checkbox"/> N/A If yes, describe under DESCRIPTION OF OPERATIONS below			WC5003664	1/3/2023	1/3/2024	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ 500,000 E.L. DISEASE - EA EMPLOYEE \$ 500,000 E.L. DISEASE - POLICY LIMIT \$ 500,000

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

## CERTIFICATE HOLDER

Tuscarora Township  
3546 S. Straits Hwy  
PO Box 220  
Indian River, MI 49749

## 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

*David L. Chapman*



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

02/09/2023

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<b>PRODUCER</b> Rice Insurance LLC 1400 Broadway  Bellingham WA 98225	<b>CONTACT NAME:</b> Mallory Visser <b>PHONE (A/C, No, Ext):</b> (360) 734-1161 <b>E-MAIL ADDRESS:</b> malloryv@riceinsurance.com <b>FAX (A/C, No):</b> (360) 734-1173																					
<b>INSURED</b> CertaSite, LLC 9855 Crosspoint Blvd., Suite 126  Indianapolis IN 46256	<table><tr><th colspan="2">INSURER(S) AFFORDING COVERAGE</th><th>NAIC #</th></tr><tr><td>INSURER A:</td><td>Nautilus Insurance Company</td><td>17370</td></tr><tr><td>INSURER B:</td><td>Zurich American Insurance Company</td><td>16535</td></tr><tr><td>INSURER C:</td><td></td><td></td></tr><tr><td>INSURER D:</td><td></td><td></td></tr><tr><td>INSURER E:</td><td></td><td></td></tr><tr><td>INSURER F:</td><td></td><td></td></tr></table>	INSURER(S) AFFORDING COVERAGE		NAIC #	INSURER A:	Nautilus Insurance Company	17370	INSURER B:	Zurich American Insurance Company	16535	INSURER C:			INSURER D:			INSURER E:			INSURER F:		
INSURER(S) AFFORDING COVERAGE		NAIC #																				
INSURER A:	Nautilus Insurance Company	17370																				
INSURER B:	Zurich American Insurance Company	16535																				
INSURER C:																						
INSURER D:																						
INSURER E:																						
INSURER F:																						

**COVERAGES****CERTIFICATE NUMBER:** CL2211300595**REVISION NUMBER:**

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INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS														
A	<input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b> <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR  GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PRO-JECT <input checked="" type="checkbox"/> LOC OTHER:	Y	Y	ECP203900910	11/15/2022	11/15/2023	<table><tr><td>EACH OCCURRENCE</td><td>\$ 1,000,000</td></tr><tr><td>DAMAGE TO RENTED PREMISES (Ea occurrence)</td><td>\$ 100,000</td></tr><tr><td>MED EXP (Any one person)</td><td>\$ 5,000</td></tr><tr><td>PERSONAL &amp; ADV INJURY</td><td>\$ 1,000,000</td></tr><tr><td>GENERAL AGGREGATE</td><td>\$ 2,000,000</td></tr><tr><td>PRODUCTS - COMP/OP AGG</td><td>\$ 2,000,000</td></tr><tr><td>Professional Liability</td><td>\$ 1,000,000</td></tr></table>	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	\$ 2,000,000	PRODUCTS - COMP/OP AGG	\$ 2,000,000	Professional Liability	\$ 1,000,000
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	\$ 2,000,000																				
PRODUCTS - COMP/OP AGG	\$ 2,000,000																				
Professional Liability	\$ 1,000,000																				
B	<b>AUTOMOBILE LIABILITY</b> <input checked="" type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY	Y	Y	BAP648006300	11/15/2022	11/15/2023	<table><tr><td>COMBINED SINGLE LIMIT (Ea accident)</td><td>\$ 1,000,000</td></tr><tr><td>BODILY INJURY (Per person)</td><td>\$</td></tr><tr><td>BODILY INJURY (Per accident)</td><td>\$</td></tr><tr><td>PROPERTY DAMAGE (Per accident)</td><td>\$</td></tr></table>	COMBINED SINGLE LIMIT (Ea accident)	\$ 1,000,000	BODILY INJURY (Per person)	\$	BODILY INJURY (Per accident)	\$	PROPERTY DAMAGE (Per accident)	\$						
COMBINED SINGLE LIMIT (Ea accident)	\$ 1,000,000																				
BODILY INJURY (Per person)	\$																				
BODILY INJURY (Per accident)	\$																				
PROPERTY DAMAGE (Per accident)	\$																				
A	<b>UMBRELLA LIAB</b> <input checked="" type="checkbox"/> OCCUR <b>EXCESS LIAB</b> <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$	Y	Y	FFX203901010	11/15/2022	11/15/2023	<table><tr><td>EACH OCCURRENCE</td><td>\$ 5,000,000</td></tr><tr><td>AGGREGATE</td><td>\$ 5,000,000</td></tr></table>	EACH OCCURRENCE	\$ 5,000,000	AGGREGATE	\$ 5,000,000										
EACH OCCURRENCE	\$ 5,000,000																				
AGGREGATE	\$ 5,000,000																				
B	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N N	N/A	WC636020800	11/15/2022	11/15/2023	<table><tr><td><input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTHER</td><td></td></tr><tr><td>E.L. EACH ACCIDENT</td><td>\$ 1,000,000</td></tr><tr><td>E.L. DISEASE - EA EMPLOYEE</td><td>\$ 1,000,000</td></tr><tr><td>E.L. DISEASE - POLICY LIMIT</td><td>\$ 1,000,000</td></tr></table>	<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						
<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)

Certificate Holder is Additional Insured for General Liability for Ongoing Operations per form ECP1246 0121 and Completed Operations per form ECP1248 0121. Coverage is Primary and Non-Contributory. Waiver of Subrogation applies per form ECP1260 0121. Per Project Aggregate applies per form ECP1289 0121. Auto Additional Insured and Waiver of Subrogation apply per attached forms. Workers Comp Waiver of Subrogation applies per form WC000313 0484. All endorsements apply per written contract. Umbrella follows form to the underlying policies.

**CERTIFICATE HOLDER****CANCELLATION**Tuscarora Township  
3546 South Straits Highway

Indian River

MI 49749

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

*Joe Tejeda*

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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
02/23/2022

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).

<b>PRODUCER</b> Larkin Group of Traverse City 13900 S West Bay Shore Drive  Traverse City MI 49684		<b>CONTACT NAME:</b> Beth McCardel <b>PHONE (A/C, No, Ext):</b> (231) 947-8800 <b>FAX (A/C, No):</b> (231) 346-6111 <b>E-MAIL ADDRESS:</b> bmccardel@larkingrp.com	
<b>INSURED</b> DROST LANDSCAPE, INC. PO BOX 696 2010 CEDAR VALLEY ROAD PETOSKEY MI 49770-0696		<b>INSURER(S) AFFORDING COVERAGE</b> <b>INSURER A:</b> Selective Insurance Co of America <b>INSURER B:</b> Accident Fund Natl. Ins. Co. <b>INSURER C:</b> <b>INSURER D:</b> <b>INSURER E:</b> <b>INSURER F:</b>	
		<b>NAIC #</b> 12305	

**COVERAGES** **CERTIFICATE NUMBER:** 2022/23 **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	
A	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY			S 2417572	02/24/2022	02/24/2023	EACH OCCURRENCE	\$ 1,000,000
	<input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	\$ 500,000
							MED EXP (Any one person)	\$ 15,000
							PERSONAL & ADV INJURY	\$ 1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	\$ 2,000,000
	<input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC						PRODUCTS - COMP/OP AGG	\$ 2,000,000
	OTHER:							\$
A	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY			S 2417572	02/24/2022	02/24/2023	COMBINED SINGLE LIMIT (Ea accident)	\$ 1,000,000
	<input checked="" type="checkbox"/> ANY AUTO						BODILY INJURY (Per person)	\$
	<input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS						BODILY INJURY (Per accident)	\$
	<input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	\$
A	<input checked="" type="checkbox"/> UMBRELLA LIAB			S 2417572	02/24/2022	02/24/2023	EACH OCCURRENCE	\$ 5,000,000
	<input type="checkbox"/> EXCESS LIAB	<input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS-MADE					AGGREGATE	\$ 5,000,000
	<input type="checkbox"/> DED <input checked="" type="checkbox"/> RETENTION \$ 0							\$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY			WCV6125268	03/28/2022	03/28/2023	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	N/A				E.L. EACH ACCIDENT	\$ 500,000
	If yes, describe under DESCRIPTION OF OPERATIONS below:						E.L. DISEASE - EA EMPLOYEE	\$ 500,000
							E.L. DISEASE - POLICY LIMIT	\$ 500,000

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

## CERTIFICATE HOLDER

## CANCELLATION

MI	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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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
03/15/2023

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<b>PRODUCER</b> Larkin Group of Traverse City 13900 S West Bay Shore Drive  Traverse City MI 49684		<b>CONTACT NAME:</b> Beth McCardel <b>PHONE (A/C, No, Ext):</b> (231) 947-8800 <b>FAX (A/C, No):</b> (231) 346-6111 <b>E-MAIL ADDRESS:</b> bmccardel@larkingrp.com	
<b>INSURED</b> DROST LANDSCAPE, INC. PO BOX 696 2010 CEDAR VALLEY ROAD PETOSKEY MI 49770-0696		<b>INSURER(S) AFFORDING COVERAGE</b> <b>INSURER A:</b> Selective Insurance Co of America <b>INSURER B:</b> Accident Fund Natl. Ins. Co. <b>INSURER C:</b> INTACT SPECIALTY SOLUTION <b>INSURER D:</b> <b>INSURER E:</b> <b>INSURER F:</b>	
		<b>NAIC #</b> 12305	

## COVERAGES

CERTIFICATE NUMBER: 2022/23

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
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 checked="" type="checkbox"/> PROJECT <input type="checkbox"/> LOC OTHER:			S 2417572	02/24/2022	02/24/2023	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 500,000 MED EXP (Any one person) \$ 15,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000 \$
	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" 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			S 2417572	02/24/2022	02/24/2023	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 type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED <input checked="" type="checkbox"/> RETENTION \$ 0			S 2417572	02/24/2022	02/24/2023	EACH OCCURRENCE \$ 5,000,000 AGGREGATE \$ 5,000,000 \$
	<input checked="" type="checkbox"/> 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 N	N/A	WCV6125268	03/28/2022	03/28/2023	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTHER E.L. EACH ACCIDENT \$ 500,000 E.L. DISEASE - EA EMPLOYEE \$ 500,000 E.L. DISEASE - POLICY LIMIT \$ 500,000
C	Pollution Liability			793-01-21-89-0000	10/05/2022	10/05/2023	Policy Limit \$1,000,000

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

## CERTIFICATE HOLDER

## CANCELLATION

Tuscarora Township

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



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

02/23/2022

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PRODUCER	CONTACT NAME: Beth McCardel
Larkin Group of Traverse City	PHONE (A/C, No, Ext): (231) 947-8800
13900 S West Bay Shore Drive	FAX (A/C, No): (231) 346-6111
	E-MAIL ADDRESS: bmccardel@larkingrp.com
Traverse City MI 49684	INSURER(S) AFFORDING COVERAGE
	INSURER A: Selective Insurance Co of America
INSURED	INSURER B: Accident Fund Natl. Ins. Co.
DROST LANDSCAPE, INC.	INSURER C:
PO BOX 696	INSURER D:
2010 CEDAR VALLEY ROAD	INSURER E:
PETOSKEY MI 49770-0696	INSURER F:

## COVERAGES

CERTIFICATE NUMBER: 2022/23

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
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 checked="" type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:			S 2417572	02/24/2022	02/24/2023	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 500,000 MED EXP (Any one person) \$ 15,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000
A	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY			S 2417572	02/24/2022	02/24/2023	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
A	<input checked="" type="checkbox"/> UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED <input checked="" type="checkbox"/> RETENTION \$ 0			S 2417572	02/24/2022	02/24/2023	EACH OCCURRENCE \$ 5,000,000 AGGREGATE \$ 5,000,000
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 N	N/A	WCV6125268	03/28/2022	03/28/2023	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ 500,000 E.L. DISEASE - EA EMPLOYEE \$ 500,000 E.L. DISEASE - POLICY LIMIT \$ 500,000

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

## CERTIFICATE HOLDER

## 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

MI

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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

12/19/2022

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.

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<b>PRODUCER</b> North Country Insurance Agency, Inc PO Box 518  Indian River MI 49749		<b>CONTACT NAME:</b> Terry Baxter <b>PHONE (A/C, No, Ext):</b> 231-238-9882 <b>FAX (A/C, No):</b> 231-238-4321 <b>E-MAIL ADDRESS:</b> Generalmail@northcountryins.com	
		<b>INSURER(S) AFFORDING COVERAGE</b>	
		<b>INSURER A:</b> Property-Owners Insurance Company	<b>NAIC #</b> 01063100
		<b>INSURER B:</b> Auto-Owners Insurance Company	01063100
		<b>INSURER C:</b> Home-Owners Insurance Company	01063100
		<b>INSURER D:</b>	
		<b>INSURER E:</b>	
		<b>INSURER F:</b>	

**COVERAGES****CERTIFICATE NUMBER:** 20211228170757751**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	ADOL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY			33023720	12/05/2022	12/05/2023	EACH OCCURRENCE \$ 2,000,000
	<input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR		DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 300,000				
			MED EXP (Any one person) \$ 10,000				
			PERSONAL & ADV INJURY \$ 2,000,000				
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE \$ 2,000,000
	<input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PROJECT <input type="checkbox"/> LOC						PRODUCTS - COMPI/OP AGG \$ 2,000,000
	OTHER:						\$
B	<input type="checkbox"/> AUTOMOBILE LIABILITY			53-935954-00	07/05/2022	07/05/2023	COMBINED SINGLE LIMIT (Ea accident) \$
	<input type="checkbox"/> ANY AUTO		BODILY INJURY (Per person) \$ 250,000				
	<input checked="" type="checkbox"/> OWNED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY		BODILY INJURY (Per accident) \$ 500,000				
	<input checked="" type="checkbox"/> HIRED AUTOS ONLY		PROPERTY DAMAGE (Per accident) \$ 100,000				
							\$
B	<input checked="" type="checkbox"/> UMBRELLA LIAB			49-023-420-01	12/05/2022	12/05/2023	EACH OCCURRENCE \$ 2,000,000
	<input type="checkbox"/> EXCESS LIAB	<input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS-MADE	AGGREGATE \$ 2,000,000				
	<input type="checkbox"/> DED <input type="checkbox"/> RETENTION \$		\$				
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY			33037255	12/05/2022	12/05/2023	PER STATUTE <input type="checkbox"/> OTH-ER <input type="checkbox"/>
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	<input type="checkbox"/> Y <input type="checkbox"/> N	E.L. EACH ACCIDENT \$ 500,000				
	If yes, describe under DESCRIPTION OF OPERATIONS below	N/A	E.L. DISEASE - EA EMPLOYEE \$ 500,000				
			E.L. DISEASE - POLICY LIMIT \$ 500,000				

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

**CERTIFICATE HOLDER****CANCELLATION**

Cheboygan County  
870 S Main St  
Cheboygan MI 49721

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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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

5/31/2022

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<b>PRODUCER</b> NFP Property & Casualty Services(Primary Casualty) 45 Executive Drive, Plainview, NY 11803 NFP Canada Corp*184 Front Street - Suite 601 Toronto ON M5A 4N3	<b>CONTACT NAME:</b> RISK MANAGEMENT NE <b>PHONE (A/C, No, Ext):</b> 516-327-2700 <b>E-MAIL ADDRESS:</b> RiskCerts@nfp.com <b>FAX (A/C, No):</b> 516-327-2800
<b>INSURED</b> GFL Environmental Holdings (US), Inc and its subsidiaries 3301 Benson Drive - Suite 601 Raleigh NC 27609	<b>INSURER(S) AFFORDING COVERAGE</b> INSURER A: Ironshore Specialty Insurance Company INSURER B: National Union Fire Insurance Company of Pittsburg INSURER C: Chubb Insurance Company of Canada INSURER D: AIU Insurance Company INSURER E: Underwriters Lloyds London INSURER F:
	<b>NAIC #</b> 25445 19445 19399 32727

**COVERAGES**

CERTIFICATE NUMBER: 910757927

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	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR  GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC <input checked="" type="checkbox"/> OTHER: Loc/Project Agg			6882279	6/1/2022	6/1/2023	EACH OCCURRENCE \$4,400,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$1,000,000 MED EXP (Any one person) \$10,000 PERSONAL & ADV INJURY \$4,400,000 GENERAL AGGREGATE \$20,000,000 PRODUCTS - COMP/OP AGG \$4,400,000 Loc/Project Agg \$4,400,000
B	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY			9767485 (AOS) 9767484 (VA)	6/1/2022 6/1/2022	6/1/2023 6/1/2023	COMBINED SINGLE LIMIT (Ea accident) \$4,400,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
C	<input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> EXCESS LIAB <input type="checkbox"/> DED <input checked="" type="checkbox"/> RETENTION \$10,000			XBC602852*	6/1/2022	6/1/2023	EACH OCCURRENCE \$7,500,000 AGGREGATE \$7,500,000 Limits shown in CND\$ \$
D	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 N	N/A	WC35901818 (AOS) WC35901819 (CA) WC35901820 (WI)	6/1/2022 6/1/2022 6/1/2022	6/1/2023 6/1/2023 6/1/2023	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$5,000,000 E.L. DISEASE - EA EMPLOYEE \$5,000,000 E.L. DISEASE - POLICY LIMIT \$5,000,000
A	Contractors Pollution Equipment Including Leased/Rented			ICELLUW00121214 UP2205227	6/1/2022 6/1/2022	6/1/2023 6/1/2023	Each Incident/Agg Limit Per Occurrence \$20,000,000 SELF INSURED

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

**CERTIFICATE HOLDER****CANCELLATION**

Evidence - Generic

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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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
12/16/2022

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).

<b>PRODUCER</b> Britton-Gallagher and Associates, Inc. One Cleveland Center, Floor 30 1375 East 9th Street Cleveland OH 44114	<b>CONTACT NAME:</b>	
	<b>PHONE (A/C, No, Ext):</b> 216-658-7100	<b>FAX (A/C, No):</b> 216-658-7101
<b>INSURED</b> Great Lakes Fireworks LLC 3275 W M76 P.O. Box 276 West Branch MI 48661	<b>E-MAIL ADDRESS:</b> info@brittongallagher.com	
	<b>INSURER(S) AFFORDING COVERAGE</b>	
	<b>INSURER A:</b> Everest Indemnity Insurance Co.	
	<b>INSURER B:</b> Everest Denali Insurance Company	
	<b>INSURER C:</b> Axis Surplus Ins Company	
	<b>INSURER D:</b>	
<b>INSURER E:</b>		
<b>INSURER F:</b>		

**COVERAGES** **CERTIFICATE NUMBER:** 656317220 **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
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 checked="" type="checkbox"/> PROJECT <input type="checkbox"/> LOC OTHER:			SI8GL01969-221	1/21/2022	1/21/2023	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 500,000 MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000
B	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS			SI8CA00273-221	1/21/2022	1/21/2023	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
C	<input type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> EXCESS LIAB <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$			P-001-000798280-01	2/4/2022	1/21/2023	EACH OCCURRENCE \$ 4,000,000 AGGREGATE \$ 4,000,000
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	N/A		PER STATUTE OTH-ER 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)  
Additional insured extension of coverage is provided by above referenced General Liability policy where required by written agreement.  
DISPLAY DATE: July 2nd, 2023 RAIN DATE: July 5th, 2023 LOCATION: Veterans Pier at DeVoe Beach: 6566 Oak Glen St., Indian River, MI 49749

Tuscarora Township including all its elected and appointed officials, employees, volunteers, board, commissions, and/or other authorities; Columbus Beach Club and all its members, boards, employees, and volunteers

<b>CERTIFICATE HOLDER</b>  TUSCARORA TOWNSHIP PO BOX 220 INDIAN RIVER MI 49749	<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 
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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
03/15/2023

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).

<b>PRODUCER</b> BKC Insurance Services 220 Water Street  Cheboygan MI 49721		<b>CONTACT NAME:</b> Rose Waite <b>PHONE (A/C, No, Ext):</b> <b>FAX (A/C, No):</b> <b>E-MAIL ADDRESS:</b> rwaite@bkcinurance.com	
<b>INSURED</b> K & J Septic Service, LLC 2360 River Rd  Potoskey MI 49770		<b>INSURER(S) AFFORDING COVERAGE</b> <b>INSURER A:</b> Michigan Ins Co <b>INSURER B:</b> Atlantic States Ins Co <b>INSURER C:</b> <b>INSURER D:</b> <b>INSURER E:</b> <b>INSURER F:</b>	
		<b>NAIC #</b> 10857 22586M	

## COVERAGES

CERTIFICATE NUMBER: CL2281223460

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
A	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY			CPJ9356718	09/01/2022	09/01/2023	EACH OCCURRENCE \$ 1,000,000
	<input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR		DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000				
			MED EXP (Any one person) \$ 5,000				
			PERSONAL & ADV INJURY \$ 1,000,000				
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE \$ 2,000,000
	<input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC						PRODUCTS - COMP/OP AGG \$ 2,000,000
	OTHER:						\$
A	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY			CCJ9356718	09/01/2022	09/01/2023	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000
	<input checked="" type="checkbox"/> ANY AUTO						BODILY INJURY (Per person) \$
	<input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS						BODILY INJURY (Per accident) \$
	<input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident) \$
							\$
A	<input checked="" type="checkbox"/> UMBRELLA LIAB			CXJ9356718	09/01/2022	09/01/2023	EACH OCCURRENCE \$ 5,000,000
	<input type="checkbox"/> EXCESS LIAB						AGGREGATE \$ 5,000,000
	<input type="checkbox"/> DED <input type="checkbox"/> RETENTION \$						\$
	<input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS-MADE						
B	<input checked="" type="checkbox"/> WORKERS COMPENSATION AND EMPLOYERS' LIABILITY			1000015062	09/01/2022	09/01/2023	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	Y/N					E.L. EACH ACCIDENT \$ 500,000
	If yes, describe under DESCRIPTION OF OPERATIONS below	Y	N/A				E.L. DISEASE - EA EMPLOYEE \$ 500,000
							E.L. DISEASE - POLICY LIMIT \$ 500,000

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

<b>CERTIFICATE HOLDER</b>  Tuscarora Township 3545 S Straits Hwy  Indian River MI 49749	<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  <i>Rose M Waite</i>
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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

6/30/2022

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).

<b>PRODUCER</b> Hylant - Grand Rapids 85 Campau Ave. NW, Ste 100 Grand Rapids MI 49503	<b>CONTACT NAME:</b>
	<b>PHONE (A/C, No, Ext):</b> 616-855-7900 <b>FAX (A/C, No):</b> 616-855-7910
<b>INSURED</b> Kalamazoo Sanitary Supply, Inc. DBA KSS Enterprises 5053 Sports Dr Kalamazoo MI 49009-7117	<b>E-MAIL ADDRESS:</b> GRCerts@hylant.com
	<b>INSURER(S) AFFORDING COVERAGE</b>
<b>License#:</b> 23894 <b>KALASAN-01</b>	<b>INSURER A:</b> FCCI Insurance Company <b>NAIC #</b> 10178
	<b>INSURER B:</b>
	<b>INSURER C:</b>
	<b>INSURER D:</b>
	<b>INSURER E:</b>
	<b>INSURER F:</b>

**COVERAGES****CERTIFICATE NUMBER:** 1335978063**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
A	<input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b> <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR  GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PROJECT <input checked="" type="checkbox"/> LOC OTHER:			CPP100058615	7/5/2022	7/5/2023	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 \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000 \$
A	<input checked="" type="checkbox"/> <b>AUTOMOBILE LIABILITY</b> <input checked="" type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY			CA100057564	7/5/2022	7/5/2023	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
A	<input checked="" type="checkbox"/> <b>UMBRELLA LIAB</b> <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> DED <input checked="" type="checkbox"/> RETENTION \$ 0			UMB100058616	7/5/2022	7/5/2023	EACH OCCURRENCE \$ 10,000,000 AGGREGATE \$ 10,000,000 \$
A	<input checked="" type="checkbox"/> <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	WC0100058617	7/5/2022	7/5/2023	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.I. EACH ACCIDENT \$ 500,000 E.I. DISEASE - EA EMPLOYEE \$ 500,000 E.I. DISEASE - POLICY LIMIT \$ 500,000

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

**CERTIFICATE HOLDER****CANCELLATION**

For Informational Purposes

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

*Nicholas R. Hylant*

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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
09/20/2022

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).

<b>PRODUCER</b> FEDERATED MUTUAL INSURANCE COMPANY HOME OFFICE: P.O. BOX 328 OWATONNA, MN 55060		<b>CONTACT NAME:</b> CLIENT CONTACT CENTER <b>PHONE (A/C, No, Ext):</b> 888-333-4949 <b>FAX (A/C, No):</b> 507-446-4664 <b>E-MAIL ADDRESS:</b> CLIENTCONTACTCENTER@FEDINS.COM	
<b>INSURED</b> M & M PLUMBING, HEATING AND COOLING, INC. PO BOX 576 INDIAN RIVER, MI 49749-0576		<b>INSURER(S) AFFORDING COVERAGE</b> <b>INSURER A:</b> FEDERATED MUTUAL INSURANCE COMPANY <b>INSURER B:</b> <b>INSURER C:</b> <b>INSURER D:</b> <b>INSURER E:</b> <b>INSURER F:</b>	
202-292-9		NAIC # 13935	

## COVERAGES

CERTIFICATE NUMBER: 0

REVISION NUMBER: 0

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	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR  GENERAL AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:	N	N	1837774	07/29/2022	07/29/2023	EACH OCCURRENCE \$1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$100,000 MED EXP (Any one person) EXCLUDED PERSONAL & ADV INJURY \$1,000,000 GENERAL AGGREGATE \$2,000,000 PRODUCTS - COM/OP AGG \$2,000,000
A	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" 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	N	N	1837774	07/29/2022	07/29/2023	COMBINED SINGLE LIMIT (Ea accident) \$1,000,000 BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)
A	<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 type="checkbox"/> RETENTION	N	N	1837776	07/29/2022	07/29/2023	EACH OCCURRENCE \$2,000,000 AGGREGATE \$2,000,000
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	<input type="checkbox"/> Y <input type="checkbox"/> N	N/A	1837775	07/29/2022	07/29/2023	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$500,000 E.L. DISEASE - EA EMPLOYEE \$500,000 E.L. DISEASE - POLICY LIMIT \$500,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)  
THIS COPY IS NOT TO BE REPRODUCED FOR ISSUANCE OF CERTIFICATES.

## CERTIFICATE HOLDER

## CANCELLATION

A CERTIFICATE HAS BEEN FILED WITH EACH OF YOUR CERTIFICATE HOLDERS.	00	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>Michael G Kern</i>	

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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

2/10/2023

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).

<b>PRODUCER</b> North Country Insurance Agency, Inc PO Box 518  Indian River MI 49749		<b>CONTACT NAME:</b> Kate Porter <b>PHONE (A/C, No. Ext):</b> 231-238-9882 <b>FAX (A/C, No):</b> 231-238-4321 <b>E-MAIL ADDRESS:</b> Generalmail@northcountryins.com	
		<b>INSURER(S) AFFORDING COVERAGE</b> INSURER A: Auto Owners Insurance Company	<b>NAIC #</b> 01063100
<b>INSURED</b> Michael Mattson Julie Mattson DBA Mattson & Sons Well Drilli 9558 S. Straits Hwy. Wolverine MI 49799-9761		INSURER B: INSURER C: INSURER D: INSURER E: INSURER F:	

**COVERAGES**

CERTIFICATE NUMBER: 20230210131720490

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	
A	COMMERCIAL GENERAL LIABILITY			33162112	03/11/2022	03/11/2023	EACH OCCURRENCE	\$ 1,000,000
	<input checked="" type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	\$ 300,000
							MED EXP (Any one person)	\$ 10,000
							PERSONAL & ADV INJURY	\$ 1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	\$ 2,000,000
	<input type="checkbox"/> POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOG						PRODUCTS - COMP/OP AGG	\$ 2,000,000
	OTHER:							\$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	\$
	ANY AUTO						BODILY INJURY (Per person)	\$
	OWNED AUTOS ONLY						BODILY INJURY (Per accident)	\$
	HIRED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	\$
	SCHEDULED AUTOS							\$
	NON-OWNED AUTOS ONLY							\$
	UMBRELLA LIAB						EACH OCCURRENCE	\$
	EXCESS LIAB						AGGREGATE	\$
	DED							\$
	RETENTION \$							\$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY			33084078	03/11/2022	03/11/2023	PER STATUTE	OTH-ER
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	Y/N						
	If yes, describe under DESCRIPTION OF OPERATIONS below							
							E.L. EACH ACCIDENT	\$ 500,000
							E.L. DISEASE - EA EMPLOYEE	\$ 500,000
							E.L. DISEASE - POLICY LIMIT	\$ 500,000

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

**CERTIFICATE HOLDER****CANCELLATION**

Tuscarora Township  
5454 S Straits Hwy  
Indian River, MI 49749

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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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

6/30/2022

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).

<b>PRODUCER</b> Holmes Murphy Associates/CSDZ, LLC 225 South Sixth Street STE 1900 Minneapolis MN 55402	<b>CONTACT NAME:</b> Allie Darling <b>PHONE (A/C, No, Ext):</b> 612-322-6041 <b>FAX (A/C, No):</b> <b>E-MAIL ADDRESS:</b> adarling@csdz.com
<b>INSURED</b> M&H Facility Operations, Inc. 2440 Deming Way Middleton, WI 53562	<b>INSURER(S) AFFORDING COVERAGE</b> <b>INSURER A:</b> XL Specialty Insurance <b>INSURER B:</b> Zurich American Insurance Company <b>INSURER C:</b> American Guarantee & Liability Ins. Co. <b>INSURER D:</b> <b>INSURER E:</b> <b>INSURER F:</b>

**COVERAGES****CERTIFICATE NUMBER:** 679062624**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	<input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b> <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR <input checked="" type="checkbox"/> Cont Liab Per <input checked="" type="checkbox"/> Policy Form/XCU GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PROJECT <input checked="" type="checkbox"/> LOC OTHER:			GLO138723300	7/1/2022	7/1/2023	EACH OCCURRENCE \$2,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$500,000 MED EXP (Any one person) \$50,000 PERSONAL & ADV INJURY \$2,000,000 GENERAL AGGREGATE \$4,000,000 PRODUCTS - COMP/OP AGG \$4,000,000 \$
B	<input checked="" type="checkbox"/> <b>AUTOMOBILE LIABILITY</b> <input checked="" type="checkbox"/> ANY AUTO OWNED AUTOS ONLY HIRED AUTOS ONLY SCHEDULED AUTOS NON-OWNED AUTOS ONLY			BAP138723100	7/1/2022	7/1/2023	COMBINED SINGLE LIMIT (Ea accident) \$2,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
C	<input checked="" type="checkbox"/> <b>UMBRELLA LIAB</b> <input checked="" type="checkbox"/> EXCESS LIAB DED <input checked="" type="checkbox"/> RETENTION \$ 0			AUC095226000	7/1/2022	7/1/2023	EACH OCCURRENCE \$10,000,000 AGGREGATE \$10,000,000 \$
C	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N N	N/A	WC138723300	7/1/2022	7/1/2023	<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
B A	Property Professional Liability			CPP182316700 DPR9995754	7/1/2022 7/1/2022	7/1/2023 7/1/2023	Bldg/BPP: \$21,406,735 Per Claim: \$10,000,000 Per Aggregate: \$10,000,000

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

**CERTIFICATE HOLDER****CANCELLATION**

Tuscarora Township 3546 South Straits Highway Indian River MI 49749	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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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
03/15/2023

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).

<b>PRODUCER</b> BKC Insurance Services 220 Water Street  Cheboygan MI 49721	<b>CONTACT NAME:</b> Rose Waite <b>PHONE (A/C, No, Ext):</b> <b>FAX (A/C, No):</b> <b>E-MAIL ADDRESS:</b> rwaite@bkcinurance.com <b>INSURER(S) AFFORDING COVERAGE</b> <b>INSURER A:</b> Benchmark Insurance Co <b>INSURER B:</b> <b>INSURER C:</b> <b>INSURER D:</b> <b>INSURER E:</b> <b>INSURER F:</b>
<b>INSURED</b> Merchant Excavating & Septic Inc. 485 VFW Rd.  Cheboygan MI 49721	<b>NAIC #</b>

**COVERAGES** **CERTIFICATE NUMBER:** CL2231604552 **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
A	<input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b> <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:			CP5000618	01/06/2022	01/06/2023	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 \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000
A	<b>AUTOMOBILE LIABILITY</b> <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY			CA5000276	01/06/2022	01/06/2023	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 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 <input type="checkbox"/> RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$
A	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below Y/N <input checked="" type="checkbox"/> Y	N/A		WC5000824	01/06/2022	01/06/2023	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ 500,000 E.L. DISEASE - EA EMPLOYEE \$ 500,000 E.L. DISEASE - POLICY LIMIT \$ 500,000

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

<b>CERTIFICATE HOLDER</b> Tuscarora Township  Indian River MI 49749	<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.  <b>AUTHORIZED REPRESENTATIVE</b> <i>Rose M Waite</i>
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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

2/13/2023

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 Peterson McGregor & Associates 1368 Business Park Dr Traverse City MI 49686	CONTACT NAME: Tammy Manders	PHONE (A/C, No, Ext): 231-489-7037	FAX (A/C, No): 231-922-7275
	E-MAIL ADDRESS: tmanders@team-pma.com		
INSURED Northern Power Sweeping Services, LLC DBA Otsego Excavating 7808 Wilkinson Rd. Gaylord MI 49735	INSURER(S) AFFORDING COVERAGE		NAIC #
	INSURER A: Fremont Mutual Ins Co		13994
	INSURER B:		
	INSURER C:		
	INSURER D:		
	INSURER E:		
INSURER F:			

## COVERAGES

CERTIFICATE NUMBER: 794100675

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/SUBR INSD WVD	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 checked="" type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:		CPP0107175	4/1/2022	4/1/2023	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 \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000 \$
A	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY		CAP0037952	4/1/2022	4/1/2023	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
A	<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 \$ 10,000		CUP0037253	4/1/2022	4/1/2023	EACH OCCURRENCE \$ 1,000,000 AGGREGATE \$ 1,000,000 \$
A	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	N/A	WCP0029516	4/1/2022	4/1/2023	<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

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

## CERTIFICATE HOLDER

## CANCELLATION

Tuscarora Township

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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NORTTAN-01

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## CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

3/14/2023

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).

<b>PRODUCER</b> General Agency Company 525 E. Broadway Mount Pleasant, MI 48858	<b>CONTACT NAME:</b> Jennifer Robinson		
	<b>PHONE (A/C, No, Ext):</b> (989) 817-4265	<b>FAX (A/C, No):</b> (989) 772-1855	
	<b>E-MAIL ADDRESS:</b> jrobinson@ga-ins.com		
<b>INSURED</b>  Northern Tank Truck Service PO Box 8 Waters, MI 49797	<b>INSURER(S) AFFORDING COVERAGE</b>		<b>NAIC #</b>
	<b>INSURER A:</b> HDI Global Insurance Company		41343
	<b>INSURER B:</b> Accident Fund Ins Co of America		10166
	<b>INSURER C:</b> GuideOne National Insurance Company		14167
	<b>INSURER D:</b>		
	<b>INSURER E:</b>		
<b>INSURER F:</b>			

## 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
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 checked="" type="checkbox"/> POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC OTHER:			GG09C00017803	1/1/2022	1/1/2023	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000 MED EXP (Any one person) \$ 10,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000
A	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY			GA09C00044001	1/1/2022	1/1/2023	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
A	<input checked="" type="checkbox"/> UMBRELLA LIAB <input type="checkbox"/> EXCESS LIAB DED <input checked="" type="checkbox"/> RETENTION \$ 10,000 <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS-MADE			GU09C00017803	1/1/2022	1/1/2023	EACH OCCURRENCE \$ 1,000,000 AGGREGATE \$ 1,000,000 Pers/Adv Inj \$ 1,000,000
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY 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	WCV6179703	1/1/2022	1/1/2023	<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
C	Excess Umbrella			56000290000	1/1/2022	1/1/2023	Occurrence/Aggregate 3,000,000

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

## CERTIFICATE HOLDER

## CANCELLATION

Tuscarora Township  
3546 S Straits Highway  
PO Box 220  
Indian River, MI 49749

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





# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

04/04/2022

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.

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<b>PRODUCER</b>  <b>Loyalty Insurance Agency Inc.</b> <b>41575 Joy Road Ste 100</b> <b>Canton, MI 48187</b>	<b>CONTACT NAME:</b> Sandra Canedo	<b>FAX (A/C, No):</b> 734-454-5457	
	<b>PHONE (A/C, No, Ext):</b> 734-454-5450	<b>E-MAIL ADDRESS:</b> sandra@loyaltyinsurance.com	
<b>INSURED</b>  <b>Ostlund Pest Control North Inc</b> <b>PO Box 700</b> <b>Indian River, MI 49749</b>	<b>INSURER(S) AFFORDING COVERAGE</b>		<b>NAIC #</b>
	<b>INSURER A:</b> Secura Insurance Companies		<b>22543</b>
	<b>INSURER B:</b> Secura Insurance Company		<b>22543</b>
	<b>INSURER C:</b> Accident Fund Insurance Company of America		
	<b>INSURER D:</b>		
	<b>INSURER E:</b>		
<b>INSURER F:</b>			

**COVERAGES****CERTIFICATE NUMBER:** 00019035-619023**REVISION NUMBER:** 15

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 SUBR INSD WVD	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 checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:		CP3265743	04/01/2022	04/01/2023	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 300,000 MED EXP (Any one person) \$ 10,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000
B	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY		A3326601	04/01/2022	04/01/2023	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED <input type="checkbox"/> RETENTION \$					EACH OCCURRENCE \$ AGGREGATE \$
C	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 checked="" type="checkbox"/> Y N/A	AF WCP 100039168	04/05/2022	04/05/2023	<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

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

Workers Comp: Marie Burfiend

**CERTIFICATE HOLDER****CANCELLATION****Ostlund Pest Control North Inc**  
**PO Box 700**  
**Indian River, MI 49749**

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

(SCA)



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

04/04/2022

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	CONTACT NAME: Sandra Canedo PHONE (A/C, No, Ext): 734-454-5450 E-MAIL ADDRESS: sandra@loyaltyinsurance.com	FAX (A/C, No): 734-454-5457
Loyalty Insurance Agency Inc. 41575 Joy Road Ste 100 Canton, MI 48187	INSURER(S) AFFORDING COVERAGE	
INSURED	INSURER A:	Secura Insurance Companies
	INSURER B:	Secura Insurance Company
	INSURER C:	Accident Fund Insurance Company of America
	INSURER D:	
	INSURER E:	
Ostlund Pest Control North Inc PO Box 700 Indian River, MI 49749	INSURER F:	

## COVERAGES

CERTIFICATE NUMBER: 00019035-619023

REVISION NUMBER: 15

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
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 checked="" type="checkbox"/> POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC OTHER:			CP3265743	04/01/2022	04/01/2023	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 300,000 MED EXP (Any one person) \$ 10,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000
B	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY			A3326601	04/01/2022	04/01/2023	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED <input type="checkbox"/> RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$
C	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 Y	N/A	AF WCP 100039168	04/05/2022	04/05/2023	<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

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

Workers Comp: Marie Burfiend

## CERTIFICATE HOLDER

## CANCELLATION

Ostlund Pest Control North Inc  
PO Box 700  
Indian River, MI 49749

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

Sandra Canedo (SCA)

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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YY)  
02/14/2023

PRODUCER <b>DESIGNPRO INSURANCE GROUP</b> P.O. BOX 511106 LIVONIA, MI 48151 E-MAIL: <a href="mailto:DESIGNPRO@AMERITECH.NET">DESIGNPRO@AMERITECH.NET</a>	PH: 734-425-9710	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 <b>PERFORMANCE ENGINEERS, INC.</b> 406 PETOSKEY AVENUE CHARLEVOIX, MI 49720	<table border="1"><thead><tr><th>INSURERS AFFORDING COVERAGE</th><th>NAIC#</th></tr></thead><tbody><tr><td>INSURER A: CNA INSURANCE COMPANY</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></tbody></table>		INSURERS AFFORDING COVERAGE	NAIC#	INSURER A: CNA INSURANCE COMPANY		INSURER B:		INSURER C:		INSURER D:		INSURER E:	
INSURERS AFFORDING COVERAGE	NAIC#													
INSURER A: CNA INSURANCE COMPANY														
INSURER B:														
INSURER C:														
INSURER D:														
INSURER E:														

## COVERAGES

Serial # 100901

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 INSR	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YYYY)	POLICY EXPIRATION DATE (MM/DD/YYYY)	LIMITS
		<b>GENERAL LIABILITY</b> <input type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> OCCUR  GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC				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"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS				COMBINED SINGLE LIMIT (Ea accident) \$  BODILY INJURY (Per person) \$  BODILY INJURY (Per accident) \$  PROPERTY DAMAGE (Per accident) \$
		<b>GARAGE LIABILITY</b> <input type="checkbox"/> ANY AUTO				AUTO ONLY - EA ACCIDENT \$  OTHER THAN AUTO ONLY: EA ACC \$ AGG \$
		<b>EXCESS / UMBRELLA LIABILITY</b> <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE  DEDUCTIBLE RETENTION \$				EACH OCCURRENCE \$ AGGREGATE \$ \$ \$ \$
		<b>WORKER'S COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? <input type="checkbox"/> Y / <input type="checkbox"/> N (Mandatory in NH) If yes, describe under SPECIAL PROVISIONS below				WC STATUTORY LIMITS <input type="checkbox"/> OTH-ER <input type="checkbox"/> E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
A		<b>OTHER</b> <b>ARCHITECTS/ENGINEERS PROFESSIONAL LIABILITY</b>	#AEH-591899495	04-01-22	04-01-23	PER CLAIM LIMIT : \$1,000,000 AGGREGATE LIMIT : \$1,000,000

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

## CERTIFICATE HOLDER

TUSCARORA TOWNSHIP  
3546 S. STRAITS HIGHWAY  
INDIAN RIVER, MI 49749

## CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER 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



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

3/14/2023

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).

<b>PRODUCER</b> Peterson McGregor & Associates 1368 Business Park Dr Traverse City MI 49686	<b>CONTACT NAME:</b> Janet Douglas <b>PHONE (A/C, No, Ext):</b> 231-944-7027 <b>E-MAIL ADDRESS:</b> jdouglas@team-pma.com <b>FAX (A/C, No):</b> 231-922-7275
<b>INSURED</b> Ramsby Drilling, Inc. 1865 S Straits Hwy Indian River MI 49749	<b>INSURER(S) AFFORDING COVERAGE</b> INSURER A : Hastings Mutual Insurance Co. INSURER B : INSURER C : INSURER D : INSURER E : INSURER F :
RAMDR-1	NAIC # 14176

**COVERAGES**

CERTIFICATE NUMBER: 1604392077

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
A	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC <input type="checkbox"/> OTHER:			CPP9702127	1/1/2022	1/1/2023	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 \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000 \$
A	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> NON-OWNED AUTOS ONLY			ACV9700030	1/1/2022	1/1/2023	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
A	<input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> EXCESS LIAB <input type="checkbox"/> DED <input checked="" type="checkbox"/> RETENTION \$ 0 <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS-MADE			ULC9700032	1/1/2022	1/1/2023	EACH OCCURRENCE \$ 5,000,000 AGGREGATE \$ 5,000,000 \$
A	<input checked="" type="checkbox"/> 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 N	N/A	0009700031	1/1/2022	1/1/2023	<input checked="" type="checkbox"/> PER STATUTE E.L. EACH ACCIDENT \$ 500,000 E.L. DISEASE - EA EMPLOYEE \$ 500,000 E.L. DISEASE - POLICY LIMIT \$ 500,000

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

**CERTIFICATE HOLDER****CANCELLATION**

Tuscarora Township  
PO Box 220  
Indian River MI 49749

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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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

2/13/2023

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**  
Peterson McGregor & Associates  
1368 Business Park Dr  
Traverse City MI 49686

**CONTACT**  
NAME: Janet Douglas  
PHONE (A/C, No, Ext): 231-944-7027 FAX (A/C, No): 231-922-7275  
E-MAIL ADDRESS: jdouglas@team-pma.com

**INSURED**  
Ramsby Drilling, Inc.  
1865 S Straits Hwy  
Indian River MI 49749

RAMDR-1

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A: Hastings Mutual Insurance Co	14176
INSURER B:	
INSURER C:	
INSURER D:	
INSURER E:	
INSURER F:	

**COVERAGES**

CERTIFICATE NUMBER: 659482824

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
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 checked="" type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:			CPP9702127	1/1/2023	1/1/2024	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 \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000 \$
A	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> NON-OWNED AUTOS ONLY			ACV9700030	1/1/2023	1/1/2024	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
A	<input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> EXCESS LIAB <input type="checkbox"/> DED <input checked="" type="checkbox"/> RETENTION \$ 0 <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS-MADE			ULC9700032	1/1/2023	1/1/2024	EACH OCCURRENCE \$ 5,000,000 AGGREGATE \$ 5,000,000 \$
A	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	0009700031	1/1/2023	1/1/2024	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ 500,000 E.L. DISEASE - EA EMPLOYEE \$ 500,000 E.L. DISEASE - POLICY LIMIT \$ 500,000

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

**CERTIFICATE HOLDER**

Tuscarora Township  
PO Box 220  
Indian River MI 49749

**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

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# NOTICE OF EXCLUSION

Michigan Department of Licensing and Regulatory Affairs  
Workers' Compensation Agency  
PO Box 30016, Lansing, MI 48909  
(517) 284-8922

## DEPARTMENT OF LICENSING and REGULATORY AFFAIRS WORKERS' COMPENSATION AGENCY NOTICE OF EXCLUSION (WC-337 ON FILE)

8-22-19 MJH

Read instructions and general information sheet prior to completing

A. Company/Business Name(s) <u>Rhadigan &amp; Sons Inc</u>		Telephone Number <u>517 242 7757</u>		D. Federal ID Number <u>38 280 2606</u>	
B. Principal Office Address (Street Number and Name) <u>3673 Greenman's Pt</u>		City <u>Cheboygan</u>		State <u>MI</u>	ZIP Code <u>49721</u>
C. Type of Business <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Liability Company <input checked="" type="checkbox"/> Corporation					
E. Name of sole proprietor, partners, officers of corporation, or members who are also managers of limited liability company.					
Name <u>Denise H. Rhadigan</u>		Title <u>President</u>			
Name <u>John V. Rhadigan</u>		Title <u>Secretary/treasurer</u>			
Name <u>Eric M. Rhadigan</u>		Title <u>vice President</u>			
Name <u></u>		Title <u></u>			
F. PERSONS SIGNING BELOW CERTIFY THAT THEY ARE EMPLOYED BY EMPLOYER AND ARE ELIGIBLE TO BE EXCLUDED UNDER THE MICHIGAN WORKERS' DISABILITY COMPENSATION ACT (SEE INSTRUCTIONS AND GENERAL INFORMATION SHEET). EACH PERSON SIGNING THIS FORM VOLUNTARILY ELECTS TO BE EXCLUDED FROM BEING CONSIDERED AN EMPLOYEE UNDER THE ACT. THIS EXCLUSION REMAINS IN EFFECT NO MORE THAN 20 DAYS AFTER THE NOTICE OF TERMINATION OF EXCLUSION, FORM WC-338, IS RECEIVED BY OUR AGENCY. (SEE R408.41C)					
Name of Employee (Type or Print) <u>Denise H. Rhadigan</u>		Signature of Employee <u>[Signature]</u>		Social Security Number <u>XXX-XX-7240</u>	
<input checked="" type="checkbox"/> Corporate Officer <input type="checkbox"/> Partner <input type="checkbox"/> Member and Manager <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent					
Name of Employee (Type or Print) <u>John V. Rhadigan</u>		Signature of Employee <u>[Signature]</u>		Social Security Number <u>XXX-XX-7343</u>	
<input checked="" type="checkbox"/> Corporate Officer <input type="checkbox"/> Partner <input type="checkbox"/> Member and Manager <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent					
Name of Employee (Type or Print) <u>Eric M. Rhadigan</u>		Signature of Employee <u>[Signature]</u>		Social Security Number <u>XXX-XX-8061</u>	
<input checked="" type="checkbox"/> Corporate Officer <input type="checkbox"/> Partner <input type="checkbox"/> Member and Manager <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent					
Name of Employee (Type or Print) <u></u>		Signature of Employee <u></u>		Social Security Number <u>XXX-XX-</u>	
<input type="checkbox"/> Corporate Officer <input type="checkbox"/> Partner <input type="checkbox"/> Member and Manager <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent					
G. As an authorized representative of the employer, I have read sections 418.161(2), 418.161(3), 418.161(4), and 418.161(5) of the Michigan Workers' Disability Compensation Act of 1969. I have also read rule 408.41b and rule 408.41c. I certify that the excluded employees comprise all of the employees of this employer and are eligible to be excluded. I understand this exclusion shall remain in effect no more than 20 days after the Notice of Termination of Exclusion, Form WC-338, is received by the agency. I further certify that all parties signing this exclusion have received a copy prior to filing.					
<u>[Signature]</u> Employer Authorized Signature		Subscribed and sworn to before me this <u>20th</u> day of <u>August</u> , 20 <u>19</u> .			
<u>Denise H. Rhadigan / Pres</u> Employer Authorized Representative/Title (Please Print)		<u>Kate Porter</u> Notary Public			
		County: <u>Cheboygan</u> Commission Expires: <u>April 26, 2023</u>			

LARA is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.

Authority: **KATE PORTER**  
Notary Public, STATE OF MICHIGAN  
Penalty: **COUNTY OF CHEBOYGAN**  
My Commission Expires **April 26, 2023**  
Acting in the County of Cheboygan

# CERTIFICATE OF INSURANCE

☐ FARM BUREAU MUTUAL INSURANCE COMPANY OF MICHIGAN  
☒ FARM BUREAU GENERAL INSURANCE COMPANY OF MICHIGAN

Lansing, Michigan 48909

☐ AMENDED

Name and Address of Certificate Holder:

TUSCARORA TWP

Named Insured and Address:

 ROSE'S SEPTIC SERVICE LLC  
 4296 LEVERING RD  
 CHEBOYGAN MI 49721

Issue Date: 02/10/2023

This is to certify that the following policy(ies) of insurance has (have) been or will be issued by the Company to the Named Insured. This certificate is not a guarantee that the policy(ies) will remain in effect until its (their) stated expiration date. In the event of cancellation of any of the insurance policies before the expiration date, the Company will endeavor to mail notice of such cancellation to the Certificate Holder designated above at their last known address, but failure to mail such notice shall impose no obligation or liability of any kind upon the Company. 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 policy(ies) of insurance indicated below. The information conveyed in this Certificate of Insurance is only valid for the indicated policy periods. Certificates of Insurance for subsequent policy periods must be requested by the Certificate Holder.

Type of Insurance	Policy Number	Policy Period	Limits of Liability
Business Auto Liability • Specifically Described Autos (Symbol 7)  <input type="checkbox"/> Hired Auto (Symbol 8) <input type="checkbox"/> Non-Owned Auto (Symbol 9)	BAP-2758071	Eff. 03/05/2022 Exp. 03/05/2023	Combined Single Limit Each Accident \$ 300,000
Worker's Disability Compensation		Eff. Exp.	Coverage A - Statutory Coverage B - Bodily Injury by Accident \$ Each Accident (Employer's Liab.) Bodily Injury by Disease \$ Each Employee Bodily Injury by Disease \$ Policy Limit
Comprehensive General Liability or Commercial Package <input checked="" type="checkbox"/> Including <input type="checkbox"/> Excluding Products-Completed Operations <input type="checkbox"/> Hired Auto <input type="checkbox"/> Non-Owned Auto <input type="checkbox"/> CERTIFICATE HOLDER Is an Additional Insured on the Comprehensive General Liability Policy. <input type="checkbox"/> Excluding:	S2757256	Eff. 03/08/2022 Exp. 03/08/2023	Each Occurrence \$ 500,000 Products Aggregate \$ 1,000,000 General Aggregate \$ 1,000,000  Medical Payments Limit \$ 10,000
Owners' or Contractors' Protective Liability		Eff. Exp.	Each Occurrence \$ General Aggregate \$
Products - Completed Operations Liability		Eff. Exp.	Each Occurrence \$ Products Aggregate \$
Umbrella Liability		Eff. Exp.	Limit \$
Farmowners Liability Including Products Business Pursuits <input type="checkbox"/> Excluded <input type="checkbox"/> Included		Eff. Exp.	Limit \$ Type: Describe:
Other		Eff. Exp.	

  
 Authorized Signature

5173

Agent No.

(231) 627-9061

Agent Phone Number



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
02/17/2023

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).

<b>PRODUCER</b> Burns & Eustice Insurance 220 Water Street  Cheboygan MI 49721		<b>CONTACT NAME:</b> Jessica Duquette <b>PHONE (A/C, No, Ext):</b> (231) 844-0701 <b>FAX (A/C, No):</b> <b>E-MAIL ADDRESS:</b> jduquette@bkcsurance.com	
		<b>INSURER(S) AFFORDING COVERAGE</b>	
		<b>INSURER A:</b> Pioneer State Mutual Ins. Co	
		<b>INSURER B:</b>	
		<b>INSURER C:</b>	
		<b>INSURER D:</b>	
		<b>INSURER E:</b>	
		<b>INSURER F:</b>	

**COVERAGES** **CERTIFICATE NUMBER:** CL2241408152 **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
A	<input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b> <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR			PK00000493	03/15/2022	03/15/2023	EACH OCCURRENCE \$ 1,000,000
			DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 50,000				
			MED EXP (Any one person) \$ 5,000				
			PERSONAL & ADV INJURY \$ 1,000,000				
	GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:						GENERAL AGGREGATE \$ 2,000,000
							PRODUCTS - COMP/OP AGG \$ 2,000,000
							GLADV \$
	<b>AUTOMOBILE LIABILITY</b> <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <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"/> EXCESS LIAB <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS-MADE						EACH OCCURRENCE \$
							AGGREGATE \$
							\$
	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below						PER STATUTE <input type="checkbox"/> OTH-ER <input type="checkbox"/>
							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)  
Certificate holder

<b>CERTIFICATE HOLDER</b> Tuscarora Township 3546 S Straits Hwy PO Box 220 Indian River MI 49749	<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 
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## Determination of Worker Status

**Purpose:** Policyholders submit this form to request the determination of the status of a worker for the purpose of completing his or her workers compensation audit. This form will only be used to determine whether or not remuneration paid to a worker will be included on the policyholder's audit. This form is only valid for the worker and policy period listed below. This determination is for the audit period in question and does not affect the payment of claims.

**Completing the form:** Answer all questions as completely as possible. **Attach additional sheets if you need more space.** Provide information for the worker and policy period stated below. Determinations are based on the entire relationship between the policyholder and worker.

TUSCARORA TOWNSHIP

Accident Fund Policyholder

Policy Period

WCV 0215291 16 01

Policy Number

In order to make a determination as to whether an Employer/Employee status exists, please complete this analysis and provide as much of the following documentation as possible. This information must be provided on an annual basis.

Worker's Name <b>Ellen August</b>		Worker's DBA (applicable) <b>Classic Cleaning</b>	
Worker's Address (Include street address, city, state and Zip code.) <b>10701 Parke Rd., Alanson, MI 49706</b>		Worker's Tax ID <div style="background-color: black; width: 100px; height: 1.2em;"></div>	
Worker is a:	<input checked="" type="checkbox"/> Sole Proprietorship  Did the sole proprietor use any employees, casual labor, or uninsured subcontractors to complete the work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation	<input type="checkbox"/> Limited Liability Company

- A. How did the worker obtain the job? ☐ Application ☒ Bid ☐ Employment Agency ☐ Other (specify)  
 Type of pay the worker receives: ☐ Salary ☐ Commission ☒ Hourly Wage ☐ Piece Work ☐ Lump sum ☐ Other (specify)
- B. If the work is done under a written agreement between the policyholder and the worker, attach a copy (preferably signed by both parties). Describe the terms and conditions of the work arrangement.
- C. What specific training or instruction is the worker given by the policyholder? **None**
- D. How does the worker receive work assignments? And who determines how and when the assignments are performed? **Per attached copy**
- E. Is the worker required to provide the services personally? **No**
- F. If substitutes or helpers are needed, who hires them? **Self** Who pays them? **Classic Cleaning**
- G. List the supplies, equipment, materials and property provided by each party:  
 The policyholder: **All**  
 The worker: **None**  
 Other party: **None**
- H. What expenses are incurred by the worker in the performance of services for the policyholder? **None**
- I. Does the worker carry insurance (e.g., workers compensation, general liability, etc.)? If "Yes", please attach copies. **Yes**
- J. List the benefits available to the worker (e.g., paid vacations, sick pay, pensions, bonuses). **None**
- K. Can the relationship be terminated by either party without incurring liability or penalty? If "No," explain your answer. **Yes**
- L. Does the worker perform similar services for others? If "Yes," is the worker required to get approval from the policyholder? **Yes/No**
- M. What type of advertising, if any, does the worker do (e.g., business listing in a directory, business cards, etc.)? Provide copies, if applicable. **None**

**Signature**

I declare that I have examined this request, including accompanying documents, and to the best of my knowledge and belief, the facts presented are true, correct and complete. This form must be signed by the policyholder (i.e., Owner, Partner, Corporate Officer, Member/Manager) who has personal knowledge of the facts.

Signature **Ellen August** Title **Owner** Date **9/2/21**

## Determination of Worker Status

**Purpose:** Policyholders submit this form to request the determination of the status of a worker for the purpose of completing his or her workers compensation audit. This form will only be used to determine whether or not remuneration paid to a worker will be included on the policyholder's audit. This form is only valid for the worker and policy period listed below. This determination is for the audit period in question and does not affect the payment of claims.

**Completing the form:** Answer all questions as completely as possible. **Attach additional sheets if you need more space.** Provide information for the worker and policy period stated below. Determinations are based on the entire relationship between the policyholder and worker.

TUSCARORA TOWNSHIP

Accident Fund Policyholder

Policy Period

WCV 0215291 16 01

Policy Number

In order to make a determination as to whether an Employer/Employee status exists, please complete this analysis and provide as much of the following documentation as possible. This information must be provided on an annual basis.

Worker's Name <u>Ellen August</u>		Worker's DBA (applicable) <u>Classic Cleaning</u>	
Worker's Address (Include street address, city, state and Zip code.) <u>10701 Parke Rd., Alanson, MI 49706</u>		Worker's Tax ID <u>[REDACTED]</u>	
Worker is a:	<input checked="" type="checkbox"/> Sole Proprietorship  Did the sole proprietor use any employees, casual labor, or uninsured subcontractors to complete the work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Partnership	<input type="checkbox"/> Corporation
<input type="checkbox"/> Limited Liability Company			

- A. How did the worker obtain the job? ☐ Application ☒ Bid ☐ Employment Agency ☐ Other (specify)  
 Type of pay the worker receives: ☐ Salary ☐ Commission ☒ Hourly Wage ☐ Piece Work ☐ Lump sum ☐ Other (specify)
- B. If the work is done under a written agreement between the policyholder and the worker, attach a copy (preferably signed by both parties). Describe the terms and conditions of the work arrangement.
- C. What specific training or instruction is the worker given by the policyholder? None
- D. How does the worker receive work assignments? And who determines how and when the assignments are performed? Per attached copy
- E. Is the worker required to provide the services personally? No
- F. If substitutes or helpers are needed, who hires them? Self Who pays them? Classic Cleaning
- G. List the supplies, equipment, materials and property provided by each party:  
 The policyholder: All  
 The worker: None  
 Other party: None
- H. What expenses are incurred by the worker in the performance of services for the policyholder? None
- I. Does the worker carry insurance (e.g., workers compensation, general liability, etc.)? If "Yes", please attach copies. Yes
- J. List the benefits available to the worker (e.g., paid vacations, sick pay, pensions, bonuses). None
- K. Can the relationship be terminated by either party without incurring liability or penalty? If "No," explain your answer. Yes
- L. Does the worker perform similar services for others? If "Yes," is the worker required to get approval from the policyholder? Yes/No
- M. What type of advertising, if any, does the worker do (e.g., business listing in a directory, business cards, etc.)? Provide copies, if applicable. None

### Signature

I declare that I have examined this request, including accompanying documents, and to the best of my knowledge and belief, the facts presented are true, correct and complete. This form must be signed by the policyholder (i.e., Owner, Partner, Corporate Officer, Member/Manager) who has personal knowledge of the facts.

Signature Ellen August

Title Owner

Date 9/4/20

## Determination of Worker Status

**Purpose:** Policyholders submit this form to request the determination of the status of a worker for the purpose of completing his or her workers compensation audit. This form will only be used to determine whether or not remuneration paid to a worker will be included on the policyholder's audit. This form is only valid for the worker and policy period listed below. This determination is for the audit period in question and does not affect the payment of claims.

**Completing the form:** Answer all questions as completely as possible. **Attach additional sheets if you need more space.** Provide information for the worker and policy period stated below. Determinations are based on the entire relationship between the policyholder and worker.

Tuscarora Township

WCV 0215291 16 01

Accident Fund Policyholder

Policy Period

Policy Number

In order to make a determination as to whether an Employer/Employee status exists, please complete this analysis and provide as much of the following documentation as possible. This information must be provided on an annual basis.

Worker's Name <b>Bruce Thompson</b>		Worker's DBA (applicable)	
Worker's Address (Include street address, city, state and Zip code.) <b>2063 Miller Road, Alanson, MI 49706</b>		Worker's Tax ID <div style="background-color: black; width: 100px; height: 1.2em;"></div>	
Worker is a:	<input type="checkbox"/> Sole Proprietorship  Did the sole proprietor use any employees, casual labor, or uninsured subcontractors to complete the work? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Partnership	<input type="checkbox"/> Corporation
<input type="checkbox"/> Limited Liability Company			

- A. How did the worker obtain the job? ☐ Application ☒ Bid ☐ Employment Agency ☐ Other (specify)  
 Type of pay the worker receives: ☐ Salary ☐ Commission ☐ Hourly Wage ☒ Piece Work ☐ Lump sum ☐ Other (specify)
- B. If the work is done under a written agreement between the policyholder and the worker, **attach a copy** (preferably signed by both parties). Describe the terms and conditions of the work arrangement.
- C. What specific training or instruction is the worker given by the policyholder? **None**
- D. How does the worker receive work assignments? And who determines how and when the assignments are performed?  
**By phone call when a burial is scheduled**
- E. Is the worker required to provide the services personally? **No**
- F. If substitutes or helpers are needed, who hires them? **Self** Who pays them? **Thompson**
- G. List the supplies, equipment, materials and property provided by each party:  
 The policyholder: **None**  
 The worker: **Shovels and loader**  
 Other party: **None**
- H. What expenses are incurred by the worker in the performance of services for the policyholder? **None**
- I. Does the worker carry insurance (e.g., workers compensation, general liability, etc.)? If "Yes", please attach copies. **Yes**
- J. List the benefits available to the worker (e.g., paid vacations, sick pay, pensions, bonuses). **None**
- K. Can the relationship be terminated by either party without incurring liability or penalty? If "No," explain your answer. **Yes**
- L. Does the worker perform similar services for others? If "Yes," is the worker required to get approval from the policyholder? **Yes**
- M. What type of advertising, if any, does the worker do (e.g., business listing in a directory, business cards, etc.)? **Provide copies, if applicable. Yes**

### Signature

I declare that I have examined this request, including accompanying documents, and to the best of my knowledge and belief, the facts presented are true, correct and complete. This form must be signed by the policyholder (i.e., Owner, Partner, Corporate Officer, Member/Manager) who has personal knowledge of the facts.

Signature Bruce Thompson Title Owner Date 8-30-2021



# CERTIFICATE OF LIABILITY INSURANCE

1/1/2022

DATE (MM/DD/YYYY)  
12/14/2020

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 LOCKTON COMPANIES 3657 BRIARPARK DRIVE, SUITE 700 HOUSTON TX 77042 866-260-3538	CONTACT NAME:	
	PHONE (A/C, No, Ext):	FAX (A/C, No):
	E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : ACE American Insurance Company	22667
	INSURER B : Indemnity Insurance Co of North America	43575
	INSURER C : ACE Fire Underwriters Insurance Company	20702
	INSURER D : ACE Property & Casualty Insurance Co	20699
	INSURER E :	
	INSURER F :	

INSURED 1300299 WASTE MANAGEMENT HOLDINGS, INC. & ALL AFFILIATED & SUBSIDIARY COMPANIES INCLUDING: WASTE MANAGEMENT OF NORTHERN MICHIGAN 2294 CASS ROAD TRAVERSE CITY MI 49685

**COVERAGES**

CERTIFICATE NUMBER: 3491037

REVISION NUMBER: XXXXXXXX

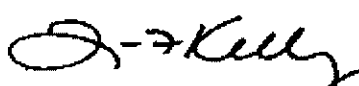
THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE 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
A	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR <input checked="" type="checkbox"/> XCU INCLUDED <input checked="" type="checkbox"/> ISO FORM CG00010413 GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PRO-JECT <input checked="" type="checkbox"/> LOC OTHER:	Y	Y	HDO G71572985	01/01/2021	01/01/2022	EACH OCCURRENCE \$ 5,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 5,000,000 MED EXP (Any one person) \$ XXXXXXXX PERSONAL & ADV INJURY \$ 5,000,000 GENERAL AGGREGATE \$ 6,000,000 PRODUCTS - COMP/OP AGG \$ 6,000,000 \$
A	AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO <input checked="" type="checkbox"/> OWNED AUTOS ONLY <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> MCS-90 <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY	Y	Y	MMT H25308645	01/01/2021	01/01/2022	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ XXXXXXXX BODILY INJURY (Per accident) \$ XXXXXXXX PROPERTY DAMAGE (Per accident) \$ XXXXXXXX \$ XXXXXXXX
D	<input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> EXCESS LIAB DED RETENTION \$	Y	Y	XOOG27929242 006	01/01/2021	01/01/2022	EACH OCCURRENCE \$ 15,000,000 AGGREGATE \$ 15,000,000 \$
B A C	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 N	N/A	Y WLR C6781180A (AOS) WLR C67811768 (AZ,CA & MA) SCF C67811847 (WI)	01/01/2021 01/01/2021 01/01/2021	01/01/2022 01/01/2022 01/01/2022	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ 3,000,000 E.L. DISEASE - EA FMPI OYFE \$ 3,000,000 E.L. DISEASE - POLICY LIMIT \$ 3,000,000
A	EXCESS AUTO LIABILITY	Y	Y	XSA H25308608	01/01/2021	01/01/2022	COMBINED SINGLE LIMIT \$9,000,000 (EACH ACCIDENT)

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

BLANKET WAIVER OF SUBROGATION IS GRANTED IN FAVOR OF CERTIFICATE HOLDER ON ALL POLICIES WHERE AND TO THE EXTENT REQUIRED BY WRITTEN CONTRACT WHERE PERMISSIBLE BY LAW. CERTIFICATE HOLDER IS NAMED AS AN ADDITIONAL INSURED (EXCEPT FOR WORKERS' COMP/EL) WHERE AND TO THE EXTENT REQUIRED BY WRITTEN CONTRACT.

**CERTIFICATE HOLDER****CANCELLATION**

3491037 TUSCARORA TOWNSHIP PO BOX 220 INDIAN RIVER MI 49749	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 



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

08/30/2021

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).

<b>PRODUCER</b> Insurance By Burley Alanson Office 6244 River Street; PO Box 800 Alanson, MI 49706 Brenda Keith	<b>231-548-2211</b>	<b>CONTACT NAME:</b> Brenda Keith <b>PHONE (A/C, No, Ext):</b> 231-548-2211 <b>FAX (A/C, No):</b> 231-548-5508 <b>E-MAIL ADDRESS:</b>
<b>INSURER(S) AFFORDING COVERAGE</b>		<b>NAIC #</b>
<b>INSURER A:</b> Auto-Owners Insurance Company		<b>18988</b>
<b>INSURER B:</b>		
<b>INSURER C:</b>		
<b>INSURER D:</b>		
<b>INSURER E:</b>		
<b>INSURER F:</b>		

**INSURED**  
Bruce Thompson  
2063 Miller Rd  
Alanson, MI 49706

## 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 SUBR INSD / WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	<input checked="" type="checkbox"/> <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:		33076899	10/21/2020	10/21/2021	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Per occurrence) \$ 50,000 MED EXP (Any one person) \$ 6,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 1,000,000 PRODUCTS - COMP/OP AGG \$ 1,000,000 COMBINED SINGLE LIMIT (Per accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ UMBRELLA LIAB EXCESS LIAB \$ DED RETENTION \$ WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) <input type="checkbox"/> Y/N If yes, describe under DESCRIPTION OF OPERATIONS below
	<b>AUTOMOBILE LIABILITY</b> <input type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY					EACH OCCURRENCE \$ AGGREGATE \$ PER STATUTE <input type="checkbox"/> OTH-ER <input type="checkbox"/> F.I. EACH ACCIDENT \$ F.I. DISEASE - EA EMPLOYEE \$ F.I. DISEASE - POLICY LIMIT \$
	<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				

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

## CERTIFICATE HOLDER

TUSCARO

Tuscarora Township  
3546 S Straits Highway  
Indian River, MI 49749

## 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  
Brenda Keith



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

8/30/2021

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).

<b>PRODUCER</b> North Country Insurance Agency, Inc PO Box 518  Indian River MI 49749		<b>CONTACT NAME:</b> PHONE (A/C, No, Ext): 231-238-9882 FAX (A/C, No): 231-238-4321 E-MAIL ADDRESS: Generalmail@northcountryins.com	
		<b>INSURER(S) AFFORDING COVERAGE</b>	<b>NAIC #</b>
		INSURER A: Auto-Owners Insurance Company	01063100
		INSURER B:	
		INSURER C:	
		INSURER D:	
		INSURER E:	
		INSURER F:	

**COVERAGES**

CERTIFICATE NUMBER: 20210830133431882

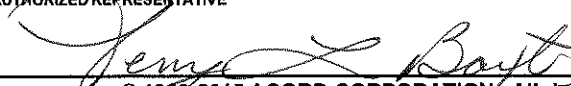
REVISION NUMBER:

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
A	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY			33672647	06/20/2021	06/20/2022	EACH OCCURRENCE \$ 100,000
	<input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 50,000
							MED EXP (Any one person) \$ 5,000
							PERSONAL & ADV INJURY \$ 1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE \$ 1,000,000
	<input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC						PRODUCTS - COMP/OP AGG \$ 1,000,000
	OTHER:						\$
	<b>AUTOMOBILE LIABILITY</b>						COMBINED SINGLE LIMIT (Ea accident) \$
	<input type="checkbox"/> ANY AUTO						BODILY INJURY (Per person) \$
	<input type="checkbox"/> OWNED AUTOS ONLY	<input type="checkbox"/> SCHEDULED AUTOS					BODILY INJURY (Per accident) \$
	<input type="checkbox"/> HIRED AUTOS ONLY	<input type="checkbox"/> NON-OWNED AUTOS ONLY					PROPERTY DAMAGE (Per accident) \$
							\$
	<b>UMBRELLA LIAB</b>	<input type="checkbox"/> OCCUR					EACH OCCURRENCE \$
	<b>EXCESS LIAB</b>	<input type="checkbox"/> CLAIMS-MADE					AGGREGATE \$
	<input type="checkbox"/> DED <input type="checkbox"/> RETENTION \$						\$
	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b>						PER STATUTE <input type="checkbox"/> OTH-ER <input type="checkbox"/>
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N	N/A				E.L. EACH ACCIDENT \$
	If yes, describe under DESCRIPTION OF OPERATIONS below						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)

**CERTIFICATE HOLDER****CANCELLATION**

Tuscarora Township PO BOX 220 Indian River MI 49749	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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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
8/30/2021

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).

<b>PRODUCER</b> Holmes Murphy Associates/CSDZ, LLC 225 South Sixth Street STE 1900 Minneapolis MN 55402	<b>CONTACT NAME:</b> Allie Darling	<b>FAX (A/C, No):</b>	
	<b>PHONE (A/C, No, Ext):</b> 612-322-6041	<b>E-MAIL ADDRESS:</b> adarling@csdz.com	
<b>INSURED</b> M&H Facility Operations, Inc. 2440 Deming Way Middleton, WI 53562	<b>INSURER(S) AFFORDING COVERAGE</b>		<b>NAIC #</b>
	INSURER A : Travelers Indemnity Company		25658
	INSURER B : Charter Oak Fire Insurance Company		25615
	INSURER C : Travelers Property Casualty Co. America		25674
	INSURER D : XL Specialty Insurance		37885
	INSURER E :		
INSURER F :			

**COVERAGES** **CERTIFICATE NUMBER:** 511274809 **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
A	<input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b> <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR <input checked="" type="checkbox"/> Cont Liab Per <input checked="" type="checkbox"/> Policy Form/XCU GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PRO-JECT <input checked="" type="checkbox"/> LOC OTHER:			P6305C656013TIA20	12/1/2020	12/1/2021	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 300,000 MED EXP (Any one person) \$ 10,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000 \$
B	<input checked="" type="checkbox"/> <b>AUTOMOBILE LIABILITY</b> <input checked="" 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			8101L2755752043G	12/1/2020	12/1/2021	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"/> <b>UMBRELLA LIAB</b> <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> DED <input checked="" type="checkbox"/> RETENTION \$ 0			CUP0K3011012043	12/1/2020	12/1/2021	EACH OCCURRENCE \$ 9,000,000 AGGREGATE \$ 9,000,000 \$
C A A	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N N	N/A	B8J3002332043G UB8J2154322043E UB8J3173932043V	12/1/2020 12/1/2020 12/1/2020	12/1/2021 12/1/2021 12/1/2021	<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 D	Property Professional/Pollution Liability			P6305C656013TIA20 DPR9967599	12/1/2020 10/25/2020	12/1/2021 10/25/2021	Bldg/BPP: \$12,825,012 Per Claim: \$5,000,000 Per Aggregate: \$10,000,000

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

## CERTIFICATE HOLDER

## CANCELLATION

Tuscarora Township 3546 South Straits Highway Indian River MI 49749	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>Paula A. Dixon</i>

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BRUCE-3

OP ID: KV

# CERTIFICATE OF LIABILITY INSURANCE

 DATE (MM/DD/YYYY)  
 09/16/2019

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.

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PRODUCER BKC Insurance Services PO Box 326 220 Water Street Cheboygan, MI 49721 Kimberly Valot		231-627-4381 CONTACT NAME: Kim Valot PHONE (A/C, No, Ext): 231-627-4381 FAX (A/C, No): 231-627-5171 E-MAIL ADDRESS: kvalot@bkcinurance.com	
INSURED Bruce Thompson 2063 Miller Rd Alanson, MI 49706		INSURER(S) AFFORDING COVERAGE INSURER A: Benchmark Insurance Co INSURER B: INSURER C: INSURER D: INSURER E: INSURER F:	
		NAIC # 41394	

**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 WYD	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:			CP5000572	12/05/2018	12/05/2019	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 \$ 2,000,000 PRODUCTS - COMPIOP AGG \$ 2,000,000
A	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY			CA5000249	12/05/2018	12/05/2019	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
	UMBRELLA LIAB EXCESS LIAB DED RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below						PER STATUTE <input type="checkbox"/> OTH-ER <input type="checkbox"/> 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)

## CERTIFICATE HOLDER

TUSCA-1

 Tuscarora Township  
 PO Box 220  
 Indian River, MI 49749

## 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  
 Kimberly Valot





BRUCE-3

OP ID: KV

# **CERTIFICATE OF LIABILITY INSURANCE**

 DATE (MM/DD/YYYY)  
 09/02/2020

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PRODUCER BKC Insurance Services PO Box 326 220 Water Street Cheboygan, MI 49721 Kimberly Valot		CONTACT NAME: Kim Valot PHONE (A/C, No, Ext): 231-627-4381 E-MAIL ADDRESS: kvalot@bkcsinsurance.com		FAX (A/C, No): 231-627-5171	
INSURED Bruce Thompson 2063 Miller Rd Alanson, MI 49706		INSURER(S) AFFORDING COVERAGE INSURER A: Benchmark Insurance Co INSURER B: INSURER C: INSURER D: INSURER E: INSURER F:			
				NAIC # 41394	

## COVERAGES

## CERTIFICATE NUMBER:

## REVISION NUMBER:

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INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	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:			CP5000572	12/05/2018	12/05/2019	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 \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000
A	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY			CA5000249	12/05/2018	12/05/2019	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
	UMBRELLA LIAB EXCESS LIAB DED RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below			N/A			PER STATUTE OTH-ER 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)

## CERTIFICATE HOLDER

## CANCELLATION

TUSCA-1  Tuscarora Township PO Box 220 Indian River, MI 49749	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 Kimberly Valot
---	---



## CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
9/16/2019

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.

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PRODUCER	North Country Insurance Agency, Inc PO Box 518 Indian River MI 49749	CONTACT NAME:			
		PHONE (A/C, No, Ext):	231-238-9882	FAX (A/C, No):	231-238-4321
		E-MAIL ADDRESS:	Generalmail@northcountryins.com		
		INSURER(S) AFFORDING COVERAGE			NAIC #
		INSURER A: Auto-Owners Insurance Agency Inc.			01063100
		INSURER B:			
		INSURER C:			
		INSURER D:			
		INSURER E:			
		INSURER F:			

## COVERAGES

## CERTIFICATE NUMBER:

## REVISION NUMBER:

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INSR LTR	TYPE OF INSURANCE	ADDL SUBR INED / DED	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:		33672647	06/20/2018	06/20/2019	EACH OCCURRENCE \$ 100,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 50,000 MED EXP (Any one person) \$ 5,000 PERSONAL & ADV INJURY \$ 100,000 GENERAL AGGREGATE \$ 100,000 PRODUCTS - COMPIOP AGG \$ 100,000
	AUTOMOBILE LIABILITY <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) \$
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED <input type="checkbox"/> RETENTION \$					EACH OCCURRENCE \$ AGGREGATE \$
	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				PER STATUTE <input type="checkbox"/> OTH-ER <input type="checkbox"/> 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)

## CERTIFICATE HOLDER

## CANCELLATION

Tuscarora Township  
3546 S Straits Hwy  
Indian River MI 49749

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:



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
09/25/2018

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.

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<b>PRODUCER</b> Holmes Murphy & Assoc - WI 10 E. Doty Street, Suite 800 Madison, WI 53703		<b>CONTACT NAME:</b> Linda Bomarito <b>PHONE (A/C, No, Ext):</b> 309-282-3903 <b>E-MAIL ADDRESS:</b> lbomarito@holmesmurphy.com	<b>FAX (A/C, No):</b> 866-501-3945
<b>INSURED</b> Mead & Hunt, Inc. M & H Architecture, Inc. 2440 Deming Way Middleton, WI 53562		<b>INSURER(S) AFFORDING COVERAGE</b> <b>INSURER A:</b> XL SPECIALTY INS CO <b>INSURER B:</b> <b>INSURER C:</b> <b>INSURER D:</b> <b>INSURER E:</b> <b>INSURER F:</b>	
		<b>NAIC #</b> 37885	

**COVERAGES****CERTIFICATE NUMBER:** 54077411**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"/> HIRED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <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"/> EXCESS LIAB DED <input type="checkbox"/> RETENTION \$						EACH OCCURRENCE	\$
							AGGREGATE	\$
								\$
	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	<input type="checkbox"/> Y <input type="checkbox"/> N	N/A				PER STATUTE	OTH-ER
							E.L. EACH ACCIDENT	\$
							E.L. DISEASE - EA EMPLOYEE	\$
							E.L. DISEASE - POLICY LIMIT	\$
A	<b>Professional Liability</b> (Claims Made)			DPR9931217	10/25/18	10/25/19	Each Claim	5,000,000
							Aggregate	10,000,000

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

Pollution Liability Included

**CERTIFICATE HOLDER**

\*\*\*FOR PROPOSAL PURPOSES ONLY\*\*\*

**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

*Paula R. N. 10/7*

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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
09/18/2019

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 Holmes Murphy & Assoc - WI 10 E. Doty Street, Suite 800 Madison, WI 53703	1-800-527-9049	CONTACT NAME: Linda Bomarito PHONE (A/C, No, Ext): 309-282-3903 E-MAIL ADDRESS: lbomarito@holmesmurphy.com	FAX (A/C, No): 866-501-3945
INSURED Mead & Hunt, Inc. M & H Architecture, Inc. 2440 Deming Way Middleton, WI 53562		INSURER(S) AFFORDING COVERAGE INSURER A: XL SPECIALTY INS CO INSURER B: INSURER C: INSURER D: INSURER E: INSURER F:	
		NAIC # 37885	

**COVERAGES**

CERTIFICATE NUMBER: 57283128

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
	COMMERCIAL GENERAL LIABILITY <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 \$ \$
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> NON-OWNED AUTOS ONLY						COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
	UMBRELLA LIAB EXCESS LIAB DED <input type="checkbox"/> RETENTION \$ <input type="checkbox"/>						EACH OCCURRENCE \$ AGGREGATE \$ \$
	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						PER STATUTE <input type="checkbox"/> OTH-ER <input type="checkbox"/> E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
A	Professional Liability (Claims Made)			DPR9931217	10/25/18	10/25/19	Each Claim 5,000,000 Aggregate 10,000,000

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

Pollution Liability Included

**CERTIFICATE HOLDER**Tuscarora Township  
3546 South Straits Hwy  
Indian River, MI 49749

USA

**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

Paula A. Smith



# CERTIFICATE OF LIABILITY INSURANCE

BRUCE-3

OP ID: KV

DATE (MM/DD/YYYY)  
12/06/2017

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).

<b>PRODUCER</b> 231-627-4381 Barnich Kavanaugh & Cooper Inc P.O. Box 326, 220 Water Street Cheboygan, MI 49721-0326 Kimberly Valot		<b>CONTACT</b> Kim Valot PHONE: 231-627-4381 (A/C, No, Ext): FAX: (A/C, No): E-MAIL: kvalot@bkcinurance.com ADDRESS:	
<b>INSURED</b> Bruce Thompson 2063 Miller Rd Alanson, MI 49706		<b>INSURER(S) AFFORDING COVERAGE</b> INSURER A: Benchmark Insurance Co INSURER B: INSURER C: INSURER D: INSURER E: INSURER F:	
		<b>NAIC #</b> 41394	

## 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
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 checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC <input type="checkbox"/> OTHER			CP5000572	12/05/2017	12/05/2018	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 \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000
A	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY			CA5000249	12/05/2017	12/05/2018	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ EACH OCCURRENCE \$ AGGREGATE \$
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED <input type="checkbox"/> RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$ PER STATUTE <input type="checkbox"/> OTH-ER <input type="checkbox"/>
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below		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)

## CERTIFICATE HOLDER

## CANCELLATION

TUSCA-1  Tuscarora Township PO Box 220 Indian River, MI 49749	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 Kimberly Valot
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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
1/15/2019

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).

<b>PRODUCER</b> McDonnell Agency, Inc. 20031 Carlysle Suite 1 Dearborn MI 48124		<b>CONTACT NAME:</b> Michele Barnard-Ladd <b>PHONE (A/C, No, Ext):</b> (313) 561-4360 <b>FAX (A/C, No):</b> (313) 277-3669 <b>E-MAIL ADDRESS:</b>	
<b>INSURED</b> James Hill 304 W. Indian Woods Trails Indian River MI 49749		<b>INSURER(S) AFFORDING COVERAGE</b> <b>INSURER A:</b> Westfield Insurance Company <b>INSURER B:</b> <b>INSURER C:</b> <b>INSURER D:</b> <b>INSURER E:</b> <b>INSURER F:</b>	
		<b>NAIC #</b> 24112	

## COVERAGES

CERTIFICATE NUMBER: 2020-Indian River

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
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 checked="" type="checkbox"/> POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC OTHER:			CWP014378K	1/18/2019	1/18/2020	EACH OCCURRENCE \$ 1,000,000
			DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 500,000				
			MED EXP (Any one person) \$ 5,000				
			PERSONAL & ADV INJURY \$ 1,000,000				
	<input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> NON-OWNED AUTOS						GENERAL AGGREGATE \$ 1,000,000
	<input type="checkbox"/> UMBRELLA LIAB <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> DED <input type="checkbox"/> RETENTION \$						PRODUCTS - COMP/OP AGG \$ 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						Employee Benefits \$
							COMBINED SINGLE LIMIT (Ea accident) \$
							BODILY INJURY (Per person) \$
							BODILY INJURY (Per accident) \$
							PROPERTY DAMAGE (Per accident) \$
							\$
							EACH OCCURRENCE \$
							AGGREGATE \$
							\$
							PER STATUTE <input type="checkbox"/> OTH-ER <input type="checkbox"/>
							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)

## CERTIFICATE HOLDER

## CANCELLATION

director@indianriverlibrary.c  Tuscarora Township Attn: Mara 3546 S. Straits Hwy Indian River, MI 49749	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  Thomas J. McDonnell
--	--

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## CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
9/16/2019

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.

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PRODUCER	North Country Insurance Agency, Inc PO Box 518 Indian River MI 49749	CONTACT NAME:		
		PHONE (A/C, No, Ext): 231-238-9882	FAX (A/C, No): 231-238-4321	
		E-MAIL ADDRESS: Generalmail@northcountryins.com		
		INSURER(S) AFFORDING COVERAGE	NAIC #	
		INSURER A: Auto-Owners Insurance Agency Inc,	01063100	
INSURED	Ellen August DBA Classic Cleaning 10701 Parke Rd. Alanson MI 49706	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 SUBR INSD WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY		33672647	06/20/2019	06/20/2020	EACH OCCURRENCE \$ 100,000
	<input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR					DAMAGE TO RENTED PREMISES (Per occurrence) \$ 50,000
						MED EXP (Any one person) \$ 5,000
						PERSONAL & ADV INJURY \$ 100,000
	GEN'L AGGREGATE LIMIT APPLIES PER:					GENERAL AGGREGATE \$ 100,000
	<input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC					PRODUCTS - COMP/OP AGG \$ 100,000
	OTHER:					\$
	AUTOMOBILE LIABILITY					COMBINED SINGLE LIMIT (Per accident) \$
	ANY AUTO					BODILY INJURY (Per person) \$
	OWNED AUTOS ONLY	<input type="checkbox"/> SCHEDULED AUTOS				BODILY INJURY (Per accident) \$
	HIRED AUTOS ONLY	<input type="checkbox"/> NON-OWNED AUTOS ONLY				PROPERTY DAMAGE (Per accident) \$
	UMBRELLA LIAB	<input type="checkbox"/> OCCUR				EACH OCCURRENCE \$
	EXCESS LIAB	<input type="checkbox"/> CLAIMS-MADE				AGGREGATE \$
	DED	RETENTION \$				\$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY	<input type="checkbox"/> Y/N	N/A			PER STATUTE <input type="checkbox"/> OTH-ER <input type="checkbox"/>
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	<input type="checkbox"/>				E.I. EACH ACCIDENT \$
	If yes, describe under DESCRIPTION OF OPERATIONS below					E.I. DISEASE - EA EMPLOYEE \$
						E.I. DISEASE - POLICY LIMIT \$

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

## CERTIFICATE HOLDER

## CANCELLATION

Tuscarora Township  
3546 S Straits Hwy  
Indian River MI 49749

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

*John L. Barta*

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BRUCE-3

OP ID: KV

# **CERTIFICATE OF LIABILITY INSURANCE**

DATE (MM/DD/YYYY)

09/02/2020

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.

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<b>PRODUCER</b> BKC Insurance Services PO Box 326 220 Water Street Cheboygan, MI 49721 Kimberly Valot		231-627-4381 <b>CONTACT NAME:</b> Kim Valot <b>PHONE (A/C, No, Ext):</b> 231-627-4381 <b>FAX (A/C, No):</b> 231-627-5171 <b>E-MAIL ADDRESS:</b> kvalot@bkcinurance.com	
<b>INSURED</b> Bruce Thompson 2063 Miller Rd Alanson, MI 49706		<b>INSURER(S) AFFORDING COVERAGE</b> <b>INSURER A:</b> Benchmark Insurance Co <b>INSURER B:</b> <b>INSURER C:</b> <b>INSURER D:</b> <b>INSURER E:</b> <b>INSURER F:</b>	
		<b>NAIC #</b> 41394	

## **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
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:			CP5000572	12/05/2019	12/05/2020	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 \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000
A	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY			CA5000249	12/05/2019	12/05/2020	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
	UMBRELLA LIAB EXCESS LIAB OCCUR CLAIMS-MADE DED RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in MI) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N	N/A				PER STATUTE OTH-ER 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)

## **CERTIFICATE HOLDER**

TUSCA-1

Tuscarora Township  
 PO Box 220  
 Indian River, MI 49749

## **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  
 Kimberly Valot





**Federated Mutual Insurance Company**  
121 East Park Square, Owatonna, MN 55060  
(507) 455-5200

**WORKERS COMPENSATION AND EMPLOYER'S LIABILITY INSURANCE POLICY  
INFORMATION PAGE**

Mutual Company Participating Nonassessable Policy

Phone: 800-533-0472 NCCI Carrier Code: 16446

Producer / Agent: Alex Ososki

Policy No. **1809769**  
Prior Policy No.  
Account No. **197-663-8**

**ITEM 1. NAMED INSURED AND ADDRESS:**

**Tanner Electric Inc.**  
**1339 S Straits Hwy**  
**Indian River, MI 49749-9701**

Entity Type **S Corporation**  
FEIN **46-1770453**

See Extension of Information Page "Named Insured"

Other workplaces not shown above: See Extension of Information Page "Other Workplaces of the Insured"

**ITEM 2. POLICY PERIOD:** The policy period is from **01/01/2021** to **01/01/2022** 12:01 A.M. Standard time, at the insured's mailing address.

**ITEM 3. COVERAGE:**

- A. WORKERS COMPENSATION INSURANCE:** Part One of the policy applies to the Workers Compensation law of the states listed here: **MI**
- B. EMPLOYERS LIABILITY INSURANCE:** Part Two of the policy applies to work in each state listed in Item 3.A. The limits of our liability under Part Two are: Bodily Injury by Accident **\$500,000** each accident  
Bodily Injury by Disease **\$500,000** policy limit  
Bodily Injury by Disease **\$500,000** each employee
- C. OTHER STATES INSURANCE:** Part Three of the policy applies to states, if any, listed here: **All states except states designated in Item 3.A. and ND OH WA WY**
- D. ENDORSEMENTS:** This policy includes these endorsements and schedules: See Extension of Information Page "List of Endorsements"

**ITEM 4. PREMIUM:** The premium for this policy will be determined by our Manual of Rules, Classifications, Rates, and Rating Plans. All information required below is subject to verification and change by audit to be made **ANNUALLY**.

Loc. No.	Name No.	Code No.	Classification of Operations	Prem. Basis Est. Total Ann. Remun.	Rate Per \$100 Remun.	Estimated Annual Premium
See Extension of Information Page "Schedule of Operations"						

Minimum Premium  
**\$461**

Total Estimated Annual Premium  
Total State Surcharges  
Total Estimated Cost  
Deposit Amount

This policy consists of: (1) this Information Page; and (2) the Workers Compensation and Employers Liability Insurance Policy (the WC-F-5).



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
03/31/2020

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).

<b>PRODUCER</b> UNITEL 1128 Lincoln Mall Suite 200 Lincoln NE 68508		<b>CONTACT NAME:</b> Ginger Paulsen <b>PHONE (A/C, No, Ext):</b> (402) 434-7200 <b>FAX (A/C, No):</b> (402) 434-7272 <b>E-MAIL ADDRESS:</b> gpaulsen@unitelinsurance.com	
<b>INSURED</b> Merit Network, Inc. 880 Technology Drive, Suite B Ann Arbor MI 48108		<b>INSURER(S) AFFORDING COVERAGE</b> <b>INSURER A:</b> Travelers Property Casualty of America <b>INSURER B:</b> Phoenix Insurance Co <b>INSURER C:</b> <b>INSURER D:</b> <b>INSURER E:</b> <b>INSURER F:</b>	
		<b>NAIC #</b> 25674 25623	

## COVERAGES

**CERTIFICATE NUMBER:** 20/21-ALL LINES

**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
A	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR	Y		ZLP 31M95173	04/01/2020	04/01/2021	EACH OCCURRENCE \$ 1,000,000
	DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 300,000						
	MED EXP (Any one person) \$ 10,000						
	PERSONAL & ADV INJURY \$ 1,000,000						
GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC OTHER:							GENERAL AGGREGATE \$ 2,000,000
							PRODUCTS - COMP/OP AGG \$ 2,000,000
B	<b>AUTOMOBILE LIABILITY</b> <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY			BA-9M472849	04/01/2020	04/01/2021	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000
	BODILY INJURY (Per person) \$						
	BODILY INJURY (Per accident) \$						
	PROPERTY DAMAGE (Per accident) \$						
A	<input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE			CUP-9M475053	04/01/2020	04/01/2021	EACH OCCURRENCE \$ 15,000,000
	AGGREGATE \$ 15,000,000						
	DED <input checked="" type="checkbox"/> RETENTION \$ 10,000						
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				PER STATUTE <input type="checkbox"/> OTH-ER <input type="checkbox"/>
							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)

Certificate holder is additional insured under the General Liability per contract regarding The Reach Michigan Mile Collaborative (REACH-3MC Round II)

## CERTIFICATE HOLDER

## CANCELLATION

Tuscarora Township PO Box 220  Indian River MI 49749-0220	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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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
10/20/2020

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PRODUCER Holmes Murphy & Assoc - WI 1600 Aspen Commons Suite 990 Middleton, WI 53562	1-800-527-9049	CONTACT NAME: Linda Bomarito PHONE (A/C, No, Ext): 309-282-3903 FAX (A/C, No): 866-501-3945 E-MAIL: lbomarito@holmesmurphy.com ADDRESS: 1bomarito@holmesmurphy.com
INSURED Mead & Hunt, Inc. M & H Architecture, Inc. 2440 Deming Way Middleton, WI 53562		INSURER(S) AFFORDING COVERAGE INSURER A: XL SPECIALTY INS CO INSURER B: INSURER C: INSURER D: INSURER E: INSURER F:

COVERAGES CERTIFICATE NUMBER: 60531621 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
	COMMERCIAL GENERAL LIABILITY <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 \$ \$
	AUTOMOBILE LIABILITY <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) \$ \$
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED <input type="checkbox"/> RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$ \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY 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				PER STATUTE <input type="checkbox"/> OTH-ER <input type="checkbox"/> E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
A	Professional Liability (Claims Made)			DPR9967599	10/25/20	10/25/21	Each Claim 5,000,000 Aggregate 10,000,000

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

Pollution Liability Included

## CERTIFICATE HOLDER

Tuscarora Township  
3546 South Straits Hwy  
Indian River, MI 49749

USA

## 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

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ACORD 25 (2016/03)  
lbomarito  
60531621

The ACORD name and logo are registered marks of ACORD



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

08/31/2020

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.

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<b>PRODUCER</b> Specialty Insurance, LTD. P.O. Box 16901 West Haven, CT 06516 http://specialtyinsuranceltd.com	<b>CONTACT NAME:</b> Thomas Plouffe / Michael Plouffe <b>PHONE (A/C, No, Ext):</b> 203-931-7095 <b>FAX (A/C, No):</b> 203-931-0682 <b>E-MAIL ADDRESS:</b> certificates@specialtyinsuranceltd.com																					
<b>INSURED</b> Family Fun Tyme Amusements, LLC 2340 44th Gales Burg MI 49053	<table border="1"><tr><th colspan="2">INSURER(S) AFFORDING COVERAGE</th><th>NAIC #</th></tr><tr><td>INSURER A:</td><td>Certain Underwriters @Lloyds of London</td><td>15792</td></tr><tr><td>INSURER B:</td><td></td><td></td></tr><tr><td>INSURER C:</td><td></td><td></td></tr><tr><td>INSURER D:</td><td></td><td></td></tr><tr><td>INSURER E:</td><td></td><td></td></tr><tr><td>INSURER F:</td><td></td><td></td></tr></table>	INSURER(S) AFFORDING COVERAGE		NAIC #	INSURER A:	Certain Underwriters @Lloyds of London	15792	INSURER B:			INSURER C:			INSURER D:			INSURER E:			INSURER F:		
INSURER(S) AFFORDING COVERAGE		NAIC #																				
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INSURER B:																						
INSURER C:																						
INSURER D:																						
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INSURER F:																						

**COVERAGES****CERTIFICATE NUMBER:****REVISION NUMBER:**

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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 checked="" type="checkbox"/> LOC OTHER:	X		CC/19-0101	07/01/20	07/01/21	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence)	\$ 1,000,000 \$ 300,000
							MED EXP (Any one person)	\$ 5,000
							PERSONAL & ADV INJURY	\$ 1,000,000
							GENERAL AGGREGATE	\$ 2,000,000
							PRODUCTS - COMP/OP AGG	\$ 2,000,000
								\$
	<b>AUTOMOBILE LIABILITY</b> <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> NON-OWNED AUTOS ONLY						COMBINED SINGLE LIMIT (Ea accident)	\$
							BODILY INJURY (Per person)	\$
							BODILY INJURY (Per accident)	\$
							PROPERTY DAMAGE (Per accident)	\$
								\$
	<input type="checkbox"/> UMBRELLA LIAB <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> DED <input type="checkbox"/> RETENTION \$						EACH OCCURRENCE	\$
							AGGREGATE	\$
								\$
	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> 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				PER STATUTE OTHER	
							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)

The Certificate Holder is added as an additional insured as respects Fall Fest Indian River, located at Marina Park, 3471 Club Dr., Indian River, MI 49749 from Sept 8-14, 2020.

**CERTIFICATE HOLDER****CANCELLATION**

Tuscarora Township  
3546 S Straits Highway  
Indian River, MI 49749  
Phone # (231) 238-0970

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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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

10/21/2020

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<b>PRODUCER</b> Insurance By Burley Alanson Office 6244 River Street; PO Box 800 Alanson, MI 49706 Brenda Keith	231-548-2211 <b>CONTACT NAME:</b> Brenda Keith <b>PHONE (A/C, No, Ext):</b> 231-548-2211 <b>FAX (A/C, No):</b> 231-548-5508 <b>E-MAIL ADDRESS:</b> <b>INSURER(S) AFFORDING COVERAGE</b> <b>INSURER A:</b> Auto-Owners Insurance Company <b>INSURER B:</b> <b>INSURER C:</b> <b>INSURER D:</b> <b>INSURER E:</b> <b>INSURER F:</b>	<b>NAIC #</b> 18988
--	--	------------------------

**INSURED**  
 Bruce Thompson  
 2063 Miller Rd  
 Alanson, MI 49706

## 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
A	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <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:			33076899	10/21/2020	10/21/2021	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Per occurrence) \$ 50,000 MED EXP (Any one person) \$ 5,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 1,000,000 PRODUCTS - COMP/OP AGG \$ 1,000,000
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY						COMBINED SINGLE LIMIT (Per accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED <input type="checkbox"/> RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY 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				PER STATUTE <input type="checkbox"/> OTH-ER <input type="checkbox"/> 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)

## CERTIFICATE HOLDER

TUSCARO

Tuscarora Township  
 3546 S Straits Highway  
 Indian River, MI 49749

## 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  
 Brenda Keith



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

08/30/2021

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<b>PRODUCER</b> Insurance By Burley Alanson Office 6244 River Street; PO Box 800 Alanson, MI 49706 Brenda Keith	<b>CONTACT NAME:</b> Brenda Keith <b>PHONE (A/C, No, Ext):</b> 231-548-2211 <b>FAX (A/C, No):</b> 231-548-5508 <b>E-MAIL ADDRESS:</b> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 80%;">INSURER(S) AFFORDING COVERAGE</th> <th style="width: 20%;">NAIC #</th> </tr> <tr> <td><b>INSURER A:</b> Auto-Owners Insurance Company</td> <td>18988</td> </tr> <tr> <td><b>INSURER B:</b></td> <td></td> </tr> <tr> <td><b>INSURER C:</b></td> <td></td> </tr> <tr> <td><b>INSURER D:</b></td> <td></td> </tr> <tr> <td><b>INSURER E:</b></td> <td></td> </tr> <tr> <td><b>INSURER F:</b></td> <td></td> </tr> </table>	INSURER(S) AFFORDING COVERAGE	NAIC #	<b>INSURER A:</b> Auto-Owners Insurance Company	18988	<b>INSURER B:</b>		<b>INSURER C:</b>		<b>INSURER D:</b>		<b>INSURER E:</b>		<b>INSURER F:</b>	
INSURER(S) AFFORDING COVERAGE	NAIC #														
<b>INSURER A:</b> Auto-Owners Insurance Company	18988														
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<b>INSURER D:</b>															
<b>INSURER E:</b>															
<b>INSURER F:</b>															
<b>INSURED</b> Bruce Thompson 2063 Miller Rd Alanson, MI 49706															

**COVERAGES****CERTIFICATE NUMBER:****REVISION NUMBER:**

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A	<input checked="" type="checkbox"/> <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:			33076899	10/21/2020	10/21/2021	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 50,000 MED EXP (Any one person) \$ 5,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 1,000,000 PRODUCTS - COMP/OP AGG \$ 1,000,000
	<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 <input checked="" type="checkbox"/> N If yes, describe under DESCRIPTION OF OPERATIONS below						PER STATUTE <input type="checkbox"/> OTH-ER <input type="checkbox"/> 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)

**CERTIFICATE HOLDER**

TUSCARO

Tuscarora Township  
 3546 S Straits Highway  
 Indian River, MI 49749

**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  
 Brenda Keith



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

11/24/2021

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).

<b>PRODUCER</b> Holmes Murphy Associates/CSDZ, LLC 225 South Sixth Street STE 1900 Minneapolis MN 55402	<b>CONTACT NAME:</b> Allie Darling <b>PHONE (A/C, No, Ext):</b> 612-322-6041 <b>FAX (A/C, No):</b> <b>E-MAIL ADDRESS:</b> adarling@csdz.com
<b>INSURED</b> M&H Facility Operations, Inc. 2440 Deming Way Middleton, WI 53562	<b>INSURER(S) AFFORDING COVERAGE</b> <b>INSURER A:</b> Travelers Indemnity Company <b>INSURER B:</b> Charter Oak Fire Insurance Company <b>INSURER C:</b> Travelers Property Casualty Co. America <b>INSURER D:</b> XL Specialty Insurance <b>INSURER E:</b> <b>INSURER F:</b>

**COVERAGES****CERTIFICATE NUMBER:** 1726422505**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
A	<input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b> <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR <input checked="" type="checkbox"/> Cont Liab Per <input checked="" type="checkbox"/> Policy Form/XCU GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PROJECT <input checked="" type="checkbox"/> LOC OTHER:			6308S701301	12/1/2021	12/1/2022	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 300,000 MED EXP (Any one person) \$ 10,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000 \$
B	<b>AUTOMOBILE LIABILITY</b> <input checked="" type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> NON-OWNED AUTOS ONLY			8108S688704	12/1/2021	12/1/2022	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"/> <b>UMBRELLA LIAB</b> <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED <input checked="" type="checkbox"/> RETENTION \$ 0			CUP8S887858	12/1/2021	12/1/2022	EACH OCCURRENCE \$ 10,000,000 AGGREGATE \$ 10,000,000 \$
A C A	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N N	N/A	UB8696243 UB8S698039 UB8S699509	12/1/2021 12/1/2021 12/1/2021	12/1/2022 12/1/2022 12/1/2022	<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 D	Property Professional Liability			6308S701301 DPR9984620	12/1/2021 10/25/2021	12/1/2022 10/25/2022	Bldg/BPP: \$12,825,012 Per Claim: \$5,000,000 Per Aggregate: \$10,000,000

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

**CERTIFICATE HOLDER****CANCELLATION**

Tuscarora Township  
3546 South Straits Highway  
Indian River MI 49749

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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# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

8/30/2021

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).

<b>PRODUCER</b> North Country Insurance Agency, Inc PO Box 518  Indian River MI 49749		<b>CONTACT NAME:</b> <b>PHONE (A/C No. Ext):</b> 231-238-9882 <b>FAX (A/C No):</b> 231-238-4321 <b>E-MAIL ADDRESS:</b> Generalmail@northcountryins.com	
		<b>INSURER(S) AFFORDING COVERAGE</b>	
		<b>INSURER A:</b> Auto-Owners Insurance Company	
		<b>INSURER B:</b>	
		<b>INSURER C:</b>	
		<b>INSURER D:</b>	
		<b>INSURER E:</b>	
		<b>INSURER F:</b>	
<b>INSURED</b> Ellen August DBA Classic Cleaning 10701 Parke Rd. Alanson MI 49706		<b>NAIC #</b> 01063100	

**COVERAGES****CERTIFICATE NUMBER:** 20210830133431882**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
A	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY			33672647	06/20/2021	06/20/2022	EACH OCCURRENCE \$ 100,000
	<input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 50,000
							MED EXP (Any one person) \$ 5,000
							PERSONAL & ADV INJURY \$ 1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE \$ 1,000,000
	<input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC						PRODUCTS - COMP/OP AGG \$ 1,000,000
	OTHER:						\$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident) \$
	<input type="checkbox"/> ANY AUTO						BODILY INJURY (Per person) \$
	<input type="checkbox"/> OWNED AUTOS ONLY	<input type="checkbox"/> SCHEDULED AUTOS					BODILY INJURY (Per accident) \$
	<input type="checkbox"/> HIRED AUTOS ONLY	<input type="checkbox"/> NON-OWNED AUTOS ONLY					PROPERTY DAMAGE (Per accident) \$
	<input type="checkbox"/> AUTOS ONLY	<input type="checkbox"/> AUTOS ONLY					\$
	UMBRELLA LIAB						EACH OCCURRENCE \$
	EXCESS LIAB						AGGREGATE \$
	<input type="checkbox"/> DED <input type="checkbox"/> RETENTION \$						\$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY						PER STATUTE <input type="checkbox"/> OTH-ER <input type="checkbox"/>
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)			<input type="checkbox"/> Y <input type="checkbox"/> N			E.L. EACH ACCIDENT \$
	If yes, describe under DESCRIPTION OF OPERATIONS below			N/A			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)

**CERTIFICATE HOLDER****CANCELLATION**

Tuscarora Township  
PO BOX 220  
Indian River MI 49749

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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CARRIER NUMBER  
17388NAMED INSURED  
Tanner Electric IncPOLICY  
6722457POLICY TERM  
01/01/2023 to 01/01/2024AGENT  
**0210852**AGENT  
BKC Insurance  
220 Water St.  
Cheboygan, MI 49721**New  
Declaration**ACCOUNT  
700001156507POLICY  
6722457ISSUE DATE  
12/29/2022 at  
02:41 PM**Information Page**POLICY TERM  
01/01/2023 to  
01/01/2024 12:01  
AM

Phone: (231) 627-4381 Agent: 0210852/0210852\_52843

Insurer: Frankenmuth Insurance Company  
Affinity Group: Chamber of Commerce - MI  
Carrier Number: 17388**Billing  
Information**

PAYMENT PLAN 12-Pay

BILLING METHOD Direct Bill - An Account Invoice or Payment Schedule will be mailed to you.

Payments and credits may be applied to all policies on the same billing account and may be applied from one policy term to another. Payment received for less than the billed amount may be pro-rated to each policy and may result in cancellation of all policies for nonpayment of premium.

**ITEM 1. Named Insured**Tanner Electric Inc  
1351 S Straits Hwy  
Indian River, MI 49749-9701LEGAL ENTITY Corporation  
FEIN \*\*0453  
AUDIT FREQUENCY Annual  
STATE ID 5929288A-MI**ITEM 2. Policy Period**

01/01/2023 to 01/01/2024 12:01 a.m. Standard Time at the address of the insured as stated herein.

**ITEM 3A. Workers' Compensation Insurance**Part One of the policy applies to the Workers' Compensation Law of the states listed here:  
**Michigan****ITEM 3B. Employer's Liability Insurance**

Part Two of the policy applies to work in each state listed in Item 3A. The limits of our liability under Part Two are:

Bodily Injury by Accident	\$500,000	each accident
Bodily Injury by Disease	\$500,000	each employee
Bodily Injury by Disease	\$500,000	policy limit

**Item 3C. Other States Insurance**

Part Three of the policy applies to the states, if any, listed here: All states except North Dakota, Ohio, Washington, Wyoming, and states designated in item 3A of the Declarations.

**Item 3D. Endorsements and Schedules**

See attached schedule for a list of endorsements and schedules forming part of this policy.

**Item 4. Classifications of Operations\***

See Attached for Classification of Operations by State

The premium for this policy will be determined by our manual of rules, classifications, rates and rating plans. All information required below is subject to verification and change by audit.

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☐ VOID☐ CORRECTED

PAYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no. TUSCARORA TOWNSHIP PO BOX 220 INDIAN RIVER, MI 49749 (231) 238-0970			1 Rents	OMB No. 1545-0115  <b>2020</b>  Form 1099-MISC	<b>Miscellaneous Income</b>
			\$		
			2 Royalties		
			\$		
			3 Other income	4 Federal income tax withheld	<b>Copy A</b> For Internal Revenue Service Center  File with Form 1096.  For Privacy Act and Paperwork Reduction Act Notice, see the 2020 General Instructions for Certain Information Returns.
			\$ 4815.52	\$	
PAYER'S TIN	RECIPIENT'S TIN		5 Fishing boat proceeds	6 Medical and health care payments	
			\$	\$	
RECIPIENT'S name			7 Payer made direct sales of \$5,000 or more of consumer products to a buyer (recipient) for resale <input type="checkbox"/>	8 Substitute payments in lieu of dividends or interest	
BRUCE THOMPSON			\$	\$	
Street address (including apt. no.)			9 Crop insurance proceeds	10 Gross proceeds paid to an attorney	
2063 MILLER ROAD			\$	\$	
City or town, state or province, country, and ZIP or foreign postal code			11	12 Section 409A deferrals	
ALANSON MI 49706				\$	
Account number (see instructions)	FATCA filing requirement <input type="checkbox"/>	2nd TIN not <input type="checkbox"/>	13 Excess golden parachute payments	14 Nonqualified deferred compensation	
			\$	\$	
			15 State tax withheld	16 State/Payer's state no.	17 State income
			\$		\$
			\$		\$

Form 1099-MISC

41-0852411

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☐ VOID☐ CORRECTED

PAYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no. TUSCARORA TOWNSHIP PO BOX 220 INDIAN RIVER, MI 49749 (231) 238-0970			1 Rents	OMB No. 1545-0115  <b>2020</b>  Form 1099-MISC	<b>Miscellaneous Income</b>
			\$		
			2 Royalties		
			\$		
			3 Other income	4 Federal income tax withheld	<b>Copy A</b> For Internal Revenue Service Center  File with Form 1096.  For Privacy Act and Paperwork Reduction Act Notice, see the 2020 General Instructions for Certain Information Returns.
			\$ 4989.17	\$	
PAYER'S TIN	RECIPIENT'S TIN		5 Fishing boat proceeds	6 Medical and health care payments	
			\$	\$	
RECIPIENT'S name			7 Payer made direct sales of \$5,000 or more of consumer products to a buyer (recipient) for resale <input type="checkbox"/>	8 Substitute payments in lieu of dividends or interest	
CLASSIC CLEANING			\$	\$	
Street address (including apt. no.)			9 Crop insurance proceeds	10 Gross proceeds paid to an attorney	
10701 PARKE RD.			\$	\$	
City or town, state or province, country, and ZIP or foreign postal code			11	12 Section 409A deferrals	
ALANSON, MI 49706				\$	
Account number (see instructions)	FATCA filing requirement <input type="checkbox"/>	2nd TIN not <input type="checkbox"/>	13 Excess golden parachute payments	14 Nonqualified deferred compensation	
			\$	\$	
			15 State tax withheld	16 State/Payer's state no.	17 State income
			\$		\$
			\$		\$

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☐ VOID☐ CORRECTED

PAYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no. TUSCARORA TOWNSHIP PO BOX 220 INDIAN RIVER, MI 49749 (231) 238-0970			1 Rents \$	OMB No. 1545-0115  <b>2020</b> Form 1099-MISC	<b>Miscellaneous Income</b>
			2 Royalties \$		
			3 Other income \$	4 Federal income tax withheld \$	
			5 Fishing boat proceeds \$	6 Medical and health care payments \$	
PAYER'S TIN  [REDACTED]	RECIPIENT'S TIN  [REDACTED]				<b>Copy A</b> <b>For</b> <b>Internal Revenue Service Center</b>  File with Form 1096. For Privacy Act and Paperwork Reduction Act Notice, see the <b>2020 General Instructions for Certain Information Returns.</b>
RECIPIENT'S name MCGRAW MORRIS P.C.		7 Payer made direct sales of \$5,000 or more of consumer products to a buyer (recipient) for resale <input type="checkbox"/>	8 Substitute payments in lieu of dividends or interest \$		
Street address (including apt. no.) 2075 WEST BIG BEAVER, STE. 750		9 Crop insurance proceeds \$	10 Gross proceeds paid to an attorney \$		
City or town, state or province, country, and ZIP or foreign postal code TROY MI 48084		11 \$	12 Section 409A deferrals \$		
Account number (see instructions)	FATCA filing requirement <input type="checkbox"/>	2nd TIN not <input type="checkbox"/>	13 Excess golden parachute payments \$	14 Nonqualified deferred compensation \$ 2162.50	
			15 State tax withheld \$	16 State/Payer's state no. \$	17 State income \$

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			2 Royalties \$		
			3 Other income \$	4 Federal income tax withheld \$	
			5 Fishing boat proceeds \$	6 Medical and health care payments \$	
PAYER'S TIN  [REDACTED]	RECIPIENT'S TIN  [REDACTED]				<b>Copy A</b> <b>For</b> <b>Internal Revenue Service Center</b>  File with Form 1096. For Privacy Act and Paperwork Reduction Act Notice, see the <b>2020 General Instructions for Certain Information Returns.</b>
RECIPIENT'S name MILLER, CANFIELD, PADDOCK,		7 Payer made direct sales of \$5,000 or more of consumer products to a buyer (recipient) for resale <input type="checkbox"/>	8 Substitute payments in lieu of dividends or interest \$		
Street address (including apt. no.) AND STONE PO BOX 640348		9 Crop insurance proceeds \$	10 Gross proceeds paid to an attorney \$		
City or town, state or province, country, and ZIP or foreign postal code DETROIT MI 48264-0348		11 \$	12 Section 409A deferrals \$		
Account number (see instructions)	FATCA filing requirement <input type="checkbox"/>	2nd TIN not <input type="checkbox"/>	13 Excess golden parachute payments \$	14 Nonqualified deferred compensation \$ 29000.00	
			15 State tax withheld \$	16 State/Payer's state no. \$	17 State income \$

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Department of the Treasury - Internal Revenue Service

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PAYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no. TUSCARORA TOWNSHIP PO BOX 220 INDIAN RIVER, MI 49749 (231) 238-0970			1 Rents	OMB No. 1545-0115  <b>2020</b>  Form 1099-MISC	<b>Miscellaneous Income</b>
			\$		
			2 Royalties		
			\$		
			3 Other income	4 Federal income tax withheld	<b>Copy A</b>  <b>For Internal Revenue Service Center</b>  File with Form 1096.  For Privacy Act and Paperwork Reduction Act Notice, see the <b>2020 General Instructions for Certain Information Returns.</b>
			\$ 3840.00	\$	
PAYER'S TIN	RECIPIENT'S TIN		5 Fishing boat proceeds	6 Medical and health care payments	
			\$	\$	
RECIPIENT'S name			7 Payer made direct sales of \$5,000 or more of consumer products to a buyer (recipient) for resale <input type="checkbox"/>	8 Substitute payments in lieu of dividends or interest	
K & J SEPTIC SERVICE			\$	\$	
Street address (including apt. no.)			9 Crop insurance proceeds	10 Gross proceeds paid to an attorney	
2560 RIVER ROAD			\$	\$	
City or town, state or province, country, and ZIP or foreign postal code			11	12 Section 409A deferrals	
PETOSKEY MI 49770				\$	
Account number (see instructions)	FATCA filing requirement <input type="checkbox"/>	2nd TIN not <input type="checkbox"/>	13 Excess golden parachute payments	14 Nonqualified deferred compensation	
			\$	\$	
			15 State tax withheld	16 State/Payer's state no.	17 State income
			\$		\$
			\$		\$

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PAYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no. TUSCARORA TOWNSHIP PO BOX 220 INDIAN RIVER, MI 49749 (231) 238-0970			1 Rents	OMB No. 1545-0115  <b>2020</b>  Form 1099-MISC	<b>Miscellaneous Income</b>
			\$		
			2 Royalties		
			\$		
			3 Other income	4 Federal income tax withheld	<b>Copy A</b>  <b>For Internal Revenue Service Center</b>  File with Form 1096.  For Privacy Act and Paperwork Reduction Act Notice, see the <b>2020 General Instructions for Certain Information Returns.</b>
			\$	\$	
PAYER'S TIN	RECIPIENT'S TIN		5 Fishing boat proceeds	6 Medical and health care payments	
			\$	\$	
RECIPIENT'S name			7 Payer made direct sales of \$5,000 or more of consumer products to a buyer (recipient) for resale <input type="checkbox"/>	8 Substitute payments in lieu of dividends or interest	
KIRK & HUTH, P.C.			\$	\$	
Street address (including apt. no.)			9 Crop insurance proceeds	10 Gross proceeds paid to an attorney	
ATTORNEYS AT LAW			\$	\$	
19500 HALL RD., SUITE 100					
City or town, state or province, country, and ZIP or foreign postal code			11	12 Section 409A deferrals	
CLINTON TWP. MI 48038				\$	
Account number (see instructions)	FATCA filing requirement <input type="checkbox"/>	2nd TIN not <input type="checkbox"/>	13 Excess golden parachute payments	14 Nonqualified deferred compensation	
			\$	\$ 2031.25	
			15 State tax withheld	16 State/Payer's state no.	17 State income
			\$		\$
			\$		\$

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Department of the Treasury - Internal Revenue Service

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PAYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no. TUSCARORA TOWNSHIP PO BOX 220 INDIAN RIVER, MI 49749 (231) 238-0970			1 Rents	OMB No. 1545-0115  <b>2020</b>  Form 1099-MISC	<b>Miscellaneous Income</b>
			\$		
			2 Royalties		
			\$		
			3 Other income	4 Federal income tax withheld	<b>Copy A</b> For <b>Internal Revenue Service Center</b>  File with Form 1096.  For Privacy Act and Paperwork Reduction Act Notice, see the <b>2020 General Instructions for Certain Information Returns.</b>
			\$ 10000.00	\$	
PAYER'S TIN	RECIPIENT'S TIN		5 Fishing boat proceeds	6 Medical and health care payments	
			\$	\$	
RECIPIENT'S name			7 Payer made direct sales of \$5,000 or more of consumer products to a buyer (recipient) for resale <input type="checkbox"/>	8 Substitute payments in lieu of dividends or interest	
GREAT LAKES FIREWORKS			\$	\$	
Street address (including apt. no.)			9 Crop insurance proceeds	10 Gross proceeds paid to an attorney	
24805 MARINE			\$	\$	
City or town, state or province, country, and ZIP or foreign postal code			11	12 Section 409A deferrals	
EASTPOINTE MI 48021				\$	
Account number (see instructions)	FATCA filing requirement <input type="checkbox"/>	2nd TIN not <input type="checkbox"/>	13 Excess golden parachute payments	14 Nonqualified deferred compensation	
			\$	\$	
			15 State tax withheld	16 State/Payer's state no.	17 State income
			\$	38-1812031	\$
			\$		\$

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			\$		
			2 Royalties		
			\$		
			3 Other income	4 Federal income tax withheld	<b>Copy A</b> For <b>Internal Revenue Service Center</b>  File with Form 1096.  For Privacy Act and Paperwork Reduction Act Notice, see the <b>2020 General Instructions for Certain Information Returns.</b>
			\$ 5000.00	\$	
PAYER'S TIN	RECIPIENT'S TIN		5 Fishing boat proceeds	6 Medical and health care payments	
			\$	\$	
RECIPIENT'S name			7 Payer made direct sales of \$5,000 or more of consumer products to a buyer (recipient) for resale <input type="checkbox"/>	8 Substitute payments in lieu of dividends or interest	
HILL MOUNTAIN SIGNWORKS			\$	\$	
Street address (including apt. no.)			9 Crop insurance proceeds	10 Gross proceeds paid to an attorney	
6455 PICKEREL LAKE ROAD			\$	\$	
City or town, state or province, country, and ZIP or foreign postal code			11	12 Section 409A deferrals	
PETOSKEY MI 49770				\$	
Account number (see instructions)	FATCA filing requirement <input type="checkbox"/>	2nd TIN not <input type="checkbox"/>	13 Excess golden parachute payments	14 Nonqualified deferred compensation	
			\$	\$	
			15 State tax withheld	16 State/Payer's state no.	17 State income
			\$		\$
			\$		\$

Form 1099-MISC

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41-0852411

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Department of the Treasury - Internal Revenue Service

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9595

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PAYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no. TUSCARORA TOWNSHIP PO BOX 220 INDIAN RIVER, MI 49749 (231) 238-0970			1 Rents	OMB No. 1545-0115  <b>2020</b>  Form 1099-MISC	<b>Miscellaneous Income</b>  <b>Copy A</b> For Internal Revenue Service Center  File with Form 1096. For Privacy Act and Paperwork Reduction Act Notice, see the 2020 General Instructions for Certain Information Returns.
			\$		
			2 Royalties	\$	
PAYER'S TIN			3 Other income	4 Federal income tax withheld	
RECIPIENT'S TIN			\$ 810.00	\$	
RECIPIENT'S name			5 Fishing boat proceeds	6 Medical and health care payments	
BARB ALGENSTEDT			\$	\$	
Street address (including apt. no.)			7 Payer made direct sales of \$5,000 or more of consumer products to a buyer (recipient) for resale <input type="checkbox"/>	8 Substitute payments in lieu of dividends or interest	
2743 GILPIN			9 Crop insurance proceeds	10 Gross proceeds paid to an attorney	
City or town, state or province, country, and ZIP or foreign postal code			11	12 Section 409A deferrals	
CHEBOYGAN MI 49721			\$	\$	
Account number (see instructions)	FATCA filing requirement <input type="checkbox"/>	2nd TIN not <input type="checkbox"/>	13 Excess golden parachute payments	14 Nonqualified deferred compensation	
			\$	\$	
			15 State tax withheld	16 State/Payer's state no.	17 State income
			\$		\$
			\$		\$

Form 1099-MISC

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PAYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no. TUSCARORA TOWNSHIP PO BOX 220 INDIAN RIVER, MI 49749 (231) 238-0970			1 Rents	OMB No. 1545-0115  <b>2020</b>  Form 1099-MISC	<b>Miscellaneous Income</b>  <b>Copy A</b> For Internal Revenue Service Center  File with Form 1096. For Privacy Act and Paperwork Reduction Act Notice, see the 2020 General Instructions for Certain Information Returns.
			\$		
PAYER'S TIN			3 Other income	4 Federal income tax withheld	
RECIPIENT'S TIN			\$ 957.83	\$	
RECIPIENT'S name			5 Fishing boat proceeds	6 Medical and health care payments	
DECKA DIGITAL			\$	\$	
Street address (including apt. no.)			7 Payer made direct sales of \$5,000 or more of consumer products to a buyer (recipient) for resale <input type="checkbox"/>	8 Substitute payments in lieu of dividends or interest	
8742 MCBRIDE COURT			9 Crop insurance proceeds	10 Gross proceeds paid to an attorney	
City or town, state or province, country, and ZIP or foreign postal code			11	12 Section 409A deferrals	
HARBOR SPRINGS MI 49740			\$	\$	
Account number (see instructions)	FATCA filing requirement <input type="checkbox"/>	2nd TIN not <input type="checkbox"/>	13 Excess golden parachute payments	14 Nonqualified deferred compensation	
			\$	\$	
			15 State tax withheld	16 State/Payer's state no.	17 State income
			\$		\$
			\$		\$

Form 1099-MISC

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Department of the Treasury - Internal Revenue Service

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PAYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no. TUSCARORA TOWNSHIP PO BOX 220 INDIAN RIVER, MI 49749 (231) 238-0970		OMB No. 1545-0116 <b>2020</b> Form 1099-NEC		<b>Nonemployee Compensation</b>	
1 Nonemployee compensation \$ 3000.00		2		<b>Copy A</b> <b>For</b> <b>Internal Revenue Service Center</b>  <b>File with Form 1096.</b>  <b>For Privacy Act and Paperwork Reduction Act Notice, see the 2020 General Instructions for Certain Information Returns.</b>	
PAYER'S TIN	RECIPIENT'S TIN	3			
RECIPIENT'S name QUALITY SEAL COATING		4 Federal income tax withheld \$			
Street address (including apt. no.) 2803 BERRY PATCH LANE		5 State tax withheld \$			
City or town, state or province, country, and ZIP or foreign postal code ALANSON MI 49706		6 State/Payer's state no.			
FATCA filing requirement <input type="checkbox"/>		7 State income \$			
Account number (see instructions)		2nd TIN not. <input type="checkbox"/>			

Form 1099-NEC

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PAYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no. TUSCARORA TOWNSHIP PO BOX 220 INDIAN RIVER, MI 49749 (231) 238-0970		OMB No. 1545-0116 <b>2020</b> Form 1099-NEC		<b>Nonemployee Compensation</b>	
1 Nonemployee compensation \$ 1113.05		2		<b>Copy A</b> <b>For</b> <b>Internal Revenue Service Center</b>  <b>File with Form 1096.</b>  <b>For Privacy Act and Paperwork Reduction Act Notice, see the 2020 General Instructions for Certain Information Returns.</b>	
PAYER'S TIN	RECIPIENT'S TIN	3			
RECIPIENT'S name POTTER CONSULTING		4 Federal income tax withheld \$			
Street address (including apt. no.) 5235 FOREST GATE CT		5 State tax withheld \$			
City or town, state or province, country, and ZIP or foreign postal code GRAND BLANC MI 48439		6 State/Payer's state no.			
FATCA filing requirement <input type="checkbox"/>		7 State income \$			
Account number (see instructions)		2nd TIN not. <input type="checkbox"/>			

Form 1099-NEC

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Department of the Treasury - Internal Revenue Service

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PAYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no. TUSCARORA TWP LIBRARY 3546 S STRAITS HWY INDIAN RIVER, MI (231) 238-0970			1 Rents	OMB No. 1545-0115  <b>2020</b>  Form 1099-MISC	<b>Miscellaneous Income</b>  <b>Copy C</b> For Payer or State Copy or Copy 2  For Privacy Act and Paperwork Reduction Act Notice, see the <b>2020 General Instructions for Certain Information Returns.</b>
			\$		
			2 Royalties		
3 Other income	4 Federal income tax withheld				
\$ 1859.58	\$				
PAYER'S TIN	RECIPIENT'S TIN	5 Fishing boat proceeds	6 Medical and health care payments		
		\$	\$		
RECIPIENT'S name, street address, city or town, state or province, country, and ZIP or foreign postal code CLASSIC CLEANING  10701 PARKE RD.  ALANSON, MI 49706			7 Payer made direct sales of \$5,000 or more of consumer products to a buyer (recipient) for resale <input type="checkbox"/>	8 Substitute payments in lieu of dividends or interest	
			9 Crop insurance proceeds	10 Gross proceeds paid to an attorney	
			11	12 Section 409A deferrals	
Account number (see instructions)	FATCA filing requirement <input type="checkbox"/>	2nd TIN not <input type="checkbox"/>	13 Excess golden parachute payments	14 Nonqualified deferred compensation	
			\$	\$	
			15 State tax withheld	16 State/Payer's state no.	17 State income
			\$		\$
			\$		\$

Form 1099-MISC

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Department of the Treasury - Internal Revenue Service

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PAYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no.			1 Rents	OMB No. 1545-0115  <b>2020</b>  Form 1099-MISC	<b>Miscellaneous Income</b>  <b>Copy C</b> For Payer or State Copy or Copy 2  For Privacy Act and Paperwork Reduction Act Notice, see the <b>2020 General Instructions for Certain Information Returns.</b>
			\$		
			2 Royalties		
3 Other income	4 Federal income tax withheld				
\$	\$				
PAYER'S TIN	RECIPIENT'S TIN	5 Fishing boat proceeds	6 Medical and health care payments		
		\$	\$		
RECIPIENT'S name, street address, city or town, state or province, country, and ZIP or foreign postal code			7 Payer made direct sales of \$5,000 or more of consumer products to a buyer (recipient) for resale <input type="checkbox"/>	8 Substitute payments in lieu of dividends or interest	
			9 Crop insurance proceeds	10 Gross proceeds paid to an attorney	
			11	12 Section 409A deferrals	
Account number (see instructions)	FATCA filing requirement <input type="checkbox"/>	2nd TIN not <input type="checkbox"/>	13 Excess golden parachute payments	14 Nonqualified deferred compensation	
			\$	\$	
			15 State tax withheld	16 State/Payer's state no.	17 State income
			\$		\$
			\$		\$

Form 1099-MISC

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Department of the Treasury - Internal Revenue Service

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PAYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no. TUSCARORA TWP LIBRARY 3546 S STRAITS HWY INDIAN RIVER, MI (231) 238-0970		OMB No. 1545-0116 Form <b>1099-NEC</b> Rev. January 2022 For calendar year 20 22		<b>Nonemployee Compensation</b>  <b>Copy B For Recipient</b>  This is important tax information and is being furnished to the IRS. If you are required to file a return, a negligence penalty or other sanction may be imposed on you if this income is taxable and the IRS determines that it has not been reported.
PAYER'S TIN [REDACTED]	RECIPIENT'S TIN [REDACTED]	1 Nonemployee compensation \$ 2859.01		
RECIPIENT'S name CLASSIC CLEANING		2 Payer made direct sales totaling \$5,000 or more of consumer products to recipient for resale <input type="checkbox"/>		
Street address (including apt. no.) 10701 PARKE RD. City or town, state or province, country, and ZIP or foreign postal code ALANSON, MI 49706		3 [REDACTED] 4 Federal income tax withheld \$		
Account number (see instructions)		5 State tax withheld \$	6 State identification no. \$	7 State income \$

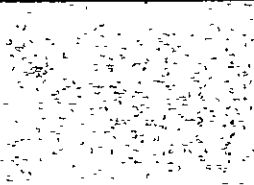
Form **1099-NEC** Department of the Treasury - Internal Revenue Service

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PAYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no. TUSCARORA TWP LIBRARY 3546 S STRAITS HWY INDIAN RIVER, MI (231) 238-0970		OMB No. 1545-0116 Form <b>1099-NEC</b> Rev. January 2022 For calendar year 20 22		<b>Nonemployee Compensation</b>  <b>Copy B For Recipient</b>  This is important tax information and is being furnished to the IRS. If you are required to file a return, a negligence penalty or other sanction may be imposed on you if this income is taxable and the IRS determines that it has not been reported.
PAYER'S TIN [REDACTED]	RECIPIENT'S TIN [REDACTED]	1 Nonemployee compensation \$ 2126.67		
RECIPIENT'S name HILL MOUNTAIN SIGNWORKS		2 Payer made direct sales totaling \$5,000 or more of consumer products to recipient for resale <input type="checkbox"/>		
Street address (including apt. no.) 6455 PICKEREL LAKE ROAD City or town, state or province, country, and ZIP or foreign postal code PETOSKEY MI 49770		3 [REDACTED] 4 Federal income tax withheld \$		
Account number (see instructions)		5 State tax withheld \$	6 State identification no. \$	7 State income \$

Form **1099-NEC** Department of the Treasury - Internal Revenue Service

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PAYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no. TUSCARORA TOWNSHIP PO BOX 220 INDIAN RIVER, MI 49749 (231) 238-0970		OMB No. 1545-0116
		Form 1099-NEC
		Rev. January 2022
		For calendar year 20 22

**Nonemployee Compensation**

PAYER'S TIN [REDACTED]	RECIPIENT'S TIN [REDACTED]	1 Nonemployee compensation \$ 17500.00		
RECIPIENT'S name GREAT LAKES FIREWORKS  Street address (including apt. no.) 24805 MARINE City or town, state or province, country, and ZIP or foreign postal code EASTPOINTE MI 48021  Account number (see instructions)		2 Payer made direct sales totaling \$5,000 or more of consumer products to recipient for resale <input type="checkbox"/>		
		3 [REDACTED]		
		4 Federal income tax withheld \$		
		5 State tax withheld \$	6 State identification no. 38-1812031	7 State income \$
		\$		\$


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Form 1099-NEC

Department of the Treasury - Internal Revenue Service

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PAYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no. TUSCARORA TOWNSHIP PO BOX 220 INDIAN RIVER, MI 49749 (231) 238-0970		OMB No. 1545-0116
		Form 1099-NEC
		Rev. January 2022
		For calendar year 20 22

**Nonemployee Compensation**

PAYER'S TIN [REDACTED]	RECIPIENT'S TIN [REDACTED]	1 Nonemployee compensation \$ 4253.33		
RECIPIENT'S name HILL MOUNTAIN SIGNWORKS  Street address (including apt. no.) 6455 PICKEREL LAKE ROAD City or town, state or province, country, and ZIP or foreign postal code PETOSKEY MI 49770  Account number (see instructions)		2 Payer made direct sales totaling \$5,000 or more of consumer products to recipient for resale <input type="checkbox"/>		
		3 [REDACTED]		
		4 Federal income tax withheld \$		
		5 State tax withheld \$	6 State identification no.	7 State income \$
		\$		\$


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Form 1099-NEC

Department of the Treasury - Internal Revenue Service

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PAYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no. TUSCARORA TOWNSHIP PO BOX 220 INDIAN RIVER, MI 49749 (231) 238-0970		OMB No. 1545-0116
		Form 1099-NEC
		Rev. January 2022
		For calendar year 20 22

**Nonemployee Compensation**

PAYER'S TIN [REDACTED]	RECIPIENT'S TIN [REDACTED]	1 Nonemployee compensation \$ 3520.00		
RECIPIENT'S name K & J SEPTIC SERVICE  Street address (including apt. no.) 2560 RIVER ROAD City or town, state or province, country, and ZIP or foreign postal code PETOSKEY MI 49770  Account number (see instructions)		2 Payer made direct sales totaling \$5,000 or more of consumer products to recipient for resale <input type="checkbox"/>		
		3 [REDACTED]		
		4 Federal income tax withheld \$		
		5 State tax withheld \$	6 State identification no.	7 State income \$
		\$		\$

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PAYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no. TUSCARORA TOWNSHIP PO BOX 220 INDIAN RIVER, MI 49749 (231) 238-0970		OMB No. 1545-0116 Form 1099-NEC Rev. January 2022 For calendar year 20 22		<b>Nonemployee Compensation</b>
PAYER'S TIN [REDACTED]	RECIPIENT'S TIN [REDACTED]	1 Nonemployee compensation \$ 6464.00		
RECIPIENT'S name BRUCE THOMPSON		2 Payer made direct sales totaling \$5,000 or more of consumer products to recipient for resale <input type="checkbox"/>		<b>Copy B For Recipient</b>  This is important tax information and is being furnished to the IRS. If you are required to file a return, a negligence penalty or other sanction may be imposed on you if this income is taxable and the IRS determines that it has not been reported.
Street address (including apt. no.) 2063 MILLER ROAD City or town, state or province, country, and ZIP or foreign postal code ALANSON MI 49706		3 [REDACTED]		
Account number (see instructions)		4 Federal income tax withheld \$		
		5 State tax withheld \$ 6 State identification no. 7 State income \$		

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Department of the Treasury - Internal Revenue Service

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PAYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no. TUSCARORA TOWNSHIP PO BOX 220 INDIAN RIVER, MI 49749 (231) 238-0970		OMB No. 1545-0116 Form 1099-NEC Rev. January 2022 For calendar year 20 22		<b>Nonemployee Compensation</b>
PAYER'S TIN [REDACTED]	RECIPIENT'S TIN [REDACTED]	1 Nonemployee compensation \$ 4000.00		
RECIPIENT'S name QUALITY SEAL COATING		2 Payer made direct sales totaling \$5,000 or more of consumer products to recipient for resale <input type="checkbox"/>		<b>Copy B For Recipient</b>  This is important tax information and is being furnished to the IRS. If you are required to file a return, a negligence penalty or other sanction may be imposed on you if this income is taxable and the IRS determines that it has not been reported.
Street address (including apt. no.) 2803 BERRY PATCH LANE City or town, state or province, country, and ZIP or foreign postal code ALANSON MI 49706		3 [REDACTED]		
Account number (see instructions)		4 Federal income tax withheld \$		
		5 State tax withheld \$ 6 State identification no. 7 State income \$		

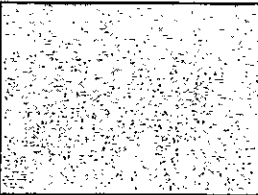
Form 1099-NEC

Department of the Treasury - Internal Revenue Service



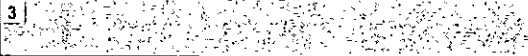
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PAYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no. TUSCARORA TOWNSHIP PO BOX 220 INDIAN RIVER, MI 49749 (231) 238-0970		OMB No. 1545-0116 Form 1099-NEC Rev. January 2022 For calendar year 20 22		<b>Nonemployee Compensation</b>
PAYER'S TIN [REDACTED]	RECIPIENT'S TIN [REDACTED]	1 Nonemployee compensation \$ 2100.00		
RECIPIENT'S name ARBOR LOGIC TREE CARE		2 Payer made direct sales totaling \$5,000 or more of consumer products to recipient for resale <input type="checkbox"/>		<b>Copy B For Recipient</b>  This is important tax information and is being furnished to the IRS. If you are required to file a return, a negligence penalty or other sanction may be imposed on you if this income is taxable and the IRS determines that it has not been reported.
Street address (including apt. no.) 3869 CLUB ROAD City or town, state or province, country, and ZIP or foreign postal code INDIAN RIVER MI 49749		3 [REDACTED]		
Account number (see instructions)		4 Federal income tax withheld \$		
		5 State tax withheld \$ 6 State identification no. 7 State income \$		

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PAYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no. TUSCARORA TOWNSHIP PO BOX 220 INDIAN RIVER, MI 49749 (231) 238-0970		OMB No. 1545-0116
		Form <b>1099-NEC</b>
		Rev. January 2022
		For calendar year 20 22

## Nonemployee Compensation

PAYER'S TIN 	RECIPIENT'S TIN 	<b>1</b> Nonemployee compensation \$ 4857.25		<b>Copy B For Recipient</b>  This is important tax information and is being furnished to the IRS. If you are required to file a return, a negligence penalty or other sanction may be imposed on you if this income is taxable and the IRS determines that it has not been reported.
RECIPIENT'S name CLASSIC CLEANING  Street address (including apt. no.) 10701 PARKE RD.  City or town, state or province, country, and ZIP or foreign postal code ALANSON, MI 49706		<b>2</b> Payer made direct sales totaling \$5,000 or more of consumer products to recipient for resale <input type="checkbox"/>		
		<b>3</b> 		
		<b>4</b> Federal income tax withheld \$		
Account number (see instructions)		<b>5</b> State tax withheld \$	<b>6</b> State identification no. -----	
		<b>5</b> State tax withheld \$	<b>6</b> State identification no. -----	<b>7</b> State income \$

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Department of the Treasury - Internal Revenue Service

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PAYER'S name, street address, city or town, province or state, country, ZIP or foreign postal code, and telephone no. DOWNTOWN DEVELOPMENT AUTHORITY 546 S. STRAITS HWY. J BOX 220 (231) 238-0970		1 Rents	OMB No. 1545-0115	<b>Miscellaneous Income</b>
		\$	Form 1099-MISC	
		2 Royalties	Rev. January 2022	
		\$	For calendar year 20 22	
PAYER'S TIN		3 Other income	4 Federal income tax withheld	<b>Copy B For Recipient</b>  This is important tax information and is being furnished to the Internal Revenue Service. If you are required to file a return, a negligence penalty or other sanction may be imposed on you if this income is taxable and the IRS determines that it has not been reported.
		\$	\$	
RECIPIENT'S TIN		5 Fishing boat proceeds	6 Medical and health care payments	
		\$	\$	
		7 Payer made direct sales of \$5,000 or more of consumer products to a buyer (recipient) for resale <input type="checkbox"/>	8 Substitute payments in lieu of dividends or inter	
RECIPIENT'S name, address, ZIP/postal code & county KIRK & HUTH, P.C.  ATTORNEYS AT LAW 19500 HALL RD., SUITE 100 CLINTON TWP. MI 48038		\$	\$	
		9 Crop insurance proceeds	10 Gross proceeds paid to an attorney	
		\$	\$ 31.25	
		11 Fish purchase for resale	12 Section 409A deferrals	
		\$	\$	
		13 FATCA filing requirement <input type="checkbox"/>	14 Excess golden parachute payments	15 Nonequalified deferred compensation
Account number (see instructions)		\$	\$	
		16 State tax withheld	17 State/Payer's state no.	18 State income
		\$	\$	\$

Form 1099-MISC

Department of the Treasury - Internal Revenue Service

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PAYER'S name, street address, city or town, province or state, country, ZIP or foreign postal code, and telephone no. TUSCARORA TOWNSHIP PO BOX 220 INDIAN RIVER, MI 49749 (231) 238-0970		1 Rents	OMB No. 1545-0115	<b>Miscellaneous Income</b>
		\$ 1500.00	Form 1099-MISC	
		2 Royalties	Rev. January 2022	
		\$	For calendar year 20 22	
PAYER'S TIN		3 Other income	4 Federal income tax withheld	<b>Copy B For Recipient</b>  This is important tax information and is being furnished to the Internal Revenue Service. If you are required to file a return, a negligence penalty or other sanction may be imposed on you if this income is taxable and the IRS determines that it has not been reported.
		\$	\$	
RECIPIENT'S TIN		5 Fishing boat proceeds	6 Medical and health care payments	
		\$	\$	
		7 Payer made direct sales of \$5,000 or more of consumer products to a buyer (recipient) for resale <input type="checkbox"/>	8 Substitute payments in lieu of dividends or inter	
RECIPIENT'S name, address, ZIP/postal code & county THOMAS SNYDER  PO BOX 847  INDIAN RIVER MI 49749		\$	\$	
		9 Crop insurance proceeds	10 Gross proceeds paid to an attorney	
		\$	\$	
		11 Fish purchase for resale	12 Section 409A deferrals	
		\$	\$	
		13 FATCA filing requirement <input type="checkbox"/>	14 Excess golden parachute payments	15 Nonequalified deferred compensation
Account number (see instructions)		\$	\$	
		16 State tax withheld	17 State/Payer's state no.	18 State income
		\$	\$	\$

Form 1099-MISC

Department of the Treasury - Internal Revenue Service

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PAYER'S name, street address, city or town, province or state, country, ZIP or foreign postal code, and telephone no. TUSCARORA TOWNSHIP PO BOX 220 INDIAN RIVER, MI 49749 (231) 238-0970		1 Rents	OMB No. 1545-0115	
		\$	Form 1099-MISC	
		2 Royalties	Rev. January 2022	
		\$	For calendar year 20 22	
		3 Other income	4 Federal income tax withheld	
		\$	\$	
PAYER'S TIN	RECIPIENT'S TIN	5 Fishing boat proceeds	6 Medical and health care payments	
		\$	\$	
RECIPIENT'S name, address, ZIP/postal code & county KIRK & HUTH, P.C.  ATTORNEYS AT LAW 19500 HALL RD., SUITE 100 CLINTON TWP. MI 48038		7 Payer made direct sales of \$5,000 or more of consumer products to a buyer (recipient) for resale <input type="checkbox"/>	8 Substitute payments in lieu of dividends or inter	
		\$	\$	
		9 Crop insurance proceeds	10 Gross proceeds paid to an attorney	
		\$	\$12491.78	
		11 Fish purchase for resale	12 Section 409A deferrals	
		\$	\$	
		13 FATCA filing requirement <input type="checkbox"/>	14 Excess golden parachute payments	
		\$	15 Nonequalified deferred compensation	
		\$	\$	
Account number (see instructions)		16 State tax withheld	17 State/Payer's state no.	
		\$	\$	
		\$	18 State income	
		\$	\$	

Miscellaneous  
Income

Copy B  
For Recipient

This is important tax information and is being furnished to the Internal Revenue Service. If you are required to file a return, a negligence penalty or other sanction may be imposed on you if this income is taxable and the IRS determines that it has not been reported.

ID / Code	Name / Desc	Gross Pay	Regular Pay	1.500x
<b>301 - POLICE</b>				
7720	POLICE OFFICERS			
14	CHAMBERLAIN, WALTER C	64,044.22	64,044.22	0.00
34	BLUMKE, BRANDON D.	71,010.43	69,890.68	1,119.75
35	DIEHL, CHRISTOPHER V	65,488.06	65,488.06	0.00
42	TEMPLE, JR, GORDON M.	82,953.20	82,953.20	0.00
59	ANDERSON, MICKELO M	67,494.21	66,680.01	814.20
66	LALONDE, STACY A	65,162.72	65,162.72	0.00
8	JOHNSON, JEFFREY A.	63,722.22	63,722.22	0.00
102	MYERSON, JANET C	63,642.73	63,225.45	417.28
70	BECKWITH, CHARLES A	2,940.00	2,940.00	0.00
130	JONES, JACKSON E	18,615.80	18,615.80	0.00
7720 Totals:		565,073.59	562,722.36	2,351.23
<b>8810-3 LIBRARIES/MUSEUMS: PR</b>				
9	JEWELL, KATHLEEN	7,273.60	7,273.60	0.00
125	BLAIR, SYDNEY N	704.00	704.00	0.00
8810-3 Totals:		7,977.60	7,977.60	0.00
<b>Unclassified No Workers' Comp Code</b>				
125	BLAIR, SYDNEY N	3,296.00	3,296.00	0.00
Unclassified Totals:		3,296.00	3,296.00	0.00
<b>8810-1 OFFICE</b>				
9	JEWELL, KATHLEEN	28,571.31	28,571.31	0.00
8810-1 Totals:		28,571.31	28,571.31	0.00
Department 301 Totals:		604,918.50	602,567.27	2,351.23
<b>215 - CLERK</b>				
<b>Unclassified No Workers' Comp Code</b>				
107	WEBB, DAWN M	23,962.10	23,962.10	0.00
Unclassified Totals:		23,962.10	23,962.10	0.00
<b>8810-1 OFFICE</b>				
83	WIMER, CINDY J	50.00	50.00	0.00
8810-1 Totals:		50.00	50.00	0.00
Department 215 Totals:		24,012.10	24,012.10	0.00

ID / Code	Name / Desc	Gross Pay	Regular Pay	1.500x
<b>101 - TOWNSHIP BOARD</b>				
8810-2	ELECTED OFFICIALS			
27	FISHER, SUSAN	7,361.25	7,361.25	0.00
84	VANCE, JANET M	4,240.08	4,240.08	0.00
121	KRAMER, ROBERT A	4,240.08	4,240.08	0.00
8810-2 Totals:		15,841.41	15,841.41	0.00
<hr/>				
8810-1	OFFICE			
122	HUGHEY, MARY E	3,935.10	3,935.10	0.00
129	ELWELL, SUMMER R	4,965.75	4,965.75	0.00
132	DECKER, LAURA L	7,258.13	7,258.13	0.00
8810-1 Totals:		16,158.98	16,158.98	0.00
<hr/>				
9220	CEMETERY OPERATIONS			
131	DILLAHA, JANICE A	161.52	161.52	0.00
9220 Totals:		161.52	161.52	0.00
<hr/>				
Department 101 Totals:		32,161.91	32,161.91	0.00
<hr/>				
<b>253 - TREASURER</b>				
8810-2	ELECTED OFFICIALS			
36	BALAZOVIC, BOBBI J	34,876.92	34,876.92	0.00
8810-2 Totals:		34,876.92	34,876.92	0.00
<hr/>				
Department 253 Totals:		34,876.92	34,876.92	0.00
<hr/>				
<b>171 - SUPERVISOR</b>				
8810-2	ELECTED OFFICIALS			
45	RIDLEY, MICHAEL E	24,431.94	24,431.94	0.00
8810-2 Totals:		24,431.94	24,431.94	0.00
<hr/>				
Department 171 Totals:		24,431.94	24,431.94	0.00
<hr/>				
<b>751 - PARKS AND REC</b>				
9102	PARK MUNICIPAL			
58	PRITCHETT, ALICE J	3,519.13	3,519.13	0.00
124	MILLER, SCOTT W	36,946.45	35,955.21	991.24
41	PURTILL, JAMES E	345.00	345.00	0.00
90	MANSON, HOWARD W	255.00	255.00	0.00
76	CHENEY, TODD N	1,500.00	1,500.00	0.00
133	HEALY, TROY A	4,291.76	4,256.46	35.30



Workers' Compensation by Department Report  
For Check Dates 07/01/2021 to 06/30/2022

ID / Code	Name / Desc	Gross Pay	Regular Pay	1.500x
9102 Totals:		46,857.34	45,830.80	1,026.54
Unclassified	No Workers' Comp Code			
118	SCHOFIELD, DOUGLAS D	48,260.00	48,260.00	0.00
123	ORMSBEE, ROBIN R	10,911.98	10,641.75	270.23
126	BOTTORFF, JACKSON C	6,056.70	5,980.20	76.50
76	CHENEY, TODD N	105.00	105.00	0.00
127	DEWYRE, MASEN A ✓	40.50	0.00	40.50
135	HUFFMAN, RYAN D ✓	934.50	934.50	0.00
Unclassified Totals:		66,308.68	65,921.45	387.23
9410	MUNICIPAL TWP COUNTY			
127	DEWYRE, MASEN A	6,168.45	6,168.45	0.00
9410 Totals:		6,168.45	6,168.45	0.00
Department 751 Totals:		119,334.47 ✓	117,920.70 ✓	1,413.77 ✓
257 - ASSESSOR ✓				
9410	MUNICIPAL TWP COUNTY			
105	GEHRES, JOHN L	45,000.02	45,000.02	0.00
9410 Totals:		45,000.02	45,000.02	0.00
8810-3	LIBRARIES/MUSEUMS: PR			
110	WITULSKI, THERESA M	14,792.04	14,792.04	0.00
8810-3 Totals:		14,792.04	14,792.04	0.00
Department 257 Totals:		59,792.06 ✓	59,792.06 ✓	0.00 ✓
247 - BOARD OF REVIEW ✓				
9410	MUNICIPAL TWP COUNTY			
49	MALENFANT, LEEANN M	472.00	472.00	0.00
80	KABAT, TERRY A	472.00	472.00	0.00
86	FULLFORD, DEBORAH M	472.00	472.00	0.00
9410 Totals:		1,416.00	1,416.00	0.00
Department 247 Totals:		1,416.00	1,416.00	0.00
655 - LIBRARY				
8810	PUBLIC LIBRARY OR MUS			
11-L	MILLER, HELEN J	16,379.36	16,341.11	38.25
14-L	ERDMANN, LORETTA	15,591.30	15,591.30	0.00

Workers' Compensation by Department Report  
For Check Dates 07/01/2021 to 06/30/2022

ID / Code	Name / Desc	Gross Pay	Regular Pay	1.500x
8810 Totals:		31,970.66	31,932.41	38.25
8810-3	LIBRARIES/MUSEUMS: PR			
119	RUTKOWSKI, KELSEY J	27,123.41	27,123.41	0.00
8810-3 Totals:		27,123.41	27,123.41	0.00
Unclassified	No Workers' Comp Code			
128	LINTZ, SANDRA L	13,366.00	13,366.00	0.00
Unclassified Totals:		13,366.00	13,366.00	0.00
Department 655 Totals:		72,460.07	72,421.82	38.25
262 - ELECTIONS ✓				
Unclassified	No Workers' Comp Code			
97	BODNAR, DAWN M	50.00	50.00	0.00
99	FISHER, CYNTHIA J	50.00	50.00	0.00
100	HAYES, KIMBERLY A	50.00	50.00	0.00
104	THORNLOW, JACQUELINE	50.00	50.00	0.00
113	LOSH, VICKI M	415.00	415.00	0.00
114	BELL, REBECCA J	50.00	50.00	0.00
115	PREDIGER, DIANNA M	370.00	370.00	0.00
116	PREDIGER, KEVIN G	370.00	370.00	0.00
117	LAFFERTY, KATHRYN S	50.00	50.00	0.00
134	KRESS, CHRISTOPHER B	270.00	270.00	0.00
Unclassified Totals:		1,725.00	1,725.00	0.00
Department 262 Totals:		1,725.00	1,725.00	0.00
Grand Totals:		975,128.97 ✓	971,325.72 ✓	3,803.25 ✓

ID / Code	Name / Desc	Gross Pay	Regular Pay	1.500x
<b>301 - POLICE</b>				
7720	POLICE OFFICERS			
14	CHAMBERLAIN, WALTER C	62,620.25	62,620.25	0.00
34	BLUMKE, BRANDON D.	70,035.08	70,035.08	0.00
35	DIEHL, CHRISTOPHER V	62,138.44	62,138.44	0.00
42	TEMPLE, JR, GORDON M.	80,162.22	80,162.22	0.00
59	ANDERSON, MICKEL M	63,930.44	63,930.44	0.00
66	LALONDE, STACY A	65,286.40	65,286.40	0.00
8	JOHNSON, JEFFREY A.	62,881.00	62,881.00	0.00
102	MYERSON, JANET C	60,532.15	60,532.15	0.00
70	BECKWITH, CHARLES A	2,977.50	2,977.50	0.00

7720 Totals: 530,563.48 530,563.48 0.00

8810-3 LIBRARIES/MUSEUMS: PR  
9 JEWELL, KATHLEEN 49,308.75 49,308.75 0.00

8810-3 Totals: 49,308.75 49,308.75 0.00

Unclassified No Workers' Comp Code  
108 LODER, DANIEL J 5,250.00 5,250.00 0.00  
125 BLAIR, SYDNEY N 1,632.00 1,632.00 0.00

Unclassified Totals: 6,882.00 6,882.00 0.00

Department 301 Totals: 586,754.23 586,754.23 0.00

**215 - CLERK**

9410 MUNICIPAL TWP COUNTY  
83 WIMER, CINDY J 1,572.43 1,298.36 274.07

9410 Totals: 1,572.43 1,298.36 274.07

Unclassified No Workers' Comp Code  
107 WEBB, DAWN M 242.13 110.50 131.63

Unclassified Totals: 242.13 110.50 131.63

Department 215 Totals: 1,814.56 1,408.86 405.70

**101 - TOWNSHIP BOARD**

8810-3 LIBRARIES/MUSEUMS: PR  
27 FISHER, SUSAN 10,089.60 10,089.60 0.00

8810-3 Totals: 10,089.60 10,089.60 0.00

8810-2 ELECTED OFFICIALS

x 201

o Need job descrip  
o Law Enforcement Officer

101 msg GT to confirm LODER/BLAIR

ID / Code	Name / Desc	Gross Pay	Regular Pay	1.500x
84	VANCE, JANET M	4,487.08	4,350.58	136.50
27	FISHER, SUSAN	16,379.52	16,192.02	187.50
19	WALDRON, CRAIG	2,119.74	2,119.74	0.00
121	KRAMER, ROBERT A	2,609.28	2,609.28	0.00
106	RODRIGUEZ, DOLLY J	28,795.35	28,795.35	0.00
8810-2 Totals:		54,390.97 ✓	54,066.97 ✓	324.00
8810-1	OFFICE			
27	FISHER, SUSAN	500.00	500.00	0.00
122	HUGHEY, MARY E	3,967.50	3,967.50	0.00
8810-1 Totals:		4,467.50	4,467.50	0.00
Department 101 Totals:		68,948.07 ✓	68,624.07 ✓	324.00 ✓
253 - TREASURER				
8810-2	ELECTED OFFICIALS			
36	BALAZOVIC, BOBBI J	34,876.92	34,876.92	0.00
8810-2 Totals:		34,876.92	34,876.92	0.00
Department 253 Totals:		34,876.92 ✓	34,876.92 ✓	0.00 ✓
171 - SUPERVISOR				
8810-2	ELECTED OFFICIALS			
45	RIDLEY, MICHAEL E	24,431.94	24,431.94	0.00
8810-2 Totals:		24,431.94 ✓	24,431.94 ✓	0.00
Department 171 Totals:		24,431.94	24,431.94	0.00
751 - PARKS AND REC				
9102	PARK MUNICIPAL			
41	PURTILL, JAMES E	10,426.44	10,426.44	0.00
73	WALKER, JOSEPH A	8,361.68	8,223.75	137.93
94	SMELTZER, DANIEL J	5,189.21	5,180.37	8.84
58	PRITCHETT, ALICE J	8,702.24	8,702.24	0.00
120	WHITMAN, CODY F	16,221.29	15,557.15	664.14
124	MILLER, SCOTT W	4,678.63	4,455.50	223.13
90	MANSON, HOWARD W	997.50	997.50	0.00
9102 Totals:		54,576.99 ✓	53,542.95 ✓	1,034.04 ✓
Unclassified				
76	CHENEY, TODD N	9,410.60	9,410.60	0.00

0 Need Job descrip  
Office Admin

ID / Code	Name / Desc	Gross Pay	Regular Pay	1.500x
118	SCHOFIELD, DOUGLAS D	35,960.00	35,960.00	0.00
123	ORMSBEE, ROBIN R	5,559.90	5,559.90	0.00
126	BOTTORFF, JACKSON C	1,183.50	1,183.50	0.00
Unclassified Totals:		52,114.00	52,114.00	0.00
<hr/>				
Department 751 Totals:		106,690.99 ✓	105,656.95 ✓	1,034.04 ✓
<hr/>				
257 - ASSESSOR				
9410	MUNICIPAL TWP COUNTY			
105	GEHRES, JOHN L	45,000.02	45,000.02	0.00
9410 Totals:		45,000.02	45,000.02	0.00
<hr/>				
8810-3	LIBRARIES/MUSEUMS: PR			
110	WITULSKI, THERESA M	13,894.50	13,894.50	0.00
8810-3 Totals:		13,894.50	13,894.50	0.00
<hr/>				
Department 257 Totals:		58,894.52 ✓	58,894.52 ✓	0.00
<hr/>				
247 - BOARD OF REVIEW				
9410	MUNICIPAL TWP COUNTY			
86	FULLFORD, DEBORAH M	354.00	354.00	0.00
80	KABAT, TERRY A	354.00	354.00	0.00
49	MALENFANT, LEEANN M	354.00	354.00	0.00
9410 Totals:		1,062.00	1,062.00	0.00
<hr/>				
Department 247 Totals:		1,062.00 ✓	1,062.00 ✓	0.00
<hr/>				
655 - LIBRARY				
8810	PUBLIC LIBRARY OR MUS			
11-L	MILLER, HELEN J	27,151.65	27,151.65	0.00
14-L	ERDMANN, LORETTA	17,192.33	17,192.33	0.00
8810 Totals:		44,343.98	44,343.98	0.00
<hr/>				
8810-3	LIBRARIES/MUSEUMS: PR			
112	WRIGHT, RUDY C	6,538.45	6,538.45	0.00
119	RUTKOWSKI, KELSEY J	5,733.80	5,733.80	0.00
8810-3 Totals:		12,272.25	12,272.25	0.00
<hr/>				
Department 655 Totals:		56,616.23 ✓	56,616.23 ✓	0.00

Workers' Compensation by Department Report  
For Check Dates 07/01/2020 to 06/30/2021

ID# / Code	Name / Desc	Gross Pay	Regular Pay	1.500x
262 - ELECTIONS				
Unclassified	No Workers' Comp Code			
97	BODNAR, DAWN M	547.75	232.00	315.75
99	FISHER, CYNTHIA J	529.50	246.00	283.50
100	HAYES, KIMBERLY A	317.25	132.00	185.25
104	THORNLOW, JACQUELINE	492.50	230.00	262.50
113	LOSH, VICKI M	743.25	334.50	408.75
114	BELL, REBECCA J	258.00	132.00	126.00
115	PREDIGER, DIANNA M	724.75	316.00	408.75
116	PREDIGER, KEVIN G	731.25	322.50	408.75
117	LAFFERTY, KATHRYN S	492.50	230.00	262.50
-----				
Unclassified Totals:		4,836.75	2,175.00	2,661.75
-----				
Department 262 Totals:		4,836.75	2,175.00	2,661.75
-----				
Grand Totals:		944,926.21	940,500.72	4,425.49

# 941 for 2022: Employer's QUARTERLY Federal Tax Return

(Rev. June 2022)

Department of the Treasury — Internal Revenue Service

950122

OMB No. 1545-0029

Employer identification number (EIN) 3 8 - 2 1 7 6 9 2 6

Name (not your trade name) Indian River Area Library

Trade name (if any)

Address PO Box 220  
 Number Street Suite or room number  
Indian River MI 49749  
 City State ZIP code  
    
 Foreign country name Foreign province/county Foreign postal code

## Report for this Quarter of 2022 (Check one.)

- ☐ 1: January, February, March  
☒ 2: April, May, June  
☐ 3: July, August, September  
☐ 4: October, November, December

Go to [www.irs.gov/Form941](http://www.irs.gov/Form941) for instructions and the latest information.

Read the separate instructions before you complete Form 941. Type or print within the boxes.

### Part 1: Answer these questions for this quarter.

1	Number of employees who received wages, tips, or other compensation for the pay period including: June 12 (Quarter 2), Sept. 12 (Quarter 3), or Dec. 12 (Quarter 4)	1	<span>4</span>
2	Wages, tips, and other compensation	2	<span>20,090</span> <span>76</span>
3	Federal income tax withheld from wages, tips, and other compensation	3	<span>1,655</span> <span>46</span>
4	If no wages, tips, and other compensation are subject to social security or Medicare tax	<input type="checkbox"/> Check and go to line 6.	

	Column 1		Column 2
5a	Taxable social security wages* <span>20,090</span> <span>76</span>	$\times 0.124 =$	<span>2,491</span> <span>25</span>
5a (i)	Qualified sick leave wages* <span></span>	$\times 0.062 =$	<span></span>
5a (ii)	Qualified family leave wages* <span></span>	$\times 0.062 =$	<span></span>
5b	Taxable social security tips <span></span>	$\times 0.124 =$	<span></span>
5c	Taxable Medicare wages & tips <span>20,090</span> <span>76</span>	$\times 0.029 =$	<span>582</span> <span>63</span>
5d	Taxable wages & tips subject to Additional Medicare Tax withholding <span></span>	$\times 0.009 =$	<span></span>
5e	Total social security and Medicare taxes. Add Column 2 from lines 5a, 5a(i), 5a(ii), 5b, 5c, and 5d		5e <span>3,073</span> <span>88</span>
5f	Section 3121(q) Notice and Demand—Tax due on unreported tips (see instructions)		5f <span></span>
6	Total taxes before adjustments. Add lines 3, 5e, and 5f		6 <span>4,729</span> <span>34</span>
7	Current quarter's adjustment for fractions of cents		7 <span>-0</span> <span>04</span>
8	Current quarter's adjustment for sick pay		8 <span></span>
9	Current quarter's adjustments for tips and group-term life insurance		9 <span></span>
10	Total taxes after adjustments. Combine lines 6 through 9		10 <span>4,729</span> <span>30</span>
11a	Qualified small business payroll tax credit for increasing research activities. Attach Form 8974		11a <span></span>
11b	Nonrefundable portion of credit for qualified sick and family leave wages for leave taken before April 1, 2021		11b <span></span>
11c	Reserved for future use		11c <span></span>

\*Include taxable qualified sick and family leave wages paid in this quarter of 2022 for leave taken after March 31, 2021, and before October 1, 2021, on line 5a. Use lines 5a(i) and 5a(ii) only for taxable qualified sick and family leave wages paid in this quarter of 2022 for leave taken after March 31, 2020, and before April 1, 2021.

► You MUST complete all three pages of Form 941 and SIGN it.

Next ►

Name (not your trade name)

Indian River Area Library

Employer identification number (EIN)

38 - 1812031

**Part 1:** Answer these questions for this quarter. (continued)

11d	Nonrefundable portion of credit for qualified sick and family leave wages for leave taken after March 31, 2021, and before October 1, 2021	11d	
11e	Reserved for future use	11e	
11f	Reserved for future use		
11g	Total nonrefundable credits. Add lines 11a, 11b, and 11d	11g	
12	Total taxes after adjustments and nonrefundable credits. Subtract line 11g from line 10	12	4,729 30
13a	Total deposits for this quarter, including overpayment applied from a prior quarter and overpayments applied from Form 941-X, 941-X (PR), 944-X, or 944-X (SP) filed in the current quarter	13a	4,729 30
13b	Reserved for future use	13b	
13c	Refundable portion of credit for qualified sick and family leave wages for leave taken before April 1, 2021	13c	
13d	Reserved for future use	13d	
13e	Refundable portion of credit for qualified sick and family leave wages for leave taken after March 31, 2021, and before October 1, 2021	13e	
13f	Reserved for future use	13f	
13g	Total deposits and refundable credits. Add lines 13a, 13c, and 13e	13g	4,729 30
13h	Reserved for future use	13h	
13i	Reserved for future use	13i	
14	Balance due. If line 12 is more than line 13g, enter the difference and see instructions	14	
15	Overpayment. If line 13g is more than line 12, enter the difference		Check one: <input type="checkbox"/> Apply to next return. <input type="checkbox"/> Send a refund.

**Part 2:** Tell us about your deposit schedule and tax liability for this quarter.

If you're unsure about whether you're a monthly schedule depositor or a semiweekly schedule depositor, see section 11 of Pub. 15.

16 Check one: ☐ Line 12 on this return is less than \$2,500 or line 12 on the return for the prior quarter was less than \$2,500, and you didn't incur a \$100,000 next-day deposit obligation during the current quarter. If line 12 for the prior quarter was less than \$2,500 but line 12 on this return is \$100,000 or more, you must provide a record of your federal tax liability. If you're a monthly schedule depositor, complete the deposit schedule below; if you're a semiweekly schedule depositor, attach Schedule B (Form 941). Go to Part 3.

☒ You were a monthly schedule depositor for the entire quarter. Enter your tax liability for each month and total liability for the quarter, then go to Part 3.

Tax liability: Month 1 1,585 51

Month 2 1,559 83

Month 3 1,583 96

Total liability for quarter 4,729 30

Total must equal line 12.

☐ You were a semiweekly schedule depositor for any part of this quarter. Complete Schedule B (Form 941), Report of Tax Liability for Semiweekly Schedule Depositors, and attach it to Form 941. Go to Part 3.

▶ You MUST complete all three pages of Form 941 and SIGN it.

Next ▶



Name (not your trade name)

Indian River Area Library

Employer identification number (EIN)

38 - 1812031

**Part 3: Tell us about your business. If a question does NOT apply to your business, leave it blank.**

17 If your business has closed or you stopped paying wages . . . . . ☐ Check here, and enter the final date you paid wages  /  / ; also attach a statement to your return. See instructions.

18 If you're a seasonal employer and you don't have to file a return for every quarter of the year . . . . ☐ Check here.

19 Qualified health plan expenses allocable to qualified sick leave wages for leave taken before April 1, 2021 19

20 Qualified health plan expenses allocable to qualified family leave wages for leave taken before April 1, 2021 20

21 Reserved for future use . . . . . 21

22 Reserved for future use . . . . . 22

23 Qualified sick leave wages for leave taken after March 31, 2021, and before October 1, 2021 23

24 Qualified health plan expenses allocable to qualified sick leave wages reported on line 23 24

25 Amounts under certain collectively bargained agreements allocable to qualified sick leave wages reported on line 23 . . . . . 25

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27 Qualified health plan expenses allocable to qualified family leave wages reported on line 26 27

28 Amounts under certain collectively bargained agreements allocable to qualified family leave wages reported on line 26 . . . . . 28

**Part 4: May we speak with your third-party designee?**

Do you want to allow an employee, a paid tax preparer, or another person to discuss this return with the IRS? See the instructions for details.

☐ Yes. Designee's name and phone number

Select a 5-digit personal identification number (PIN) to use when talking to the IRS.

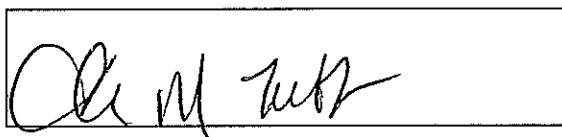
☐ No.

**Part 5: Sign here. You MUST complete all three pages of Form 941 and SIGN it.**

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

**X**

Sign your name here



Print your name here

Dawn M Webb

Print your title here

Clerk

Date

7/8/22

Best daytime phone

231-238-0970

**Paid Preparer Use Only**

Check if you're self-employed . . . ☐

Preparer's name

PTIN

Preparer's signature

Date

/  /

Firm's name (or yours if self-employed)

EIN

Address

Phone

City

State

ZIP code

941 for 2022: Employer's QUARTERLY Federal Tax Return

Department of the Treasury — Internal Revenue Service

950122

OMB No. 1545-0029

Employer identification number (EIN) 38-2176926

Name (not your trade name) Indian River Area Library

Trade name (if any)

Address PO Box 220

Number Street Suite or room number

Indian River MI 49749

City State ZIP code

Foreign country name Foreign province/county Foreign postal code

Report for this Quarter of 2022 (Check one.)

- ☒ 1: January, February, March
- ☐ 2: April, May, June
- ☐ 3: July, August, September
- ☐ 4: October, November, December

Go to [www.irs.gov/Form941](http://www.irs.gov/Form941) for instructions and the latest information.

Read the separate instructions before you complete Form 941. Type or print within the boxes.

Part 1: Answer these questions for this quarter.

1 Number of employees who received wages, tips, or other compensation for the pay period including: Mar. 12 (Quarter 1) 1 4

2 Wages, tips, and other compensation 2 20446 . 50

3 Federal income tax withheld from wages, tips, and other compensation 3 1093 . 42

4 If no wages, tips, and other compensation are subject to social security or Medicare tax ☐ Check and go to line 6.

	Column 1		Column 2
5a Taxable social security wages*	20446 . 50	$\times 0.124 =$	2537 . 85
5a (i) Qualified sick leave wages*		$\times 0.062 =$	
5a (ii) Qualified family leave wages*		$\times 0.062 =$	
5b Taxable social security tips		$\times 0.124 =$	
5c Taxable Medicare wages & tips	20446 . 50	$\times 0.029 =$	593 . 53
5d Taxable wages & tips subject to Additional Medicare Tax withholding		$\times 0.009 =$	
5e Total social security and Medicare taxes. Add Column 2 from lines 5a, 5a(i), 5a(ii), 5b, 5c, and 5d			3131 . 38
5f Section 3121(q) Notice and Demand—Tax due on unreported tips (see instructions)			
6 Total taxes before adjustments. Add lines 3, 5e, and 5f			4224 . 80
7 Current quarter's adjustment for fractions of cents			0 . 04
8 Current quarter's adjustment for sick pay			
9 Current quarter's adjustments for tips and group-term life insurance			
10 Total taxes after adjustments. Combine lines 6 through 9			4224 . 84
11a Qualified small business payroll tax credit for increasing research activities. Attach Form 8974			
11b Nonrefundable portion of credit for qualified sick and family leave wages for leave taken before April 1, 2021			
11c Reserved for future use			

\*Include taxable qualified sick and family leave wages paid in 2022 for leave taken after March 31, 2021, and before October 1, 2021, on line 5a. Use lines 5a(i) and 5a(ii) only for taxable qualified sick and family leave wages paid in 2022 for leave taken after March 31, 2020, and before April 1, 2021.

► You MUST complete all three pages of Form 941 and SIGN it.

Next ►

Name (not your trade name)

Indian River Area Library

Employer identification number (EIN)

38-2176926

**Part 3: Tell us about your business. If a question does NOT apply to your business, leave it blank.**

17 If your business has closed or you stopped paying wages . . . . . ☐ Check here, and enter the final date you paid wages  /  / ; also attach a statement to your return. See instructions.

18 If you're a seasonal employer and you don't have to file a return for every quarter of the year . . . ☐ Check here.

19	Qualified health plan expenses allocable to qualified sick leave wages for leave taken before April 1, 2021	19	<input type="text"/>
20	Qualified health plan expenses allocable to qualified family leave wages for leave taken before April 1, 2021	20	<input type="text"/>
21	Reserved for future use . . . . .	21	<input type="text"/>
22	Reserved for future use . . . . .	22	<input type="text"/>
23	Qualified sick leave wages for leave taken after March 31, 2021, and before October 1, 2021	23	<input type="text"/>
24	Qualified health plan expenses allocable to qualified sick leave wages reported on line 23	24	<input type="text"/>
25	Amounts under certain collectively bargained agreements allocable to qualified sick leave wages reported on line 23 . . . . .	25	<input type="text"/>
26	Qualified family leave wages for leave taken after March 31, 2021, and before October 1, 2021	26	<input type="text"/>
27	Qualified health plan expenses allocable to qualified family leave wages reported on line 26	27	<input type="text"/>
28	Amounts under certain collectively bargained agreements allocable to qualified family leave wages reported on line 26 . . . . .	28	<input type="text"/>

**Part 4: May we speak with your third-party designee?**

Do you want to allow an employee, a paid tax preparer, or another person to discuss this return with the IRS? See the instructions for details.

☐ Yes. Designee's name and phone number

Select a 5-digit personal identification number (PIN) to use when talking to the IRS.

☐ No.

**Part 5: Sign here. You MUST complete all three pages of Form 941 and SIGN it.**

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Sign your  
name here

Print your  
name here

Dawn M Webb

Print your  
title here

Clerk

Date

 /  / 

Best daytime phone

231-238-0970

**Paid Preparer Use Only**

Check if you're self-employed . . . ☐

Preparer's name

PTIN

Preparer's signature

Date

 /  / 

Firm's name (or yours  
if self-employed)

EIN

Address

Phone

City

State

ZIP code

**941 for 2021: Employer's QUARTERLY Federal Tax Return**

Department of the Treasury — Internal Revenue Service

951121

OMB No. 1545-0029

Employer identification number (EIN)	3	8	-	2	1	7	6	9	2	6
Name (not your trade name)	Indian River Area Library									
Trade name (if any)										
Address	PO Box 220									
Number	Street				Suite or room number					
Indian River	MI				49749					
City	State				ZIP code					
Foreign country name	Foreign province/county				Foreign postal code					

**Report for this Quarter of 2021**  
(Check one.)

- ☐ 1: January, February, March
- ☐ 2: April, May, June
- ☐ 3: July, August, September
- ☒ 4: October, November, December

Go to [www.irs.gov/Form941](http://www.irs.gov/Form941) for instructions and the latest information.

Read the separate instructions before you complete Form 941. Type or print within the boxes.

**Part 1: Answer these questions for this quarter.**

1	Number of employees who received wages, tips, or other compensation for the pay period including: <i>June 12</i> (Quarter 2), <i>Sept. 12</i> (Quarter 3), or <i>Dec. 12</i> (Quarter 4)	1	4
2	Wages, tips, and other compensation	2	15010 . 75
3	Federal income tax withheld from wages, tips, and other compensation	3	484 . 99
4	If no wages, tips, and other compensation are subject to social security or Medicare tax	<input type="checkbox"/> Check and go to line 6.	

	Column 1		Column 2
5a	Taxable social security wages* . . . . . 15010 . 75	$\times 0.124 =$	1861 . 33
5a	(i) Qualified sick leave wages* . . . . .	$\times 0.062 =$	
5a	(ii) Qualified family leave wages* . . . . .	$\times 0.062 =$	
5b	Taxable social security tips . . . . .	$\times 0.124 =$	
5c	Taxable Medicare wages & tips . . . . . 15010 . 75	$\times 0.029 =$	435 . 31
5d	Taxable wages & tips subject to Additional Medicare Tax withholding . . . . .	$\times 0.009 =$	
5e	Total social security and Medicare taxes. Add Column 2 from lines 5a, 5a(i), 5a(ii), 5b, 5c, and 5d	5e	2296 . 64
5f	Section 3121(q) Notice and Demand—Tax due on unreported tips (see instructions)	5f	
6	Total taxes before adjustments. Add lines 3, 5e, and 5f	6	2781 . 63
7	Current quarter's adjustment for fractions of cents	7	. 04
8	Current quarter's adjustment for sick pay	8	
9	Current quarter's adjustments for tips and group-term life insurance	9	
10	Total taxes after adjustments. Combine lines 6 through 9	10	2781 . 67
11a	Qualified small business payroll tax credit for increasing research activities. Attach Form 8974	11a	
11b	Nonrefundable portion of credit for qualified sick and family leave wages for leave taken before April 1, 2021	11b	
11c	Nonrefundable portion of employee retention credit	11c	

\*Include taxable qualified sick and family leave wages for leave taken after March 31, 2021, on line 5a. Use lines 5a(i) and 5a(ii) only for wages paid after March 31, 2020, for leave taken before April 1, 2021.

▶ You MUST complete all three pages of Form 941 and SIGN it.

Next ▶

Name (not your trade name)

Indian River Area Library

Employer identification number (EIN)

38-2176926

**Part 1:** Answer these questions for this quarter. (continued)

11d	Nonrefundable portion of credit for qualified sick and family leave wages for leave taken after March 31, 2021	11d	
11e	Nonrefundable portion of COBRA premium assistance credit (see instructions for applicable quarters)	11e	
11f	Number of individuals provided COBRA premium assistance		
11g	Total nonrefundable credits. Add lines 11a, 11b, 11c, 11d, and 11e	11g	0 . 00
12	Total taxes after adjustments and nonrefundable credits. Subtract line 11g from line 10	12	2781 . 67
13a	Total deposits for this quarter, including overpayment applied from a prior quarter and overpayments applied from Form 941-X, 941-X (PR), 944-X, or 944-X (SP) filed in the current quarter	13a	2781 . 67
13b	Reserved for future use	13b	
13c	Refundable portion of credit for qualified sick and family leave wages for leave taken before April 1, 2021	13c	
13d	Refundable portion of employee retention credit	13d	
13e	Refundable portion of credit for qualified sick and family leave wages for leave taken after March 31, 2021	13e	
13f	Refundable portion of COBRA premium assistance credit (see instructions for applicable quarters)	13f	
13g	Total deposits and refundable credits. Add lines 13a, 13c, 13d, 13e, and 13f	13g	2781 . 67
13h	Total advances received from filing Form(s) 7200 for the quarter	13h	
13i	Total deposits and refundable credits less advances. Subtract line 13h from line 13g	13i	2781 . 67
14	Balance due. If line 12 is more than line 13i, enter the difference and see instructions	14	0 . 00
15	Overpayment. If line 13i is more than line 12, enter the difference		0 . 00

Check one: ☐ Apply to next return. ☐ Send a refund.**Part 2:** Tell us about your deposit schedule and tax liability for this quarter.

If you're unsure about whether you're a monthly schedule depositor or a semiweekly schedule depositor, see section 11 of Pub. 15.

- 16 Check one: ☐ Line 12 on this return is less than \$2,500 or line 12 on the return for the prior quarter was less than \$2,500, and you didn't incur a \$100,000 next-day deposit obligation during the current quarter. If line 12 for the prior quarter was less than \$2,500 but line 12 on this return is \$100,000 or more, you must provide a record of your federal tax liability. If you're a monthly schedule depositor, complete the deposit schedule below; if you're a semiweekly schedule depositor, attach Schedule B (Form 941). Go to Part 3.

- ☐ You were a monthly schedule depositor for the entire quarter. Enter your tax liability for each month and total liability for the quarter, then go to Part 3.

Tax liability: Month 1

Month 2

Month 3

Total liability for quarter

Total must equal line 12.

- ☐ You were a semiweekly schedule depositor for any part of this quarter. Complete Schedule B (Form 941), Report of Tax Liability for Semiweekly Schedule Depositors, and attach it to Form 941. Go to Part 3.

▶ You MUST complete all three pages of Form 941 and SIGN it.

Next ▶

Name (not your trade name)

Employer identification number (EIN)

**Part 3: Tell us about your business. If a question does NOT apply to your business, leave it blank.**

17 If your business has closed or you stopped paying wages . . . . . ☐ Check here, and enter the final date you paid wages  /  / ; also attach a statement to your return. See instructions.

18a If you're a seasonal employer and you don't have to file a return for every quarter of the year . . . ☐ Check here.

18b If you're eligible for the employee retention credit solely because your business is a recovery startup business ☐ Check here.

19 Qualified health plan expenses allocable to qualified sick leave wages for leave taken before April 1, 2021 19  .

20 Qualified health plan expenses allocable to qualified family leave wages for leave taken before April 1, 2021 20  .

21 Qualified wages for the employee retention credit . . . . . 21  .

22 Qualified health plan expenses for the employee retention credit . . . . . 22  .

23 Qualified sick leave wages for leave taken after March 31, 2021 . . . . . 23  .

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28 Amounts under certain collectively bargained agreements allocable to qualified family leave wages reported on line 26 . . . . . 28  .

**Part 4: May we speak with your third-party designee?**

Do you want to allow an employee, a paid tax preparer, or another person to discuss this return with the IRS? See the instructions for details.

☐ Yes. Designee's name and phone number

Select a 5-digit personal identification number (PIN) to use when talking to the IRS.

☐ No.

**Part 5: Sign here. You MUST complete all three pages of Form 941 and SIGN it.**

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

**X**

Sign your name here

Print your name here

Print your title here

Date

/  /

Best daytime phone

**Paid Preparer Use Only**

Check if you're self-employed . . . ☐

Preparer's name

PTIN

Preparer's signature

Date

/  /

Firm's name (or yours if self-employed)

EIN

Address

Phone

City

State

ZIP code

**941 for 2021: Employer's QUARTERLY Federal Tax Return**

Department of the Treasury — Internal Revenue Service

951121

OMB No. 1545-0029

Employer identification number (EIN)	3	8	-	2	1	7	6	9	2	6
Name (not your trade name)	Tuscarora Township									
Trade name (if any)										
Address	PO Box 220									
Number	Street				Suite or room number					
Indian River	MI				49749					
City	State				ZIP code					
Foreign country name	Foreign province/county				Foreign postal code					

**Report for this Quarter of 2021**  
(Check one.)☐ 1: January, February, March☐ 2: April, May, June☒ 3: July, August, September☐ 4: October, November, DecemberGo to [www.irs.gov/Form941](http://www.irs.gov/Form941) for instructions and the latest information.

Read the separate instructions before you complete Form 941. Type or print within the boxes.

**Part 1: Answer these questions for this quarter.**

1	Number of employees who received wages, tips, or other compensation for the pay period including: June 12 (Quarter 2), Sept. 12 (Quarter 3), or Dec. 12 (Quarter 4)	1	4																												
2	Wages, tips, and other compensation	2	16892 . 06																												
3	Federal income tax withheld from wages, tips, and other compensation	3	822 . 33																												
4	If no wages, tips, and other compensation are subject to social security or Medicare tax	<input type="checkbox"/> Check and go to line 6.																													
<table border="1"> <thead> <tr> <th></th> <th>Column 1</th> <th></th> <th>Column 2</th> </tr> </thead> <tbody> <tr> <td>5a</td> <td>Taxable social security wages*</td> <td>16892 . 06 × 0.124 =</td> <td>2094 . 62</td> </tr> <tr> <td>5a (i)</td> <td>Qualified sick leave wages*</td> <td>× 0.062 =</td> <td></td> </tr> <tr> <td>5a (ii)</td> <td>Qualified family leave wages*</td> <td>× 0.062 =</td> <td></td> </tr> <tr> <td>5b</td> <td>Taxable social security tips</td> <td>× 0.124 =</td> <td></td> </tr> <tr> <td>5c</td> <td>Taxable Medicare wages &amp; tips</td> <td>16892 . 06 × 0.029 =</td> <td>489 . 87</td> </tr> <tr> <td>5d</td> <td>Taxable wages &amp; tips subject to Additional Medicare Tax withholding</td> <td>× 0.009 =</td> <td></td> </tr> </tbody> </table>					Column 1		Column 2	5a	Taxable social security wages*	16892 . 06 × 0.124 =	2094 . 62	5a (i)	Qualified sick leave wages*	× 0.062 =		5a (ii)	Qualified family leave wages*	× 0.062 =		5b	Taxable social security tips	× 0.124 =		5c	Taxable Medicare wages & tips	16892 . 06 × 0.029 =	489 . 87	5d	Taxable wages & tips subject to Additional Medicare Tax withholding	× 0.009 =	
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5f	Section 3121(q) Notice and Demand—Tax due on unreported tips (see instructions)	5f																													
6	Total taxes before adjustments. Add lines 3, 5e, and 5f	6	3406 . 82																												
7	Current quarter's adjustment for fractions of cents	7	- . 01																												
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\*Include taxable qualified sick and family leave wages for leave taken after March 31, 2021, on line 5a. Use lines 5a(i) and 5a(ii) only for wages paid after March 31, 2020, for leave taken before April 1, 2021.

▶ You MUST complete all three pages of Form 941 and SIGN it.

Next ▶

Name (not your trade name)

Employer identification number (EIN)

Tuscarora Township

382176926

**Part 3: Tell us about your business. If a question does NOT apply to your business, leave it blank.**

17 If your business has closed or you stopped paying wages . . . . . ☐ Check here, and enter the final date you paid wages  /  / ; also attach a statement to your return. See instructions.

18a If you're a seasonal employer and you don't have to file a return for every quarter of the year . . . . ☐ Check here.

18b If you're eligible for the employee retention credit solely because your business is a recovery startup business ☐ Check here.

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20 Qualified health plan expenses allocable to qualified family leave wages for leave taken before April 1, 2021 20  .

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☐ Yes. Designee's name and phone number

Select a 5-digit personal identification number (PIN) to use when talking to the IRS.

☐ No.

**Part 5: Sign here. You MUST complete all three pages of Form 941 and SIGN it.**

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Sign your name here

*Dawn M. Webb*

Print your name here

Dawn M. Webb

Print your title here

Clerk

Date

10/9/21

Best daytime phone

231-238-0970

**Paid Preparer Use Only**

Check if you're self-employed . . . . ☐

Preparer's name

PTIN

Preparer's signature

Date

/  /

Firm's name (or yours if self-employed)

EIN

Address

Phone

City

State

ZIP code



**941 for 2021: Employer's QUARTERLY Federal Tax Return**

Department of the Treasury — Internal Revenue Service

951121

OMB No. 1545-0029

Employer identification number (EIN) 3 8 - 2 1 7 6 9 2 6

Name (not your trade name) Indian River Area Library

Trade name (if any)

Address PO Box 160

Number  Street Indian River Suite or room number

City  State MI ZIP code 49749

Foreign country name  Foreign province/county  Foreign postal code

**Report for this Quarter of 2021**  
(Check one.)☐ 1: January, February, March☒ 2: April, May, June☐ 3: July, August, September☐ 4: October, November, DecemberGo to [www.irs.gov/Form941](http://www.irs.gov/Form941) for instructions and the latest information.

Read the separate instructions before you complete Form 941. Type or print within the boxes.

**Part 1: Answer these questions for this quarter.**

1	Number of employees who received wages, tips, or other compensation for the pay period including: June 12 (Quarter 2), Sept. 12 (Quarter 3), or Dec. 12 (Quarter 4)	1	<span style="border: 1px solid black; padding: 2px;">3</span>
2	Wages, tips, and other compensation	2	<span style="border: 1px solid black; padding: 2px;">14,966 . 31</span> ✓
3	Federal income tax withheld from wages, tips, and other compensation	3	<span style="border: 1px solid black; padding: 2px;">813 . 77</span> ✓
4	If no wages, tips, and other compensation are subject to social security or Medicare tax	<input type="checkbox"/> Check and go to line 6.	

	Column 1		Column 2
5a	Taxable social security wages* <span style="border: 1px solid black; padding: 2px;">14,966 . 31</span> × 0.124 =	<span style="border: 1px solid black; padding: 2px;">1,855.82 .</span>	*Include taxable qualified sick and family leave wages for leave taken after March 31, 2021, on line 5a. Use lines 5a(i) and 5a(ii) only for wages paid after March 31, 2020, for leave taken before April 1, 2021.
5a (i)	Qualified sick leave wages* <span style="border: 1px solid black; padding: 2px;">0 . 00</span> × 0.062 =	<span style="border: 1px solid black; padding: 2px;">0 . 00</span>	
5a (ii)	Qualified family leave wages* <span style="border: 1px solid black; padding: 2px;">0 . 00</span> × 0.062 =	<span style="border: 1px solid black; padding: 2px;">0 . 00</span>	
5b	Taxable social security tips <span style="border: 1px solid black; padding: 2px;">0 . 00</span> × 0.124 =	<span style="border: 1px solid black; padding: 2px;">0 . 00</span>	
5c	Taxable Medicare wages & tips <span style="border: 1px solid black; padding: 2px;">14,966 . 31</span> × 0.029 =	<span style="border: 1px solid black; padding: 2px;">434 . 02</span>	
5d	Taxable wages & tips subject to Additional Medicare Tax withholding <span style="border: 1px solid black; padding: 2px;">0 . 00</span> × 0.009 =	<span style="border: 1px solid black; padding: 2px;">0 . 00</span>	
5e	Total social security and Medicare taxes. Add Column 2 from lines 5a, 5a(i), 5a(ii), 5b, 5c, and 5d	5e	<span style="border: 1px solid black; padding: 2px;">2,289 . 84</span> ✓
5f	Section 3121(q) Notice and Demand—Tax due on unreported tips (see instructions)	5f	<span style="border: 1px solid black; padding: 2px;">0 . 00</span>
6	Total taxes before adjustments. Add lines 3, 5e, and 5f	6	<span style="border: 1px solid black; padding: 2px;">3,103 . 61</span> ✓
7	Current quarter's adjustment for fractions of cents	7	<span style="border: 1px solid black; padding: 2px;">0 . 00</span>
8	Current quarter's adjustment for sick pay	8	<span style="border: 1px solid black; padding: 2px;">0 . 00</span>
9	Current quarter's adjustments for tips and group-term life insurance	9	<span style="border: 1px solid black; padding: 2px;">0 . 00</span>
10	Total taxes after adjustments. Combine lines 6 through 9	10	<span style="border: 1px solid black; padding: 2px;">3,103 . 61</span> ✓
11a	Qualified small business payroll tax credit for increasing research activities. Attach Form 8974	11a	<span style="border: 1px solid black; padding: 2px;">0 . 00</span>
11b	Nonrefundable portion of credit for qualified sick and family leave wages for leave taken before April 1, 2021	11b	<span style="border: 1px solid black; padding: 2px;">0 . 00</span>
11c	Nonrefundable portion of employee retention credit	11c	<span style="border: 1px solid black; padding: 2px;">0 . 00</span>

▶ You MUST complete all three pages of Form 941 and SIGN it.

Next ▶

Name (not your trade name)

Indian River Area Library

Employer identification number (EIN)

38-2176926

**Part 3:** Tell us about your business. If a question does NOT apply to your business, leave it blank.

17 If your business has closed or you stopped paying wages . . . . . ☐ Check here, and enter the final date you paid wages  /  / ; also attach a statement to your return. See instructions.

18a If you're a seasonal employer and you don't have to file a return for every quarter of the year . . . . ☐ Check here.

18b If you're eligible for the employee retention credit solely because your business is a recovery startup business ☐ Check here.

19	Qualified health plan expenses allocable to qualified sick leave wages for leave taken before April 1, 2021	19	<input type="text"/> 0 . 00
20	Qualified health plan expenses allocable to qualified family leave wages for leave taken before April 1, 2021	20	<input type="text"/> 0 . 00
21	Qualified wages for the employee retention credit . . . . .	21	<input type="text"/> 0 . 00
22	Qualified health plan expenses for the employee retention credit . . . . .	22	<input type="text"/> 0 . 00
23	Qualified sick leave wages for leave taken after March 31, 2021 . . . . .	23	<input type="text"/> 0 . 00
24	Qualified health plan expenses allocable to qualified sick leave wages reported on line 23	24	<input type="text"/> 0 . 00
25	Amounts under certain collectively bargained agreements allocable to qualified sick leave wages reported on line 23 . . . . .	25	<input type="text"/> 0 . 00
26	Qualified family leave wages for leave taken after March 31, 2021 . . . . .	26	<input type="text"/> 0 . 00
27	Qualified health plan expenses allocable to qualified family leave wages reported on line 26	27	<input type="text"/> 0 . 00
28	Amounts under certain collectively bargained agreements allocable to qualified family leave wages reported on line 26 . . . . .	28	<input type="text"/> 0 . 00

**Part 4:** May we speak with your third-party designee?

Do you want to allow an employee, a paid tax preparer, or another person to discuss this return with the IRS? See the instructions for details.

☐ Yes. Designee's name and phone number

Select a 5-digit personal identification number (PIN) to use when talking to the IRS.

☐ No.

**Part 5:** Sign here. You MUST complete all three pages of Form 941 and SIGN it.

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

**X**

Sign your name here



Print your name here

Susan Fisher

Print your title here

Deputy Clerk

Date

7/9/21

Best daytime phone

231-238-0970

**Paid Preparer Use Only**

Check if you're self-employed . . . . ☐

Preparer's name

PTIN

Preparer's signature

Date

/  /

Firm's name (or yours if self-employed)

EIN

Address

Phone

City

State

ZIP code

Form **941 for 2021: Employer's QUARTERLY Federal Tax Return**  
(Rev. Mar. 3, 2021) Department of the Treasury — Internal Revenue Service

950121  
OMB No. 1545-0029

Employer identification number (EIN)   -

Name (not your trade name)

Trade name (if any)

Address

Number  Street  Suite or room number

City  State  ZIP code

Foreign country name  Foreign province/county  Foreign postal code

**Report for this Quarter of 2021**  
(Check one.)

- ☒ 1: January, February, March  
☐ 2: April, May, June  
☐ 3: July, August, September  
☐ 4: October, November, December

Go to [www.irs.gov/Form941](http://www.irs.gov/Form941) for instructions and the latest information.

Read the separate instructions before you complete Form 941. Type or print within the boxes.

**Part 1:** Answer these questions for this quarter.

1	Number of employees who received wages, tips, or other compensation for the pay period including: Mar. 12 (Quarter 1), June 12 (Quarter 2), Sept. 12 (Quarter 3), or Dec. 12 (Quarter 4)	1	<input type="text" value="3"/>
2	Wages, tips, and other compensation	2	<input type="text" value="12168.76"/>
3	Federal income tax withheld from wages, tips, and other compensation	3	<input type="text" value="634.53"/>
4	If no wages, tips, and other compensation are subject to social security or Medicare tax	<input type="checkbox"/> Check and go to line 6.	

	Column 1		Column 2
5a	Taxable social security wages	<input type="text" value=""/> × 0.124 =	<input type="text" value=""/>
5a (i)	Qualified sick leave wages	<input type="text" value=""/> × 0.062 =	<input type="text" value=""/>
5a (ii)	Qualified family leave wages	<input type="text" value=""/> × 0.062 =	<input type="text" value=""/>
5b	Taxable social security tips	<input type="text" value=""/> × 0.124 =	<input type="text" value=""/>
5c	Taxable Medicare wages & tips	<input type="text" value=""/> × 0.029 =	<input type="text" value=""/>
5d	Taxable wages & tips subject to Additional Medicare Tax withholding	<input type="text" value=""/> × 0.009 =	<input type="text" value=""/>
5e	Total social security and Medicare taxes. Add Column 2 from lines 5a, 5a(i), 5a(ii), 5b, 5c, and 5d	5e	<input type="text" value="1861.82"/>
5f	Section 3121(q) Notice and Demand—Tax due on unreported tips (see instructions)	5f	<input type="text" value="0.00"/>
6	Total taxes before adjustments. Add lines 3, 5e, and 5f	6	<input type="text" value="2496.35"/>
7	Current quarter's adjustment for fractions of cents	7	<input type="text" value="0.00"/>
8	Current quarter's adjustment for sick pay	8	<input type="text" value="0.00"/>
9	Current quarter's adjustments for tips and group-term life insurance	9	<input type="text" value="0.00"/>
10	Total taxes after adjustments. Combine lines 6 through 9	10	<input type="text" value="2496.35"/>
11a	Qualified small business payroll tax credit for increasing research activities. Attach Form 8974	11a	<input type="text" value="0.00"/>
11b	Nonrefundable portion of credit for qualified sick and family leave wages from Worksheet 1	11b	<input type="text" value="0.00"/>
11c	Nonrefundable portion of employee retention credit from Worksheet 1	11c	<input type="text" value="0.00"/>

► You MUST complete all three pages of Form 941 and SIGN it.

Next ►

Name (not your trade name)

Indian River Area Library

Employer identification number (EIN)

38-2176926

**Part 1:** Answer these questions for this quarter. (continued)

11d	Total nonrefundable credits. Add lines 11a, 11b, and 11c . . . . .	11d	0.00
12	Total taxes after adjustments and nonrefundable credits. Subtract line 11d from line 10 . . . . .	12	2496.35
13a	Total deposits for this quarter, including overpayment applied from a prior quarter and overpayments applied from Form 941-X, 941-X (PR), 944-X, or 944-X (SP) filed in the current quarter . . . . .	13a	2332.91
13b	Reserved for future use . . . . .	13b	
13c	Refundable portion of credit for qualified sick and family leave wages from Worksheet 1 . . . . .	13c	0.00
13d	Refundable portion of employee retention credit from Worksheet 1 . . . . .	13d	0.00
13e	Total deposits and refundable credits. Add lines 13a, 13c, and 13d . . . . .	13e	0.00
13f	Total advances received from filing Form(s) 7200 for the quarter . . . . .	13f	0.00
13g	Total deposits and refundable credits less advances. Subtract line 13f from line 13e . . . . .	13g	0.00
14	Balance due. If line 12 is more than line 13g, enter the difference and see instructions . . . . .	14	163.44
15	Overpayment. If line 13g is more than line 12, enter the difference . . . . .	Check one: <input type="checkbox"/> Apply to next return. <input type="checkbox"/> Send a refund.	

**Part 2:** Tell us about your deposit schedule and tax liability for this quarter.

If you're unsure about whether you're a monthly schedule depositor or a semiweekly schedule depositor, see section 11 of Pub. 15.

- 16 Check one: ☐ Line 12 on this return is less than \$2,500 or line 12 on the return for the prior quarter was less than \$2,500, and you didn't incur a \$100,000 next-day deposit obligation during the current quarter. If line 12 for the prior quarter was less than \$2,500 but line 12 on this return is \$100,000 or more, you must provide a record of your federal tax liability. If you're a monthly schedule depositor, complete the deposit schedule below; if you're a semiweekly schedule depositor, attach Schedule B (Form 941). Go to Part 3.

- ☐ You were a monthly schedule depositor for the entire quarter. Enter your tax liability for each month and total liability for the quarter, then go to Part 3.

Tax liability: Month 1	796.64
Month 2	857.41
Month 3	842.30
Total liability for quarter	2496.35

Total must equal line 12.

- ☐ You were a semiweekly schedule depositor for any part of this quarter. Complete Schedule B (Form 941), Report of Tax Liability for Semiweekly Schedule Depositors, and attach it to Form 941. Go to Part 3.

▶ You MUST complete all three pages of Form 941 and SIGN it.

Next ▶▶

**941 for 2020: Employer's QUARTERLY Federal Tax Return**

Department of the Treasury — Internal Revenue Service

950120

OMB No. 1545-0029

Employer identification number (EIN)	3	8	-	2	1	7	6	9	2	6
Name (not your trade name)	Indian River Area Library									
Trade name (if any)										
Address	PO Box 160									
	Number	Street						Suite or room number		
	Indian River						MI	49749		
	City						State		ZIP code	
	Foreign country name						Foreign province/county		Foreign postal code	

**Report for this Quarter of 2020**  
(Check one.)

- ☐ 1: January, February, March
- ☐ 2: April, May, June
- ☐ 3: July, August, September
- ☒ 4: October, November, December
- Go to [www.irs.gov/Form941](http://www.irs.gov/Form941) for instructions and the latest information.

Read the separate instructions before you complete Form 941. Type or print within the boxes.

**Part 1: Answer these questions for this quarter.**

1	Number of employees who received wages, tips, or other compensation for the pay period including: Sept. 12 (Quarter 3) or Dec. 12 (Quarter 4)	1	3
2	Wages, tips, and other compensation	2	15,648 . 76
3	Federal income tax withheld from wages, tips, and other compensation	3	977 . 98
4	If no wages, tips, and other compensation are subject to social security or Medicare tax	<input type="checkbox"/> Check and go to line 6.	

	Column 1		Column 2
5a	Taxable social security wages	15,648 . 76 × 0.124 =	1,940 . 45
5a (i)	Qualified sick leave wages	0 . 00 × 0.062 =	0 . 00
5a (ii)	Qualified family leave wages	0 . 00 × 0.062 =	0 . 00
5b	Taxable social security tips	0 . 00 × 0.124 =	0 . 00
5c	Taxable Medicare wages & tips	15,648 . 76 × 0.029 =	453 . 81
5d	Taxable wages & tips subject to Additional Medicare Tax withholding	0 . 00 × 0.009 =	0 . 00
5e	Total social security and Medicare taxes. Add Column 2 from lines 5a, 5a(i), 5a(ii), 5b, 5c, and 5d	5e	3,372 . 24
5f	Section 3121(q) Notice and Demand—Tax due on unreported tips (see instructions)	5f	0 . 00
6	Total taxes before adjustments. Add lines 3, 5e, and 5f	6	3,372 . 24
7	Current quarter's adjustment for fractions of cents	7	0 . 02
8	Current quarter's adjustment for sick pay	8	0 . 00
9	Current quarter's adjustments for tips and group-term life insurance	9	0 . 00
10	Total taxes after adjustments. Combine lines 6 through 9	10	8,372 . 26
11a	Qualified small business payroll tax credit for increasing research activities. Attach Form 8974	11a	0 . 00
11b	Nonrefundable portion of credit for qualified sick and family leave wages from Worksheet 1	11b	0 . 00
11c	Nonrefundable portion of employee retention credit from Worksheet 1	11c	0 . 00

▶ You MUST complete all three pages of Form 941 and SIGN it.

Next ▶

Name (not your trade name)

Employer identification number (EIN)

Indian River Area Library

38-2176926

**Part 3: Tell us about your business. If a question does NOT apply to your business, leave it blank.**

- 17 If your business has closed or you stopped paying wages . . . . . ☐ Check here, and enter the final date you paid wages  /  / ; also attach a statement to your return. See instructions.
- 18 If you're a seasonal employer and you don't have to file a return for every quarter of the year . . . ☐ Check here.
- 19 Qualified health plan expenses allocable to qualified sick leave wages . . . . . 19  0 . 00
- 20 Qualified health plan expenses allocable to qualified family leave wages . . . . . 20  0 . 00
- 21 Qualified wages for the employee retention credit . . . . . 21  0 . 00
- 22 Qualified health plan expenses allocable to wages reported on line 21 . . . . . 22  0 . 00
- 23 Credit from Form 5884-C, line 11, for this quarter . . . . . 23  0 . 00
- 24 Deferred amount of the employee share of social security tax included on line 13b . . . 24  0 . 00
- 25 Reserved for future use . . . . . 25

**Part 4: May we speak with your third-party designee?**

Do you want to allow an employee, a paid tax preparer, or another person to discuss this return with the IRS? See the instructions for details.

☐ Yes. Designee's name and phone number  

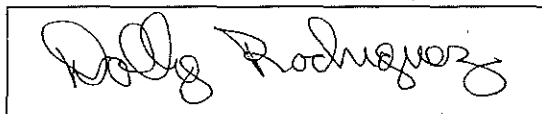
Select a 5-digit personal identification number (PIN) to use when talking to the IRS.

    ☐ No.**Part 5: Sign here. You MUST complete all three pages of Form 941 and SIGN it.**

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

**X**

Sign your name here



Print your name here

Dolly Rodriguez

Print your title here

Clerk

Date

1 / 4 / 21

Best daytime phone

231-238-0970

**Paid Preparer Use Only**Check if you're self-employed . . . ☐

Preparer's name

PTIN

Preparer's signature

Date

 /  / 

Firm's name (or yours if self-employed)

EIN

Address

Phone

City

State

ZIP code

Form **941 for 2020: Employer's QUARTERLY Federal Tax Return**  
(Rev. April 2020) Department of the Treasury — Internal Revenue Service

950120  
OMB No. 1545-0029

Employer identification number (EIN) **3 8 - 2 1 7 6 9 2 6**

Name (not your trade name) **Indian River Area Library**

Trade name (if any)

Address **PO Box 160**  
Number Street Suite or room number

**Indian River** **MI** **49749**  
City State ZIP code

Foreign country name Foreign province/county Foreign postal code

**Report for this Quarter of 2020**  
(Check one.)

- ☐ 1: January, February, March  
☐ 2: April, May, June  
☒ 3: July, August, September  
☐ 4: October, November, December
- Go to [www.irs.gov/Form941](http://www.irs.gov/Form941) for instructions and the latest information.

Read the separate instructions before you complete Form 941. Type or print within the boxes.

**Part 1: Answer these questions for this quarter.**

1	Number of employees who received wages, tips, or other compensation for the pay period including: <i>June 12</i> (Quarter 2), <i>Sept. 12</i> (Quarter 3), or <i>Dec. 12</i> (Quarter 4)	1	<b>3</b>
2	Wages, tips, and other compensation	2	<b>13,832 . 40</b>
3	Federal income tax withheld from wages, tips, and other compensation	3	<b>938 . 37</b>
4	If no wages, tips, and other compensation are subject to social security or Medicare tax	<input type="checkbox"/> Check and go to line 6.	

	Column 1		Column 2
5a	Taxable social security wages <b>13,831 . 40</b>	$\times 0.124 =$	<b>1,715 . 22</b>
5a (i)	Qualified sick leave wages <b>0 . 00</b>	$\times 0.062 =$	<b>0 . 00</b>
5a (ii)	Qualified family leave wages <b>0 . 00</b>	$\times 0.062 =$	<b>0 . 00</b>
5b	Taxable social security tips <b>0 . 00</b>	$\times 0.124 =$	<b>0 . 00</b>
5c	Taxable Medicare wages & tips <b>13,832 . 40</b>	$\times 0.029 =$	<b>401 . 14</b>
5d	Taxable wages & tips subject to Additional Medicare Tax withholding <b>0 . 00</b>	$\times 0.009 =$	<b>0 . 00</b>
5e	Total social security and Medicare taxes. Add Column 2 from lines 5a, 5a(i), 5a(ii), 5b, 5c, and 5d		
5e	<b>2,116 . 73</b>		
5f	Section 3121(q) Notice and Demand—Tax due on unreported tips (see instructions)		
5f	<b>0 . 00</b>		
6	Total taxes before adjustments. Add lines 3, 5e, and 5f		
6	<b>3,054 . 73</b>		
7	Current quarter's adjustment for fractions of cents		
7	<b>-0 . 02</b>		
8	Current quarter's adjustment for sick pay		
8	<b>0 . 00</b>		
9	Current quarter's adjustments for tips and group-term life insurance		
9	<b>0 . 00</b>		
10	Total taxes after adjustments. Combine lines 6 through 9		
10	<b>3,054 . 71</b>		
11a	Qualified small business payroll tax credit for increasing research activities. Attach Form 8974		
11a	<b>0 . 00</b>		
11b	Nonrefundable portion of credit for qualified sick and family leave wages from Worksheet 1		
11b	<b>0 . 00</b>		
11c	Nonrefundable portion of employee retention credit from Worksheet 1		
11c	<b>0 . 00</b>		

► You MUST complete all three pages of Form 941 and SIGN it.

Next ►

Name (not your trade name)

Employer identification number (EIN)

Tuscarora Township

38-1812031

**Part 3: Tell us about your business. If a question does NOT apply to your business, leave it blank.**

- 17 If your business has closed or you stopped paying wages . . . . . ☐ Check here, and enter the final date you paid wages  /  / ; also attach a statement to your return. See instructions.
- 18 If you're a seasonal employer and you don't have to file a return for every quarter of the year . . . . . ☐ Check here.
- 19 Qualified health plan expenses allocable to qualified sick leave wages . . . . . 19  0 . 00
- 20 Qualified health plan expenses allocable to qualified family leave wages . . . . . 20  0 . 00
- 21 Qualified wages for the employee retention credit . . . . . 21  0 . 00
- 22 Qualified health plan expenses allocable to wages reported on line 21 . . . . . 22  0 . 00
- 23 Credit from Form 5884-C, line 11, for this quarter . . . . . 23  0 . 00
- 24 Qualified wages paid March 13 through March 31, 2020, for the employee retention credit (use this line only for the second quarter filing of Form 941) . . . . . 24  0 . 00
- 25 Qualified health plan expenses allocable to wages reported on line 24 (use this line only for the second quarter filing of Form 941) . . . . . 25  0 . 00

**Part 4: May we speak with your third-party designee?**

Do you want to allow an employee, a paid tax preparer, or another person to discuss this return with the IRS? See the instructions for details.

☐ Yes. Designee's name and phone number  

Select a 5-digit personal identification number (PIN) to use when talking to the IRS.

    ☐ No.**Part 5: Sign here. You MUST complete all three pages of Form 941 and SIGN it.**

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Sign your name here

Print your name here

Susan Fisher

Print your title here

Clerk

Date

9/21/20

Best daytime phone

231-238-0970

**Paid Preparer Use Only**Check if you're self-employed . . . . . ☐

Preparer's name

PTIN

Preparer's signature

Date

 /  / 

Firm's name (or yours if self-employed)

EIN

Address

Phone

City

State

ZIP code



Form **941 for 2022: Employer's QUARTERLY Federal Tax Return**  
(Rev. June 2022) Department of the Treasury - Internal Revenue Service

950122  
OMB No. 1545-0029

Employer identification number (EIN)

Name (not your trade name)

Trade name (if any)

Address   
Number Street Suite or room number

City State ZIP code

Foreign country name Foreign province/county Foreign postal code

**Report for this Quarter of 2022**  
(Check one.)

☐ 1: January, February, March

☒ 2: April, May, June

☐ 3: July, August, September

☐ 4: October, November, December

Go to [www.irs.gov/Form941](http://www.irs.gov/Form941) for instructions and the latest information.

Read the separate instructions before you complete Form 941. Type or print within the boxes.

**Part 1: Answer these questions for this quarter.**

1	Number of employees who received wages, tips, or other compensation for the pay period including: <i>June 12</i> (Quarter 2), <i>Sept. 12</i> (Quarter 3), or <i>Dec. 12</i> (Quarter 4)	1	<input type="text" value="40"/>
2	Wages, tips, and other compensation	2	<input type="text" value="190,429"/> <input type="text" value="11"/>
3	Federal income tax withheld from wages, tips, and other compensation	3	<input type="text" value="16,407"/> <input type="text" value="16"/>
4	If no wages, tips, and other compensation are subject to social security or Medicare tax	<input type="checkbox"/> Check and go to line 6.	

	Column 1		Column 2
5a	Taxable social security wages* <input type="text" value="190,429"/> <input type="text" value="11"/>	$\times 0.124 =$	<input type="text" value="23,613"/> <input type="text" value="21"/>
5a (i)	Qualified sick leave wages* <input type="text"/>	$\times 0.062 =$	<input type="text"/>
5a (ii)	Qualified family leave wages* <input type="text"/>	$\times 0.062 =$	<input type="text"/>
5b	Taxable social security tips <input type="text" value="190,429"/> <input type="text" value="11"/>	$\times 0.124 =$	<input type="text" value="5,522"/> <input type="text" value="44"/>
5c	Taxable Medicare wages & tips <input type="text"/>	$\times 0.029 =$	<input type="text"/>
5d	Taxable wages & tips subject to Additional Medicare Tax withholding <input type="text"/>	$\times 0.009 =$	<input type="text"/>
5e	Total social security and Medicare taxes. Add Column 2 from lines 5a, 5a(i), 5a(ii), 5b, 5c, and 5d <input type="text" value="29,135"/> <input type="text" value="65"/>		
5f	Section 3121(q) Notice and Demand—Tax due on unreported tips (see instructions) <input type="text"/>		
6	Total taxes before adjustments. Add lines 3, 5e, and 5f <input type="text" value="45,542"/> <input type="text" value="81"/>		
7	Current quarter's adjustment for fractions of cents <input type="text" value="0"/> <input type="text" value="01"/>		
8	Current quarter's adjustment for sick pay <input type="text" value="0"/> <input type="text" value="00"/>		
9	Current quarter's adjustments for tips and group-term life insurance <input type="text"/>		
10	Total taxes after adjustments. Combine lines 6 through 9 <input type="text" value="45,542"/> <input type="text" value="82"/>		
11a	Qualified small business payroll tax credit for increasing research activities. Attach Form 8974 <input type="text"/>		
11b	Nonrefundable portion of credit for qualified sick and family leave wages for leave taken before April 1, 2021 <input type="text"/>		
11c	Reserved for future use <input type="text"/>		

\*Include taxable qualified sick and family leave wages paid in this quarter of 2022 for leave taken after March 31, 2021, and before October 1, 2021, on line 5a. Use lines 5a(i) and 5a(ii) only for taxable qualified sick and family leave wages paid in this quarter of 2022 for leave taken after March 31, 2020, and before April 1, 2021.

► You MUST complete all three pages of Form 941 and SIGN it.

Next ►

Name (not your trade name)

Township of Tuscarora

Employer identification number (EIN)

38 - 1812031

**Part 1:** Answer these questions for this quarter. (continued)

11d	Nonrefundable portion of credit for qualified sick and family leave wages for leave taken after March 31, 2021, and before October 1, 2021	11d	
11e	Reserved for future use	11e	
11f	Reserved for future use		
11g	Total nonrefundable credits. Add lines 11a, 11b, and 11d	11g	
12	Total taxes after adjustments and nonrefundable credits. Subtract line 11g from line 10	12	45,542 81
13a	Total deposits for this quarter, including overpayment applied from a prior quarter and overpayments applied from Form 941-X, 941-X (PR), 944-X, or 944-X (SP) filed in the current quarter	13a	45,446 27
13b	Reserved for future use	13b	
13c	Refundable portion of credit for qualified sick and family leave wages for leave taken before April 1, 2021	13c	
13d	Reserved for future use	13d	
13e	Refundable portion of credit for qualified sick and family leave wages for leave taken after March 31, 2021, and before October 1, 2021	13e	
13f	Reserved for future use	13f	
13g	Total deposits and refundable credits. Add lines 13a, 13c, and 13e	13g	45,446 27
13h	Reserved for future use	13h	
13i	Reserved for future use	13i	
14	Balance due. If line 12 is more than line 13g, enter the difference and see instructions	14	96 55
15	Overpayment. If line 13g is more than line 12, enter the difference		Check one: <input type="checkbox"/> Apply to next return. <input type="checkbox"/> Send a refund.

**Part 2:** Tell us about your deposit schedule and tax liability for this quarter.

If you're unsure about whether you're a monthly schedule depositor or a semiweekly schedule depositor, see section 11 of Pub. 15.

- 16 Check one: ☐ Line 12 on this return is less than \$2,500 or line 12 on the return for the prior quarter was less than \$2,500, and you didn't incur a \$100,000 next-day deposit obligation during the current quarter. If line 12 for the prior quarter was less than \$2,500 but line 12 on this return is \$100,000 or more, you must provide a record of your federal tax liability. If you're a monthly schedule depositor, complete the deposit schedule below; if you're a semiweekly schedule depositor, attach Schedule B (Form 941). Go to Part 3.

- ☐ You were a monthly schedule depositor for the entire quarter. Enter your tax liability for each month and total liability for the quarter, then go to Part 3.

Tax liability: Month 1

Month 2

Month 3

Total liability for quarter

Total must equal line 12.

- ☒ You were a semiweekly schedule depositor for any part of this quarter. Complete Schedule B (Form 941), Report of Tax Liability for Semiweekly Schedule Depositors, and attach it to Form 941. Go to Part 3.

▶ You MUST complete all three pages of Form 941 and SIGN it.

Next ▶

Name (not your trade name)

Township of Tuscarora

Employer identification number (EIN)

38 - 1812031

**Part 3: Tell us about your business. If a question does NOT apply to your business, leave it blank.**

17 If your business has closed or you stopped paying wages . . . . . ☐ Check here, and enter the final date you paid wages  /  / ; also attach a statement to your return. See instructions.

18 If you're a seasonal employer and you don't have to file a return for every quarter of the year . . . ☐ Check here.

19 Qualified health plan expenses allocable to qualified sick leave wages for leave taken before April 1, 2021 19

20 Qualified health plan expenses allocable to qualified family leave wages for leave taken before April 1, 2021 20

21 Reserved for future use . . . . . 21

22 Reserved for future use . . . . . 22

23 Qualified sick leave wages for leave taken after March 31, 2021, and before October 1, 2021 23

24 Qualified health plan expenses allocable to qualified sick leave wages reported on line 23 24

25 Amounts under certain collectively bargained agreements allocable to qualified sick leave wages reported on line 23 . . . . . 25

26 Qualified family leave wages for leave taken after March 31, 2021, and before October 1, 2021 26

27 Qualified health plan expenses allocable to qualified family leave wages reported on line 26 27

28 Amounts under certain collectively bargained agreements allocable to qualified family leave wages reported on line 26 . . . . . 28

**Part 4: May we speak with your third-party designee?**

Do you want to allow an employee, a paid tax preparer, or another person to discuss this return with the IRS? See the instructions for details.

☐ Yes. Designee's name and phone number

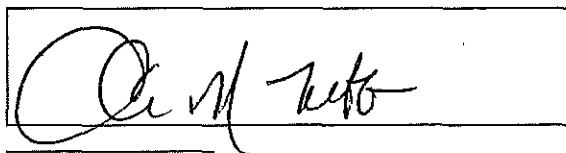
Select a 5-digit personal identification number (PIN) to use when talking to the IRS.

☐ No.

**Part 5: Sign here. You MUST complete all three pages of Form 941 and SIGN it.**

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

**X** Sign your name here



Print your name here

Dawn M Webb

Print your title here

Clerk

Date

7/8/22

Best daytime phone

231-238-0970

**Paid Preparer Use Only**

Check if you're self-employed . . . ☐

Preparer's name

PTIN

Preparer's signature

Date

/  /

Firm's name (or yours if self-employed)

EIN

Address

Phone

City

State

ZIP code

Form **941 for 2022: Employer's QUARTERLY Federal Tax Return**  
(Rev. March 2022) Department of the Treasury — Internal Revenue Service

950122  
OMB No. 1545-0029

Employer identification number (EIN)

Name (not your trade name)

Trade name (if any)

Address   
Number Street Suite or room number

City State ZIP code

Foreign country name Foreign province/county Foreign postal code

**Report for this Quarter of 2022**  
(Check one.)

- ☒ 1: January, February, March  
☐ 2: April, May, June  
☐ 3: July, August, September  
☐ 4: October, November, December

Go to [www.irs.gov/Form941](http://www.irs.gov/Form941) for instructions and the latest information.

Read the separate instructions before you complete Form 941. Type or print within the boxes.

**Part 1: Answer these questions for this quarter.**

1	Number of employees who received wages, tips, or other compensation for the pay period including: Mar. 12 (Quarter 1)	1	<input type="text" value="25"/>
2	Wages, tips, and other compensation	2	<input type="text" value="209358"/> <input type="text" value="11"/>
3	Federal income tax withheld from wages, tips, and other compensation	3	<input type="text" value="19067"/> <input type="text" value="35"/>
4	If no wages, tips, and other compensation are subject to social security or Medicare tax	<input type="checkbox"/> Check and go to line 6.	

	Column 1		Column 2
5a	Taxable social security wages* <input type="text" value="209358"/> <input type="text" value="11"/>	$\times 0.124 =$	<input type="text" value="25960"/> <input type="text" value="41"/>
5a (i)	Qualified sick leave wages* <input type="text"/>	$\times 0.062 =$	<input type="text"/>
5a (ii)	Qualified family leave wages* <input type="text"/>	$\times 0.062 =$	<input type="text"/>
5b	Taxable social security tips <input type="text"/>	$\times 0.124 =$	<input type="text"/>
5c	Taxable Medicare wages & tips <input type="text" value="209358"/> <input type="text" value="11"/>	$\times 0.029 =$	<input type="text" value="6071"/> <input type="text" value="39"/>
5d	Taxable wages & tips subject to Additional Medicare Tax withholding <input type="text"/>	$\times 0.009 =$	<input type="text"/>
5e	Total social security and Medicare taxes. Add Column 2 from lines 5a, 5a(i), 5a(ii), 5b, 5c, and 5d <input type="text" value="32031"/> <input type="text" value="80"/>		
5f	Section 3121(q) Notice and Demand—Tax due on unreported tips (see instructions) <input type="text"/>		
6	Total taxes before adjustments. Add lines 3, 5e, and 5f <input type="text" value="51099"/> <input type="text" value="15"/>		
7	Current quarter's adjustment for fractions of cents <input type="text" value="-"/> <input type="text" value="02"/>		
8	Current quarter's adjustment for sick pay <input type="text"/>		
9	Current quarter's adjustments for tips and group-term life insurance <input type="text"/>		
10	Total taxes after adjustments. Combine lines 6 through 9 <input type="text" value="51099"/> <input type="text" value="13"/>		
11a	Qualified small business payroll tax credit for increasing research activities. Attach Form 8974 <input type="text"/>		
11b	Nonrefundable portion of credit for qualified sick and family leave wages for leave taken before April 1, 2021 <input type="text"/>		
11c	Reserved for future use <input type="text"/>		

\*Include taxable qualified sick and family leave wages paid in 2022 for leave taken after March 31, 2021, and before October 1, 2021, on line 5a. Use lines 5a(i) and 5a(ii) only for taxable qualified sick and family leave wages paid in 2022 for leave taken after March 31, 2020, and before April 1, 2021.

► You MUST complete all three pages of Form 941 and SIGN it.

Next ►

Name (not your trade name)

Township of Tuscarora

Employer identification number (EIN)

38-1812031

**Part 3: Tell us about your business. If a question does NOT apply to your business, leave it blank.**

17 If your business has closed or you stopped paying wages . . . . . ☐ Check here, and enter the final date you paid wages  /  / ; also attach a statement to your return. See instructions.

18 If you're a seasonal employer and you don't have to file a return for every quarter of the year . . . . . ☐ Check here.

19 Qualified health plan expenses allocable to qualified sick leave wages for leave taken before April 1, 2021 19  .

20 Qualified health plan expenses allocable to qualified family leave wages for leave taken before April 1, 2021 20  .

21 Reserved for future use . . . . . 21  .

22 Reserved for future use . . . . . 22  .

23 Qualified sick leave wages for leave taken after March 31, 2021, and before October 1, 2021 23  .

24 Qualified health plan expenses allocable to qualified sick leave wages reported on line 23 24  .

25 Amounts under certain collectively bargained agreements allocable to qualified sick leave wages reported on line 23 . . . . . 25  .

26 Qualified family leave wages for leave taken after March 31, 2021, and before October 1, 2021 26  .

27 Qualified health plan expenses allocable to qualified family leave wages reported on line 26 27  .

28 Amounts under certain collectively bargained agreements allocable to qualified family leave wages reported on line 26 . . . . . 28  .

**Part 4: May we speak with your third-party designee?**

Do you want to allow an employee, a paid tax preparer, or another person to discuss this return with the IRS? See the instructions for details.

☐ Yes. Designee's name and phone number

Select a 5-digit personal identification number (PIN) to use when talking to the IRS.

☐ No.

**Part 5: Sign here. You MUST complete all three pages of Form 941 and SIGN it.**

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

**X**

Sign your name here

Print your name here

Dawn M Webb

Print your title here

Clerk

Date

/  /

Best daytime phone

231-238-0970

**Paid Preparer Use Only**

Check if you're self-employed . . . . . ☐

Preparer's name

PTIN

Preparer's signature

Date

/  /

Firm's name (or yours if self-employed)

EIN

Address

Phone

City

State

ZIP code

# Schedule B (Form 941):

960311

## Report of Tax Liability for Semiweekly Schedule Depositors

OMB No. 1545-0029

(Rev. January 2017)

Department of the Treasury — Internal Revenue Service

Employer identification number  
(EIN)

3 8 - 1 8 1 2 0 3 1

Name (not your trade name)

Township of Tuscarora

Calendar year

2 0 2 2

(Also check quarter)

**Report for this Quarter...**

(Check one.)

- ☒ 1: January, February, March  
☐ 2: April, May, June  
☐ 3: July, August, September  
☐ 4: October, November, December

Use this schedule to show your TAX LIABILITY for the quarter; don't use it to show your deposits. When you file this form with Form 941 or Form 941-SS, don't change your tax liability by adjustments reported on any Forms 941-X or 944-X. You must fill out this form and attach it to Form 941 or Form 941-SS if you're a semiweekly schedule depositor or became one because your accumulated tax liability on any day was \$100,000 or more. Write your daily tax liability on the numbered space that corresponds to the date wages were paid. See Section 11 in Pub. 15 for details.

**Month 1**

1		9		17		25	
2		10		18		26	
3		11		19		27	
4		12		20	7043 . 69	28	
5		13		21		29	
6	8034 . 22	14		22		30	
7		15		23		31	
8		16		24			

Tax liability for Month 1

15077 . 91

**Month 2**

1		9		17	6656 . 46	25	
2		10		18		26	
3	7814 . 01	11		19		27	
4		12		20		28	
5		13		21		29	
6		14		22	540 . 62	30	
7		15		23		31	
8		16		24			

Tax liability for Month 2

15011 . 09

**Month 3**

1		9	6915 . 01	17		25	
2		10		18		26	
3	6861 . 09	11		19		27	
4		12		20		28	
5		13		21		29	
6		14		22		30	
7		15		23		31	7400 . 54
8		16		24			

Tax liability for Month 3

21176 . 64

Fill in your total liability for the quarter (Month 1 + Month 2 + Month 3) ▶

Total must equal line 12 on Form 941 or Form 941-SS.

Total liability for the quarter

51265 . 64

Employer identification number (EIN)

Name (not your trade name)

Trade name (if any)

Address   
Number Street Suite or room number

City State ZIP code

Foreign country name Foreign province/county Foreign postal code

**Report for this Quarter of 2021**  
(Check one.)

- ☐ 1: January, February, March  
☐ 2: April, May, June  
☐ 3: July, August, September  
☒ 4: October, November, December

Go to [www.irs.gov/Form941](http://www.irs.gov/Form941) for instructions and the latest information.

Read the separate instructions before you complete Form 941. Type or print within the boxes.

**Part 1: Answer these questions for this quarter.**

1	Number of employees who received wages, tips, or other compensation for the pay period including: <i>June 12 (Quarter 2), Sept. 12 (Quarter 3), or Dec. 12 (Quarter 4)</i>	1	<input type="text" value="23"/>
2	Wages, tips, and other compensation	2	<input type="text" value="227570"/> <input type="text" value="33"/>
3	Federal income tax withheld from wages, tips, and other compensation	3	<input type="text" value="19114"/> <input type="text" value="79"/>
4	If no wages, tips, and other compensation are subject to social security or Medicare tax	<input type="checkbox"/> Check and go to line 6.	

	Column 1		Column 2
5a	Taxable social security wages* <input type="text" value="227570"/> <input type="text" value="33"/>	$\times 0.124 =$	<input type="text" value="28218"/> <input type="text" value="72"/>
5a (i)	Qualified sick leave wages* <input type="text"/>	$\times 0.062 =$	<input type="text"/>
5a (ii)	Qualified family leave wages* <input type="text"/>	$\times 0.062 =$	<input type="text"/>
5b	Taxable social security tips <input type="text"/>	$\times 0.124 =$	<input type="text"/>
5c	Taxable Medicare wages & tips <input type="text" value="227570"/> <input type="text" value="33"/>	$\times 0.029 =$	<input type="text" value="6599"/> <input type="text" value="54"/>
5d	Taxable wages & tips subject to Additional Medicare Tax withholding <input type="text"/>	$\times 0.009 =$	<input type="text"/>
5e	Total social security and Medicare taxes. Add Column 2 from lines 5a, 5a(i), 5a(ii), 5b, 5c, and 5d		5e <input type="text" value="34818"/> <input type="text" value="26"/>
5f	Section 3121(q) Notice and Demand—Tax due on unreported tips (see instructions)		5f <input type="text"/>
6	Total taxes before adjustments. Add lines 3, 5e, and 5f		6 <input type="text" value="53933"/> <input type="text" value="05"/>
7	Current quarter's adjustment for fractions of cents		7 <input type="text"/>
8	Current quarter's adjustment for sick pay		8 <input type="text"/>
9	Current quarter's adjustments for tips and group-term life insurance		9 <input type="text"/>
10	Total taxes after adjustments. Combine lines 6 through 9		10 <input type="text" value="53933"/> <input type="text" value="05"/>
11a	Qualified small business payroll tax credit for increasing research activities. Attach Form 8974		11a <input type="text"/>
11b	Nonrefundable portion of credit for qualified sick and family leave wages for leave taken before April 1, 2021		11b <input type="text"/>
11c	Nonrefundable portion of employee retention credit		11c <input type="text"/>

\*Include taxable qualified sick and family leave wages for leave taken after March 31, 2021, on line 5a. Use lines 5a(i) and 5a(ii) only for wages paid after March 31, 2020, for leave taken before April 1, 2021.

▶ You MUST complete all three pages of Form 941 and SIGN it.

Next ▶

Name (not your trade name)

Tuscarora Township

Employer identification number (EIN)

381812031

**Part 3: Tell us about your business. If a question does NOT apply to your business, leave it blank.**17 If your business has closed or you stopped paying wages . . . . . ☐ Check here, andenter the final date you paid wages  /  /  ; also attach a statement to your return. See instructions.18a If you're a seasonal employer and you don't have to file a return for every quarter of the year . . . . ☐ Check here.18b If you're eligible for the employee retention credit solely because your business is a recovery startup business ☐ Check here.19 Qualified health plan expenses allocable to qualified sick leave wages for leave taken before April 1, 2021 19  .20 Qualified health plan expenses allocable to qualified family leave wages for leave taken before April 1, 2021 20  .21 Qualified wages for the employee retention credit . . . . . 21  .22 Qualified health plan expenses for the employee retention credit . . . . . 22  .23 Qualified sick leave wages for leave taken after March 31, 2021 . . . . . 23  .24 Qualified health plan expenses allocable to qualified sick leave wages reported on line 23 24  .25 Amounts under certain collectively bargained agreements allocable to qualified sick leave wages reported on line 23 . . . . . 25  .26 Qualified family leave wages for leave taken after March 31, 2021 . . . . . 26  .27 Qualified health plan expenses allocable to qualified family leave wages reported on line 26 27  .28 Amounts under certain collectively bargained agreements allocable to qualified family leave wages reported on line 26 . . . . . 28  .**Part 4: May we speak with your third-party designee?**

Do you want to allow an employee, a paid tax preparer, or another person to discuss this return with the IRS? See the instructions for details.

☐ Yes. Designee's name and phone number  

Select a 5-digit personal identification number (PIN) to use when talking to the IRS.

    ☐ No.**Part 5: Sign here. You MUST complete all three pages of Form 941 and SIGN it.**

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Sign your  
name herePrint your  
name here

Dawn M Webb

Print your  
title here

Clerk

Date

 /  / 

Best daytime phone

231-238-2122

**Paid Preparer Use Only**Check if you're self-employed . . . ☐

Preparer's name

PTIN

Preparer's signature

Date

 /  / Firm's name (or yours  
if self-employed)

EIN

Address

Phone

City

State

ZIP code



**941 for 2021: Employer's QUARTERLY Federal Tax Return**

Department of the Treasury — Internal Revenue Service

951121

OMB No. 1545-0029

Employer identification number (EIN)	3	8	-	1	8	1	2	0	3	1
Name (not your trade name)	Tuscarora Township									
Trade name (if any)										
Address	PO Box 220									
Number	Street				Suite or room number					
Indian River	MI				49749					
City	State				ZIP code					
Foreign country name			Foreign province/county			Foreign postal code				

**Report for this Quarter of 2021**  
(Check one.)

- ☐ 1: January, February, March  
☐ 2: April, May, June  
☒ 3: July, August, September  
☐ 4: October, November, December

Go to [www.irs.gov/Form941](http://www.irs.gov/Form941) for instructions and the latest information.

Read the separate instructions before you complete Form 941. Type or print within the boxes.

**Part 1: Answer these questions for this quarter.**

1	Number of employees who received wages, tips, or other compensation for the pay period including: June 12 (Quarter 2), Sept. 12 (Quarter 3), or Dec. 12 (Quarter 4)	1	29																												
2	Wages, tips, and other compensation	2	241848 . 06																												
3	Federal income tax withheld from wages, tips, and other compensation	3	21539 . 67																												
4	If no wages, tips, and other compensation are subject to social security or Medicare tax	<input type="checkbox"/> Check and go to line 6.																													
<table border="1"><thead><tr><th></th><th>Column 1</th><th></th><th>Column 2</th></tr></thead><tbody><tr><td>5a</td><td>Taxable social security wages*</td><td>241848 . 06</td><td>× 0.124 = 29989 . 16</td></tr><tr><td>5a (i)</td><td>Qualified sick leave wages*</td><td></td><td>× 0.062 =</td></tr><tr><td>5a (ii)</td><td>Qualified family leave wages*</td><td></td><td>× 0.062 =</td></tr><tr><td>5b</td><td>Taxable social security tips</td><td></td><td>× 0.124 =</td></tr><tr><td>5c</td><td>Taxable Medicare wages &amp; tips</td><td>241848 . 06</td><td>× 0.029 = 7013 . 59</td></tr><tr><td>5d</td><td>Taxable wages &amp; tips subject to Additional Medicare Tax withholding</td><td></td><td>× 0.009 =</td></tr></tbody></table>					Column 1		Column 2	5a	Taxable social security wages*	241848 . 06	× 0.124 = 29989 . 16	5a (i)	Qualified sick leave wages*		× 0.062 =	5a (ii)	Qualified family leave wages*		× 0.062 =	5b	Taxable social security tips		× 0.124 =	5c	Taxable Medicare wages & tips	241848 . 06	× 0.029 = 7013 . 59	5d	Taxable wages & tips subject to Additional Medicare Tax withholding		× 0.009 =
	Column 1		Column 2																												
5a	Taxable social security wages*	241848 . 06	× 0.124 = 29989 . 16																												
5a (i)	Qualified sick leave wages*		× 0.062 =																												
5a (ii)	Qualified family leave wages*		× 0.062 =																												
5b	Taxable social security tips		× 0.124 =																												
5c	Taxable Medicare wages & tips	241848 . 06	× 0.029 = 7013 . 59																												
5d	Taxable wages & tips subject to Additional Medicare Tax withholding		× 0.009 =																												
5e	Total social security and Medicare taxes. Add Column 2 from lines 5a, 5a(i), 5a(ii), 5b, 5c, and 5d	5e	37002 . 75																												
5f	Section 3121(q) Notice and Demand—Tax due on unreported tips (see instructions)	5f																													
6	Total taxes before adjustments. Add lines 3, 5e, and 5f	6	58542 . 42																												
7	Current quarter's adjustment for fractions of cents	7	- . 05																												
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\*Include taxable qualified sick and family leave wages for leave taken after March 31, 2021, on line 5a. Use lines 5a(i) and 5a(ii) only for wages paid after March 31, 2020, for leave taken before April 1, 2021.

▶ You MUST complete all three pages of Form 941 and SIGN it.

Next ▶

Name (not your trade name) Tuscarora Township	Employer identification number (EIN) 381812031
--	---

**Part 3: Tell us about your business. If a question does NOT apply to your business, leave it blank.**

17 If your business has closed or you stopped paying wages . . . . . ☐ Check here, and enter the final date you paid wages  /  / ; also attach a statement to your return. See instructions.

18a If you're a seasonal employer and you don't have to file a return for every quarter of the year . . . . ☐ Check here.

18b If you're eligible for the employee retention credit solely because your business is a recovery startup business ☐ Check here.

19 Qualified health plan expenses allocable to qualified sick leave wages for leave taken before April 1, 2021 19  .

20 Qualified health plan expenses allocable to qualified family leave wages for leave taken before April 1, 2021 20  .

21 Qualified wages for the employee retention credit . . . . . 21  .

22 Qualified health plan expenses for the employee retention credit . . . . . 22  .

23 Qualified sick leave wages for leave taken after March 31, 2021 . . . . . 23  .

24 Qualified health plan expenses allocable to qualified sick leave wages reported on line 23 24  .

25 Amounts under certain collectively bargained agreements allocable to qualified sick leave wages reported on line 23 . . . . . 25  .

26 Qualified family leave wages for leave taken after March 31, 2021 . . . . . 26  .

27 Qualified health plan expenses allocable to qualified family leave wages reported on line 26 27  .

28 Amounts under certain collectively bargained agreements allocable to qualified family leave wages reported on line 26 . . . . . 28  .

**Part 4: May we speak with your third-party designee?**

Do you want to allow an employee, a paid tax preparer, or another person to discuss this return with the IRS? See the instructions for details.

☐ Yes. Designee's name and phone number

Select a 5-digit personal identification number (PIN) to use when talking to the IRS.

☐ No.

**Part 5: Sign here. You MUST complete all three pages of Form 941 and SIGN it.**

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

**X**

Sign your name here

*Dawn M. Webb*

Print your name here

Dawn M. Webb

Print your title here

Clerk

Date  10/8/2021

Best daytime phone  231-238-0970

**Paid Preparer Use Only**

Check if you're self-employed . . . . ☐

Preparer's name

PTIN

Preparer's signature

Date  /  /

Firm's name (or yours if self-employed)

EIN

Address

Phone

City  State

ZIP code

# Schedule B (Form 941):

960311

## Report of Tax Liability for Semiweekly Schedule Depositors

(Rev. January 2017)

Department of the Treasury — Internal Revenue Service

OMB No. 1545-0029

Employer identification number (EIN) 3 1 -

Name (not your trade name) Tuscarora Township

Calendar year 2 0 2 1 (Also check quarter)

### Report for this Quarter...

(Check one.)

- ☐ 1: January, February, March
- ☐ 2: April, May, June
- ☒ 3: July, August, September
- ☐ 4: October, November, December

Use this schedule to show your TAX LIABILITY for the quarter; don't use it to show your deposits. When you file this form with Form 941 or Form 941-SS, don't change your tax liability by adjustments reported on any Forms 941-X or 944-X. You must fill out this form and attach it to Form 941 or Form 941-SS if you're a semiweekly schedule depositor or became one because your accumulated tax liability on any day was \$100,000 or more. Write your daily tax liability on the numbered space that corresponds to the date wages were paid. See Section 11 in Pub. 15 for details.

#### Month 1

1		9	59	98	17		25	
2		10			18		26	
3		11			19		27	
4		12			20		28	
5		13			21		29	69
6		14			22	8593	84	
7		15			23		31	
8	7847	97	16		24			

Tax liability for Month 1

16570 . 87

#### Month 2

1		9	86	89	17		25	
2		10			18		26	
3		11			19	8771	38	
4		12			20		28	
5	8224	10	13		21		29	
6		14			22		30	
7		15			23		31	
8		16			24			

Tax liability for Month 2

17082 . 37

#### Month 3

1		9			17		25	
2	9030	35	10		18		26	
3		11			19		27	
4		12			20		28	
5		13			21		29	
6		14			22		30	7566
7		15			23		31	
8		16	8291	93	24			

Tax liability for Month 3

24889 . 13

Fill in your total liability for the quarter (Month 1 + Month 2 + Month 3) ►

Total must equal line 12 on Form 941 or Form 941-SS.

Total liability for the quarter

58542 . 37

**941 for 2021: Employer's QUARTERLY Federal Tax Return**

Department of the Treasury — Internal Revenue Service

951121

OMB No. 1545-0029

Employer identification number (EIN)	3	8	-	1	8	1	2	0	3	1
Name (not your trade name)	Township of Tuscarora									
Trade name (if any)										
Address	PO Box 220									
	Number	Street						Suite or room number		
	Indian River						MI	49749		
	City						State		ZIP code	
	Foreign country name						Foreign province/county		Foreign postal code	

**Report for this Quarter of 2021**  
(Check one.)

- ☐ 1: January, February, March
- ☒ 2: April, May, June
- ☐ 3: July, August, September
- ☐ 4: October, November, December

Go to [www.irs.gov/Form941](http://www.irs.gov/Form941) for instructions and the latest information.

Read the separate instructions before you complete Form 941. Type or print within the boxes.

**Part 1: Answer these questions for this quarter.**

1	Number of employees who received wages, tips, or other compensation for the pay period including: <i>June 12</i> (Quarter 2), <i>Sept. 12</i> (Quarter 3), or <i>Dec. 12</i> (Quarter 4)	1	35																												
2	Wages, tips, and other compensation	2	227,327 . 84																												
3	Federal income tax withheld from wages, tips, and other compensation	3	20,319 . 84																												
4	If no wages, tips, and other compensation are subject to social security or Medicare tax	<input type="checkbox"/> Check and go to line 6.																													
<table border="1"> <thead> <tr> <th></th> <th>Column 1</th> <th></th> <th>Column 2</th> </tr> </thead> <tbody> <tr> <td>5a</td> <td>Taxable social security wages*</td> <td>227,327 . 84 × 0.124 =</td> <td>28,188 . 65</td> </tr> <tr> <td>5a (i)</td> <td>Qualified sick leave wages*</td> <td> × 0.062 =</td> <td> . </td> </tr> <tr> <td>5a (ii)</td> <td>Qualified family leave wages*</td> <td> × 0.062 =</td> <td> . </td> </tr> <tr> <td>5b</td> <td>Taxable social security tips</td> <td> × 0.124 =</td> <td> . </td> </tr> <tr> <td>5c</td> <td>Taxable Medicare wages &amp; tips.</td> <td>227,327 . 84 × 0.029 =</td> <td>6,592 . 51</td> </tr> <tr> <td>5d</td> <td>Taxable wages &amp; tips subject to Additional Medicare Tax withholding</td> <td> × 0.009 =</td> <td> . </td> </tr> </tbody> </table>					Column 1		Column 2	5a	Taxable social security wages*	227,327 . 84 × 0.124 =	28,188 . 65	5a (i)	Qualified sick leave wages*	× 0.062 =	.	5a (ii)	Qualified family leave wages*	× 0.062 =	.	5b	Taxable social security tips	× 0.124 =	.	5c	Taxable Medicare wages & tips.	227,327 . 84 × 0.029 =	6,592 . 51	5d	Taxable wages & tips subject to Additional Medicare Tax withholding	× 0.009 =	.
	Column 1		Column 2																												
5a	Taxable social security wages*	227,327 . 84 × 0.124 =	28,188 . 65																												
5a (i)	Qualified sick leave wages*	× 0.062 =	.																												
5a (ii)	Qualified family leave wages*	× 0.062 =	.																												
5b	Taxable social security tips	× 0.124 =	.																												
5c	Taxable Medicare wages & tips.	227,327 . 84 × 0.029 =	6,592 . 51																												
5d	Taxable wages & tips subject to Additional Medicare Tax withholding	× 0.009 =	.																												
5e	Total social security and Medicare taxes. Add Column 2 from lines 5a, 5a(i), 5a(ii), 5b, 5c, and 5d	5e	34,781 . 16																												
5f	Section 3121(q) Notice and Demand—Tax due on unreported tips (see instructions)	5f	0 . 00																												
6	Total taxes before adjustments. Add lines 3, 5e, and 5f	6	55,101 . 00																												
7	Current quarter's adjustment for fractions of cents	7	-0 . 06																												
8	Current quarter's adjustment for sick pay	8	0 . 00																												
9	Current quarter's adjustments for tips and group-term life insurance	9	0 . 00																												
10	Total taxes after adjustments. Combine lines 6 through 9	10	55,100 . 94																												
11a	Qualified small business payroll tax credit for increasing research activities. Attach Form 8974	11a	0 . 00																												
11b	Nonrefundable portion of credit for qualified sick and family leave wages for leave taken before April 1, 2021	11b	0 . 00																												
11c	Nonrefundable portion of employee retention credit	11c	0 . 00																												

\*Include taxable qualified sick and family leave wages for leave taken after March 31, 2021, on line 5a. Use lines 5a(i) and 5a(ii) only for wages paid after March 31, 2020, for leave taken before April 1, 2021.

▶ You MUST complete all three pages of Form 941 and SIGN it.

Next ▶

# Schedule B (Form 941):

960311

## Report of Tax Liability for Semiweekly Schedule Depositors

OMB No. 1545-0029

(Rev. January 2017)

Department of the Treasury — Internal Revenue Service

Employer identification number (EIN) 3 8 - 1 8 1 2 0 3 1

Name (not your trade name) Township of Tuscarora

Calendar year 2 0 2 1 (Also check quarter)

### Report for this Quarter...

(Check one.)

☐ 1: January, February, March

☒ 2: April, May, June

☐ 3: July, August, September

☐ 4: October, November, December

Use this schedule to show your TAX LIABILITY for the quarter; don't use it to show your deposits. When you file this form with Form 941 or Form 941-SS, don't change your tax liability by adjustments reported on any Forms 941-X or 944-X. You must fill out this form and attach it to Form 941 or Form 941-SS if you're a semiweekly schedule depositor or became one because your accumulated tax liability on any day was \$100,000 or more. Write your daily tax liability on the numbered space that corresponds to the date wages were paid. See Section 11 in Pub. 15 for details.

#### Month 1

1	7,435 . 64	9		17		25	
2		10		18		26	
3		11		19		27	
4		12		20		28	
5		13		21		29	7,686 . 09
6		14	7,714 . 77	22		30	
7		15		23		31	
8		16		24			

Tax liability for Month 1

22,836 . 50

#### Month 2

1		9		17		25	
2		10		18		26	
3		11		19		27	7,444 . 46
4		12		20		28	
5		13	7,600 . 59	21		29	
6		14		22		30	
7		15		23		31	
8		16		24			

Tax liability for Month 2

15,045 . 05

#### Month 3

1		9		17		25	
2		10	7,935 . 74	18		26	
3		11		19		27	
4		12		20		28	
5		13		21		29	
6		14		22		30	
7		15		23		31	
8		16		24	9,283 . 65		

Tax liability for Month 3

17,219 . 39

Fill in your total liability for the quarter (Month 1 + Month 2 + Month 3) ►

Total must equal line 12 on Form 941 or Form 941-SS.

Total liability for the quarter

55,100 . 94

Form **941 for 2021: Employer's QUARTERLY Federal Tax Return**  
(Rev. March 2021) Department of the Treasury — Internal Revenue Service

950121  
OMB No. 1545-0029

Employer identification number (EIN)   -

Name (not your trade name)

Trade name (if any)

Address   
Number Street Suite or room number

City State ZIP code

Foreign country name Foreign province/county Foreign postal code

**Report for this Quarter of 2021**  
(Check one.)

- ☒ 1: January, February, March  
☐ 2: April, May, June  
☐ 3: July, August, September  
☐ 4: October, November, December  
Go to [www.irs.gov/Form941](http://www.irs.gov/Form941) for instructions and the latest information.

Read the separate instructions before you complete Form 941. Type or print within the boxes.

**Part 1: Answer these questions for this quarter.**

1	Number of employees who received wages, tips, or other compensation for the pay period including: Mar. 12 (Quarter 1), June 12 (Quarter 2), Sept. 12 (Quarter 3), or Dec. 12 (Quarter 4)	1	<input type="text" value="22"/>
2	Wages, tips, and other compensation	2	<input type="text" value="179992.11"/>
3	Federal income tax withheld from wages, tips, and other compensation	3	<input type="text" value="16757.25"/>
4	If no wages, tips, and other compensation are subject to social security or Medicare tax	<input type="checkbox"/> Check and go to line 6.	

	Column 1		Column 2
5a	Taxable social security wages	<input type="text" value="179992.11"/> × 0.124 =	<input type="text" value="22319.02"/>
5a (i)	Qualified sick leave wages	<input type="text" value="0.00"/> × 0.062 =	<input type="text" value="0.00"/>
5a (ii)	Qualified family leave wages	<input type="text" value="0.00"/> × 0.062 =	<input type="text" value="0.00"/>
5b	Taxable social security tips	<input type="text" value="0.00"/> × 0.124 =	<input type="text" value="0.00"/>
5c	Taxable Medicare wages & tips	<input type="text" value="179992.11"/> × 0.029 =	<input type="text" value="5219.77"/>
5d	Taxable wages & tips subject to Additional Medicare Tax withholding	<input type="text" value="0.00"/> × 0.009 =	<input type="text" value="0.00"/>
5e	Total social security and Medicare taxes. Add Column 2 from lines 5a, 5a(i), 5a(ii), 5b, 5c, and 5d	5e	<input type="text" value="27538.79"/>
5f	Section 3121(q) Notice and Demand—Tax due on unreported tips (see instructions)	5f	<input type="text" value="0.00"/>
6	Total taxes before adjustments. Add lines 3, 5e, and 5f	6	<input type="text" value="44296.04"/>
7	Current quarter's adjustment for fractions of cents	7	<input type="text" value="0.07"/>
8	Current quarter's adjustment for sick pay	8	<input type="text" value="0.00"/>
9	Current quarter's adjustments for tips and group-term life insurance	9	<input type="text" value="0.00"/>
10	Total taxes after adjustments. Combine lines 6 through 9	10	<input type="text" value="44296.11"/>
11a	Qualified small business payroll tax credit for increasing research activities. Attach Form 8974	11a	<input type="text" value="0.00"/>
11b	Nonrefundable portion of credit for qualified sick and family leave wages from Worksheet 1	11b	<input type="text" value="0.00"/>
11c	Nonrefundable portion of employee retention credit from Worksheet 1	11c	<input type="text" value="0.00"/>

► You MUST complete all three pages of Form 941 and SIGN it.

Next ►

# Schedule B (Form 941):

960311

## Report of Tax Liability for Semiweekly Schedule Depositors

OMB No. 1545-0029

(Rev. January 2017)

Department of the Treasury — Internal Revenue Service

Employer identification number (EIN) 

3	8	-	1	8	1	2	0	3	1
---	---	---	---	---	---	---	---	---	---

Name (not your trade name)

Township of Tuscarora

Calendar year

2	0	2	1
---	---	---	---

(Also check quarter)

**Report for this Quarter...**

(Check one.)

- ☒ 1: January, February, March  
☐ 2: April, May, June  
☐ 3: July, August, September  
☐ 4: October, November, December

Use this schedule to show your TAX LIABILITY for the quarter; don't use it to show your deposits. When you file this form with Form 941 or Form 941-SS, don't change your tax liability by adjustments reported on any Forms 941-X or 944-X. You must fill out this form and attach it to Form 941 or Form 941-SS if you're a semiweekly schedule depositor or became one because your accumulated tax liability on any day was \$100,000 or more. Write your daily tax liability on the numbered space that corresponds to the date wages were paid. See Section 11 in Pub. 15 for details.

**Month 1**

1		9		17		25	
2		10		18		26	
3		11		19		27	
4		12		20		28	
5		13		21	7284.63	29	
6	8481.94	14		22		30	
7		15		23		31	
8		16		24			

Tax liability for Month 1

15766.57

**Month 2**

1		9		17		25	
2		10		18	7214.66	26	
3		11		19		27	
4	7141.64	12		20		28	
5		13		21		29	
6		14		22		30	
7		15		23		31	
8		16		24			

Tax liability for Month 2

14356.30

**Month 3**

1		9		17		25	
2		10		18	7059.59	26	
3		11		19		27	
4	7113.65	12		20		28	
5		13		21		29	
6		14		22		30	
7		15		23		31	
8		16		24			

Tax liability for Month 3

14173.24

Fill in your total liability for the quarter (Month 1 + Month 2 + Month 3) ▶

Total must equal line 12 on Form 941 or Form 941-SS.

Total liability for the quarter

44296.11

Employer identification number (EIN) 3 8 - 1 8 1 2 0 3 1

Name (not your trade name) Township of Tuscarora

Trade name (if any)

Address PO Box 220  
Number Street Suite or room number

Indian River MI 49749  
City State ZIP code

Foreign country name Foreign province/county Foreign postal code

**Report for this Quarter of 2020**  
(Check one.)

- ☐ 1: January, February, March  
☐ 2: April, May, June  
☐ 3: July, August, September  
☒ 4: October, November, December
- Go to [www.irs.gov/Form941](http://www.irs.gov/Form941) for instructions and the latest information.

Read the separate instructions before you complete Form 941. Type or print within the boxes.

**Part 1: Answer these questions for this quarter.**

1	Number of employees who received wages, tips, or other compensation for the pay period including: Sept. 12 (Quarter 3) or Dec. 12 (Quarter 4)	1	<span>35</span>
2	Wages, tips, and other compensation	2	<span>238,975</span> <span>36</span>
3	Federal income tax withheld from wages, tips, and other compensation	3	<span>20,666</span> <span>42</span>
4	If no wages, tips, and other compensation are subject to social security or Medicare tax	<input type="checkbox"/> Check and go to line 6.	

	Column 1		Column 2
5a Taxable social security wages	<span>238,975</span> <span>36</span>	$\times 0.124 =$	<span>29,632</span> <span>94</span>
5a (i) Qualified sick leave wages	<span>0</span> <span>00</span>	$\times 0.062 =$	<span>0</span> <span>00</span>
5a (ii) Qualified family leave wages	<span>0</span> <span>00</span>	$\times 0.062 =$	<span>0</span> <span>00</span>
5b Taxable social security tips	<span>0</span> <span>00</span>	$\times 0.124 =$	<span>0</span> <span>00</span>
5c Taxable Medicare wages & tips	<span>238,975</span> <span>36</span>	$\times 0.029 =$	<span>6,930</span> <span>29</span>
5d Taxable wages & tips subject to Additional Medicare Tax withholding	<span>0</span> <span>00</span>	$\times 0.009 =$	<span>0</span> <span>00</span>

5e	Total social security and Medicare taxes. Add Column 2 from lines 5a, 5a(i), 5a(ii), 5b, 5c, and 5d	5e	<span>36,563</span> <span>23</span>
5f	Section 3121(q) Notice and Demand—Tax due on unreported tips (see instructions)	5f	<span>0</span> <span>00</span>
6	Total taxes before adjustments. Add lines 3, 5e, and 5f	6	<span>57,229</span> <span>65</span>
7	Current quarter's adjustment for fractions of cents	7	<span>138</span> <span>27</span>
8	Current quarter's adjustment for sick pay	8	<span>0</span> <span>00</span>
9	Current quarter's adjustments for tips and group-term life insurance	9	<span>0</span> <span>00</span>
10	Total taxes after adjustments. Combine lines 6 through 9	10	<span>57,367</span> <span>92</span>
11a	Qualified small business payroll tax credit for increasing research activities. Attach Form 8974	11a	<span>0</span> <span>00</span>
11b	Nonrefundable portion of credit for qualified sick and family leave wages from Worksheet 1	11b	<span>0</span> <span>00</span>
11c	Nonrefundable portion of employee retention credit from Worksheet 1	11c	<span>0</span> <span>00</span>

► You MUST complete all three pages of Form 941 and SIGN it.

Next ►



Name (not your trade name)

Township of Tuscarora

Employer identification number (EIN)

38-1812031

**Part 1:** Answer these questions for this quarter. (continued)

11d	Total nonrefundable credits. Add lines 11a, 11b, and 11c . . . . .	11d	<div>0 . 00</div>
12	Total taxes after adjustments and nonrefundable credits. Subtract line 11d from line 10 . . . . .	12	<div>57,367 . 92</div>
13a	Total deposits for this quarter, including overpayment applied from a prior quarter and overpayments applied from Form 941-X, 941-X (PR), 944-X, or 944-X (SP) filed in the current quarter . . . . .	13a	<div>57,894 . 25</div>
13b	Deferred amount of social security tax . . . . .	13b	<div>0 . 00</div>
13c	Refundable portion of credit for qualified sick and family leave wages from Worksheet 1 . . . . .	13c	<div>0 . 00</div>
13d	Refundable portion of employee retention credit from Worksheet 1 . . . . .	13d	<div>0 . 00</div>
13e	Total deposits, deferrals, and refundable credits. Add lines 13a, 13b, 13c, and 13d . . . . .	13e	<div>0 . 00</div>
13f	Total advances received from filing Form(s) 7200 for the quarter . . . . .	13f	<div>0 . 00</div>
13g	Total deposits, deferrals, and refundable credits less advances. Subtract line 13f from line 13e . . . . .	13g	<div>0 . 00</div>
14	Balance due. If line 12 is more than line 13g, enter the difference and see instructions . . . . .	14	<div>0 . 00</div>
15	Overpayment. If line 13g is more than line 12, enter the difference <div>526 . 33</div> Check one: <input checked="" type="checkbox"/> Apply to next return. <input type="checkbox"/> Send a refund.		

**Part 2:** Tell us about your deposit schedule and tax liability for this quarter.

If you're unsure about whether you're a monthly schedule depositor or a semiweekly schedule depositor, see section 11 of Pub. 15.

16 Check one: ☐ Line 12 on this return is less than \$2,500 or line 12 on the return for the prior quarter was less than \$2,500, and you didn't incur a \$100,000 next-day deposit obligation during the current quarter. If line 12 for the prior quarter was less than \$2,500 but line 12 on this return is \$100,000 or more, you must provide a record of your federal tax liability. If you're a monthly schedule depositor, complete the deposit schedule below; if you're a semiweekly schedule depositor, attach Schedule B (Form 941). Go to Part 3.

☐ You were a monthly schedule depositor for the entire quarter. Enter your tax liability for each month and total liability for the quarter, then go to Part 3.

Tax liability: Month 1	<div></div>
Month 2	<div></div>
Month 3	<div></div>
Total liability for quarter	<div></div> Total must equal line 12.

☒ You were a semiweekly schedule depositor for any part of this quarter. Complete Schedule B (Form 941), Report of Tax Liability for Semiweekly Schedule Depositors, and attach it to Form 941. Go to Part 3.

▶ You MUST complete all three pages of Form 941 and SIGN it.

Next ▶

# Schedule B (Form 941):

960311

## Report of Tax Liability for Semiweekly Schedule Depositors

OMB No. 1545-0029

(Rev. January 2017)

Department of the Treasury — Internal Revenue Service

Employer identification number (EIN) 

3	8	-	1	8	1	2	0	3	1
---	---	---	---	---	---	---	---	---	---

Name (not your trade name) 

Township of Tuscarora									
-----------------------	--	--	--	--	--	--	--	--	--

Calendar year 

2	0	2	0
---	---	---	---

 (Also check quarter)**Report for this Quarter...**

(Check one.)

☐ 1: January, February, March☐ 2: April, May, June☐ 3: July, August, September☒ 4: October, November, December

Use this schedule to show your TAX LIABILITY for the quarter; don't use it to show your deposits. When you file this form with Form 941 or Form 941-SS, don't change your tax liability by adjustments reported on any Forms 941-X or 944-X. You must fill out this form and attach it to Form 941 or Form 941-SS if you're a semiweekly schedule depositor or became one because your accumulated tax liability on any day was \$100,000 or more. Write your daily tax liability on the numbered space that corresponds to the date wages were paid. See Section 11 in Pub. 15 for details.

**Month 1**

1	7,203 . 73	9		17		25	
2		10		18		26	
3		11		19		27	
4		12		20		28	
5		13		21		29	8,398 . 59
6		14		22		30	
7		15	7,419 . 59	23		31	
8		16		24			

**Tax liability for Month 1**

23,022 . 03

**Month 2**

1		9		17		25	
2		10		18		26	6,913 . 01
3		11		19		27	
4		12	7,664 . 56	20		28	4,617 . 61
5		13		21		29	
6		14		22		30	
7		15		23		31	
8		16		24			

**Tax liability for Month 2**

19,195 . 18

**Month 3**

1		9		17		25	
2		10	6,953 . 70	18		26	
3		11		19		27	
4		12		20		28	
5		13		21		29	
6		14		22	8,723 . 34	30	
7		15		23		31	
8		16		24			

**Tax liability for Month 3**

15,677 . 04

Fill in your total liability for the quarter (Month 1 + Month 2 + Month 3) ▶

Total must equal line 12 on Form 941 or Form 941-SS.

**Total liability for the quarter**

57,894 . 25

**941 for 2020: Employer's QUARTERLY Federal Tax Return**

Department of the Treasury — Internal Revenue Service

950120

OMB No. 1545-0029

Employer identification number (EIN)	3	8	-	1	8	1	2	0	3	1
Name (not your trade name)	Tuscarora Township									
Trade name (if any)										
Address	PO Box 220									
Number	Street			Suite or room number						
Indian River				MI		49749				
City				State		ZIP code				
Foreign country name	Foreign province/county			Foreign postal code						

**Report for this Quarter of 2020**  
(Check one.)

- ☒ 1: January, February, March  
☐ 2: April, May, June  
☒ 3: July, August, September  
☐ 4: October, November, December

Go to [www.irs.gov/Form941](http://www.irs.gov/Form941) for instructions and the latest information.

Read the separate instructions before you complete Form 941. Type or print within the boxes.

**Part 1: Answer these questions for this quarter.**

1	Number of employees who received wages, tips, or other compensation for the pay period including: <i>June 12</i> (Quarter 2), <i>Sept. 12</i> (Quarter 3), or <i>Dec. 12</i> (Quarter 4)	1	31
2	Wages, tips, and other compensation	2	205,393 . 05
3	Federal income tax withheld from wages, tips, and other compensation	3	20,483 <sup>04</sup> - 31,425 <sup>14</sup>
4	If no wages, tips, and other compensation are subject to social security or Medicare tax	<input type="checkbox"/> Check and go to line 6.	

	Column 1		Column 2
5a Taxable social security wages	205,393 . 05	$\times 0.124 =$	25,468 . 74
5a (i) Qualified sick leave wages	0 . 00	$\times 0.062 =$	0 . 00
5a (ii) Qualified family leave wages	0 . 00	$\times 0.062 =$	0 . 00
5b Taxable social security tips	0 . 00	$\times 0.124 =$	0 . 00
5c Taxable Medicare wages & tips	205,393 . 05	$\times 0.029 =$	5,956 . 40
5d Taxable wages & tips subject to Additional Medicare Tax withholding	0 . 00	$\times 0.009 =$	0 . 00
5e Total social security and Medicare taxes. Add Column 2 from lines 5a, 5a(i), 5a(ii), 5b, 5c, and 5d	5e 31,425 . 14		
5f Section 3121(q) Notice and Demand—Tax due on unreported tips (see instructions)	5f 0 . 00		
6 Total taxes before adjustments. Add lines 3, 5e, and 5f	6 51,908 . 18		
7 Current quarter's adjustment for fractions of cents	7 -157 . 42		
8 Current quarter's adjustment for sick pay	8 0 . 00		
9 Current quarter's adjustments for tips and group-term life insurance	9 0 . 00		
10 Total taxes after adjustments. Combine lines 6 through 9	10 51,750 . 76		
11a Qualified small business payroll tax credit for increasing research activities. Attach Form 8974	11a 0 . 00		
11b Nonrefundable portion of credit for qualified sick and family leave wages from Worksheet 1	11b 0 . 00		
11c Nonrefundable portion of employee retention credit from Worksheet 1	11c 0 . 00		

▶ You MUST complete all three pages of Form 941 and SIGN it.

Next ▶

Name (not your trade name)

Employer identification number (EIN)

Tuscarora Township

38-1812031

**Part 3: Tell us about your business. If a question does NOT apply to your business, leave it blank.**

- 17 If your business has closed or you stopped paying wages . . . . . ☐ Check here, and enter the final date you paid wages  /  /  ; also attach a statement to your return. See instructions.
- 18 If you're a seasonal employer and you don't have to file a return for every quarter of the year . . . . . ☐ Check here.
- 19 Qualified health plan expenses allocable to qualified sick leave wages . . . . . 19  0 . 00
- 20 Qualified health plan expenses allocable to qualified family leave wages . . . . . 20  0 . 00
- 21 Qualified wages for the employee retention credit . . . . . 21  0 . 00
- 22 Qualified health plan expenses allocable to wages reported on line 21 . . . . . 22  0 . 00
- 23 Credit from Form 5884-C, line 11, for this quarter . . . . . 23  0 . 00
- 24 Qualified wages paid March 13 through March 31, 2020, for the employee retention credit (use this line only for the second quarter filing of Form 941) . . . . . 24  0 . 00
- 25 Qualified health plan expenses allocable to wages reported on line 24 (use this line only for the second quarter filing of Form 941) . . . . . 25  0 . 00

**Part 4: May we speak with your third-party designee?**

Do you want to allow an employee, a paid tax preparer, or another person to discuss this return with the IRS? See the instructions for details.

☐ Yes. Designee's name and phone number

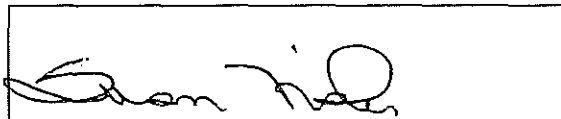
Select a 5-digit personal identification number (PIN) to use when talking to the IRS.

    ☐ No.**Part 5: Sign here. You MUST complete all three pages of Form 941 and SIGN it.**

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

**X**

Sign your name here



Print your name here

Susan Fisher

Print your title here

Clerk

Date

9/21/20

Best daytime phone

231-238-0970

**Paid Preparer Use Only**Check if you're self-employed . . . ☐

Preparer's name

PTIN

Preparer's signature

Date

 /  / 

Firm's name (or yours if self-employed)

EIN

Address

Phone

City

State

ZIP code

# Schedule B (Form 941):

960311

## Report of Tax Liability for Semiweekly Schedule Depositors

OMB No. 1545-0029

(Rev. January 2017)

Department of the Treasury — Internal Revenue Service

Employer identification number  
(EIN)

3 8 - 1 8 1 2 0 3 1

Name (not your trade name)

Tuscarora Township

Calendar year

2 0 2 0

(Also check quarter)

**Report for this Quarter...**

(Check one.)

- ☐ 1: January, February, March
- ☐ 2: April, May, June
- ☒ 3: July, August, September
- ☐ 4: October, November, December

Use this schedule to show your TAX LIABILITY for the quarter; don't use it to show your deposits. When you file this form with Form 941 or Form 941-SS, don't change your tax liability by adjustments reported on any Forms 941-X or 944-X. You must fill out this form and attach it to Form 941 or Form 941-SS if you're a semiweekly schedule depositor or became one because your accumulated tax liability on any day was \$100,000 or more. Write your daily tax liability on the numbered space that corresponds to the date wages were paid. See Section 11 in Pub. 15 for details.

**Month 1**

1		9		17		25	
2		10		18		26	
3		11		19		27	
4		12		20		28	
5		13		21		29	
6		14		22		30	
7		15		23	9,118	48	31
8	8,413	27		24			

Tax liability for Month 1

17,531 ■ 75

**Month 2**

1		9		17		25	
2		10		18		26	
3		11		19		27	
4		12		20	9,725	84	28
5		13		21		29	
6	7,869	51		22		30	
7		15		23		31	
8		16		24			

Tax liability for Month 2

17,595 ■ 35

**Month 3**

1		9		17	9,052	76	25
2		10		18		26	
3	7,570	90		19		27	
4		12		20		28	
5		13		21		29	
6		14		22		30	
7		15		23		31	
8		16		24			

Tax liability for Month 3

16,623 ■ 66

Fill in your total liability for the quarter (Month 1 + Month 2 + Month 3) ►

Total must equal line 12 on Form 941 or Form 941-SS.

Total liability for the quarter

51,750 ■ 76

☐ VOID ☐ CORRECTED (if checked)

PAYER'S name, street address, city or town, province or state, country, ZIP or foreign postal code, and telephone no. DOWNTOWN DEVELOPMENT AUTHORITY 3546 S. STRAITS HWY. PO BOX 220 (231) 238-0970			<b>1 Rents</b> \$	OMB No. 1545-0115  <b>2020</b>  Form 1099-MISC	<b>Miscellaneous Income</b>
			<b>2 Royalties</b> \$		
			<b>3 Other income</b> \$	<b>4 Federal income tax withheld</b> \$	<b>Copy 1 For State Tax Department</b>
PAYER'S TIN	RECIPIENT'S TIN <div style="background-color: black; width: 100px; height: 20px;"></div>	<b>5 Fishing boat proceeds</b> \$	<b>6 Medical and health care payments</b> \$		
RECIPIENT'S name, address, ZIP/postal code & county MILLER, CANFIELD, PADDOCK,  AND STONE PO BOX 640348  DETROIT MI 48264-0348		<b>7 Payer made direct sales of \$5,000 or more of consumer products to a buyer (recipient) for resale</b> <input type="checkbox"/>	<b>8 Substitute payments in lieu of dividends or</b> \$		
		<b>9 Crop insurance proceeds</b> \$	<b>10 Gross proceeds paid to an attorney</b> \$		
		<b>11</b>	<b>12 Section 409A deferrals</b> \$		
Account number (see instructions)	FATCA filing requirement <input type="checkbox"/>	<b>13 Excess golden parachute payments</b> \$	<b>14 Nonequalified deferred compensation</b> \$ 20800.00		
		<b>15 State tax withheld</b> \$	<b>16 State/Payer's state no.</b>	<b>17 State income</b> \$	

Form 1099-MISC

Department of the Treasury - Internal Revenue Service

☐ VOID ☐ CORRECTED (if checked)

PAYER'S name, street address, city or town, province or state, country, ZIP or foreign postal code, and telephone no. TUSCARORA TWP LIBRARY 3546 S STRAITS HWY INDIAN RIVER, MI (231) 238-0970			<b>1 Rents</b> \$	OMB No. 1545-0115  <b>2020</b>  Form 1099-MISC	<b>Miscellaneous Income</b>
			<b>2 Royalties</b> \$		
			<b>3 Other income</b> \$ 1859.58	<b>4 Federal income tax withheld</b> \$	<b>Copy 1 For State Tax Department</b>
PAYER'S TIN	RECIPIENT'S TIN <div style="background-color: black; width: 100px; height: 20px;"></div>	<b>5 Fishing boat proceeds</b> \$	<b>6 Medical and health care payments</b> \$		
RECIPIENT'S name, address, ZIP/postal code & county CLASSIC CLEANING  10701 PARKE RD.  ALANSON, MI 49706		<b>7 Payer made direct sales of \$5,000 or more of consumer products to a buyer (recipient) for resale</b> <input type="checkbox"/>	<b>8 Substitute payments in lieu of dividends or</b> \$		
		<b>9 Crop insurance proceeds</b> \$	<b>10 Gross proceeds paid to an attorney</b> \$		
		<b>11</b>	<b>12 Section 409A deferrals</b> \$		
Account number (see instructions)	FATCA filing requirement <input type="checkbox"/>	<b>13 Excess golden parachute payments</b> \$	<b>14 Nonequalified deferred compensation</b> \$		
		<b>15 State tax withheld</b> \$	<b>16 State/Payer's state no.</b>	<b>17 State income</b> \$	

Form 1099-MISC

Department of the Treasury - Internal Revenue Service

☐ VOID ☐ CORRECTED (if checked)

PAYER'S name, street address, city or town, province or state, country, ZIP or foreign postal code, and telephone no. TUSCARORA TOWNSHIP PO BOX 220 INDIAN RIVER, MI 49749 (231) 238-0970		1 Rents \$	OMB No. 1545-0115 <b>2020</b> Form 1099-MISC	Miscellaneous Income  <b>Copy 1 For State Tax Department</b>
		2 Royalties \$		
		3 Other income \$ 810.00	4 Federal income tax withheld \$	
PAYER'S TIN 38-1812031	RECIPIENT'S TIN	5 Fishing boat proceeds \$	6 Medical and health care payments \$	
RECIPIENT'S name, address, ZIP/postal code & county BARB ALGENSTEDT  2743 GILPIN  CHEBOYGAN MI 49721		7 Payer made direct sales of \$5,000 or more of consumer products to a buyer (recipient) for resale <input type="checkbox"/>	8 Substitute payments in lieu of dividends or \$	
		9 Crop insurance proceeds \$	10 Gross proceeds paid to an attorney \$	
		11	12 Section 409A deferrals \$	
Account number (see instructions)	FATCA filing requirement <input type="checkbox"/>	13 Excess golden parachute payments \$	14 Nonequalified deferred compensation \$	
		15 State tax withheld \$	16 State/Payer's state no. -----	17 State income \$
		\$	-----	\$

Form 1099-MISC

Department of the Treasury - Internal Revenue Service

☐ VOID ☐ CORRECTED (if checked)

PAYER'S name, street address, city or town, province or state, country, ZIP or foreign postal code, and telephone no. TUSCARORA TOWNSHIP PO BOX 220 INDIAN RIVER, MI 49749 (231) 238-0970		1 Rents \$	OMB No. 1545-0115 <b>2020</b> Form 1099-MISC	Miscellaneous Income  <b>Copy 1 For State Tax Department</b>
		2 Royalties \$		
		3 Other income \$ 957.83	4 Federal income tax withheld \$	
PAYER'S TIN [REDACTED]	RECIPIENT'S TIN [REDACTED]	5 Fishing boat proceeds \$	6 Medical and health care payments \$	
RECIPIENT'S name, address, ZIP/postal code & county DECKA DIGITAL  8742 MCBRIDE COURT  HARBOR SPRINGS MI 49740		7 Payer made direct sales of \$5,000 or more of consumer products to a buyer (recipient) for resale <input type="checkbox"/>	8 Substitute payments in lieu of dividends or \$	
		9 Crop insurance proceeds \$	10 Gross proceeds paid to an attorney \$	
		11	12 Section 409A deferrals \$	
Account number (see instructions)	FATCA filing requirement <input type="checkbox"/>	13 Excess golden parachute payments \$	14 Nonequalified deferred compensation \$	
		15 State tax withheld \$	16 State/Payer's state no. -----	17 State income \$
		\$	-----	\$

Form 1099-MISC

Department of the Treasury - Internal Revenue Service

☐ VOID ☐ CORRECTED (if checked)

PAYER'S name, street address, city or town, province or state, country, ZIP or foreign postal code, and telephone no. TUSCARORA TOWNSHIP PO BOX 220 INDIAN RIVER, MI 49749 (231) 238-0970		1 Rents	OMB No. 1545-0115  <b>2020</b>  Form 1099-MISC	<b>Miscellaneous Income</b>  <b>Copy 1</b> <b>For State Tax Department</b>
		\$		
		2 Royalties		
3 Other income	4 Federal income tax withheld			
\$ 10000.00	\$			
PAYER'S TIN 38-1812031	RECIPIENT'S TIN 27-1366153	5 Fishing boat proceeds	6 Medical and health care payments	
		\$	\$	
RECIPIENT'S name, address, ZIP/postal code & county GREAT LAKES FIREWORKS  24805 MARINE  EASTPOINTE MI 48021		7 Payer made direct sales of \$5,000 or more of consumer products to a buyer (recipient) for resale <input type="checkbox"/>	8 Substitute payments in lieu of dividends or	
		\$	\$	
		9 Crop insurance proceeds	10 Gross proceeds paid to an attorney	
		\$	\$	
		11	12 Section 409A deferrals	
		\$	\$	
Account number (see instructions)	FATCA filing requirement <input type="checkbox"/>	13 Excess golden parachute payments	14 Nonequalified deferred compensation	
		\$	\$	
		15 State tax withheld	16 State/Payer's state no. 38-1812031	17 State income
		\$		\$
		\$		\$

Form 1099-MISC

Department of the Treasury - Internal Revenue Service

☐ VOID ☐ CORRECTED (if checked)

PAYER'S name, street address, city or town, province or state, country, ZIP or foreign postal code, and telephone no. TUSCARORA TOWNSHIP PO BOX 220 INDIAN RIVER, MI 49749 (231) 238-0970		1 Rents	OMB No. 1545-0115  <b>2020</b>  Form 1099-MISC	<b>Miscellaneous Income</b>  <b>Copy 1</b> <b>For State Tax Department</b>
		\$		
		2 Royalties		
3 Other income	4 Federal income tax withheld			
\$ 5000.00	\$			
PAYER'S TIN [REDACTED]	RECIPIENT'S TIN [REDACTED]	5 Fishing boat proceeds	6 Medical and health care payments	
		\$	\$	
RECIPIENT'S name, address, ZIP/postal code & county HILL MOUNTAIN SIGNWORKS  6455 PICKEREL LAKE ROAD  PETOSKEY MI 49770		7 Payer made direct sales of \$5,000 or more of consumer products to a buyer (recipient) for resale <input type="checkbox"/>	8 Substitute payments in lieu of dividends or	
		\$	\$	
		9 Crop insurance proceeds	10 Gross proceeds paid to an attorney	
		\$	\$	
		11	12 Section 409A deferrals	
		\$	\$	
Account number (see instructions)	FATCA filing requirement <input type="checkbox"/>	13 Excess golden parachute payments	14 Nonequalified deferred compensation	
		\$	\$	
		15 State tax withheld	16 State/Payer's state no.	17 State income
		\$		\$
		\$		\$

Form 1099-MISC

Department of the Treasury - Internal Revenue Service



☐ VOID ☐ CORRECTED (if checked)

PAYER'S name, street address, city or town, province or state, country, ZIP or foreign postal code, and telephone no. TUSCARORA TOWNSHIP PO BOX 220 INDIAN RIVER, MI 49749 (231) 238-0970		1 Rents	OMB No. 1545-0115  <b>2020</b>  Form 1099-MISC		<b>Miscellaneous Income</b>  <b>Copy 1</b> <b>For State Tax Department</b>
		\$			
		2 Royalties			
3 Other income	4 Federal income tax withheld				
\$ 3840.00	\$				
PAYER'S TIN 38-1812031	RECIPIENT'S TIN 38-3198403	5 Fishing boat proceeds	6 Medical and health care payments		
RECIPIENT'S name, address, ZIP/postal code & county K & J SEPTIC SERVICE  2560 RIVER ROAD  PETOSKEY MI 49770		7 Payer made direct sales of \$5,000 or more of consumer products to a buyer (recipient) for resale <input type="checkbox"/>	8 Substitute payments in lieu of dividends or		
		9 Crop insurance proceeds	10 Gross proceeds paid to an attorney		
		11	12 Section 409A deferrals		
Account number (see instructions)	FATCA filing requirement <input type="checkbox"/>	13 Excess golden parachute payments	14 Nonequalified deferred compensation		
		15 State tax withheld	16 State/Payer's state no.	17 State income	
		\$		\$	
		\$		\$	

Form 1099-MISC

Department of the Treasury - Internal Revenue Service

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PAYER'S name, street address, city or town, province or state, country, ZIP or foreign postal code, and telephone no. TUSCARORA TOWNSHIP PO BOX 220 INDIAN RIVER, MI 49749 (231) 238-0970		1 Rents	OMB No. 1545-0115  <b>2020</b>  Form 1099-MISC		<b>Miscellaneous Income</b>  <b>Copy 1</b> <b>For State Tax Department</b>
		\$			
		2 Royalties			
3 Other income	4 Federal income tax withheld				
\$	\$				
PAYER'S TIN [REDACTED]	RECIPIENT'S TIN [REDACTED]	5 Fishing boat proceeds	6 Medical and health care payments		
RECIPIENT'S name, address, ZIP/postal code & county KIRK & HUTH, P.C.  ATTORNEYS AT LAW 19500 HALL RD., SUITE 100  CLINTON TWP. MI 48038		7 Payer made direct sales of \$5,000 or more of consumer products to a buyer (recipient) for resale <input type="checkbox"/>	8 Substitute payments in lieu of dividends or		
		9 Crop insurance proceeds	10 Gross proceeds paid to an attorney		
		11	12 Section 409A deferrals		
Account number (see instructions)	FATCA filing requirement <input type="checkbox"/>	13 Excess golden parachute payments	14 Nonequalified deferred compensation		
		15 State tax withheld	16 State/Payer's state no.	17 State income	
		\$		\$	
		\$		\$	

Form 1099-MISC

Department of the Treasury - Internal Revenue Service

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PAYER'S name, street address, city or town, province or state, country, ZIP or foreign postal code, and telephone no. TUSCARORA TOWNSHIP PO BOX 220 INDIAN RIVER, MI 49749 (231) 238-0970		1 Rents	OMB No. 1545-0115  <b>2020</b>  Form 1099-MISC		<b>Miscellaneous Income</b>	
		\$				
		2 Royalties				
PAYER'S TIN RECIPIENT'S TIN		\$	4 Federal income tax withheld \$		<b>Copy 1 For State Tax Department</b>	
		3 Other income				
		\$				
RECIPIENT'S name, address, ZIP/postal code & county MCGRAW MORRIS P.C.  2075 WEST BIG BEAVER, STE. 750  TROY MI 48084		5 Fishing boat proceeds	6 Medical and health care payments \$			
		\$				
		7 Payer made direct sales of \$5,000 or more of consumer products to a buyer (recipient) for resale <input type="checkbox"/>				8 Substitute payments in lieu of dividends or
Account number (see instructions)		FATCA filing requirement <input type="checkbox"/>	9 Crop insurance proceeds	10 Gross proceeds paid to an attorney \$		
		\$				
		11	12 Section 409A deferrals			
		13 Excess golden parachute payments	14 Nonequalified deferred compensation \$ 2162.50			
		\$				
		15 State tax withheld				16 State/Payer's state no.
		\$			\$	
		\$			\$	

Form 1099-MISC

Department of the Treasury - Internal Revenue Service

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PAYER'S name, street address, city or town, province or state, country, ZIP or foreign postal code, and telephone no. TUSCARORA TOWNSHIP PO BOX 220 INDIAN RIVER, MI 49749 (231) 238-0970		1 Rents	OMB No. 1545-0115  <b>2020</b>  Form 1099-MISC		<b>Miscellaneous Income</b>	
		\$				
		2 Royalties				
PAYER'S TIN RECIPIENT'S TIN		\$	4 Federal income tax withheld \$		<b>Copy 1 For State Tax Department</b>	
		3 Other income				
		\$				
RECIPIENT'S name, address, ZIP/postal code & county MILLER, CANFIELD, PADDOCK,  AND STONE PO BOX 640348  DETROIT MI 48264-0348		5 Fishing boat proceeds	6 Medical and health care payments \$			
		\$				
		7 Payer made direct sales of \$5,000 or more of consumer products to a buyer (recipient) for resale <input type="checkbox"/>				8 Substitute payments in lieu of dividends or
Account number (see instructions)		FATCA filing requirement <input type="checkbox"/>	9 Crop insurance proceeds	10 Gross proceeds paid to an attorney \$		
		\$				
		11	12 Section 409A deferrals			
		13 Excess golden parachute payments	14 Nonequalified deferred compensation \$ 29000.00			
		\$				
		15 State tax withheld				16 State/Payer's state no.
		\$			\$	
		\$			\$	

Form 1099-MISC

Department of the Treasury - Internal Revenue Service

☐ VOID ☐ CORRECTED (if checked)

PAYER'S name, street address, city or town, province or state, country, ZIP or foreign postal code, and telephone no. TUSCARORA TOWNSHIP PO BOX 220 INDIAN RIVER, MI 49749 (231) 238-0970		1 Rents \$	OMB No. 1545-0115 <b>2020</b> Form 1099-MISC		Miscellaneous Income
		2 Royalties \$			
		3 Other income \$ 4815.52	4 Federal income tax withheld \$		Copy 1 For State Tax Department
PAYER'S TIN [REDACTED]	RECIPIENT'S TIN [REDACTED]	5 Fishing boat proceeds \$	6 Medical and health care payments \$		
RECIPIENT'S name, address, ZIP/postal code & county BRUCE THOMPSON  2063 MILLER ROAD  ALANSON MI 49706		7 Payer made direct sales of \$5,000 or more of consumer products to a buyer (recipient) for resale <input type="checkbox"/>	8 Substitute payments in lieu of dividends or \$		
		9 Crop insurance proceeds \$	10 Gross proceeds paid to an attorney \$		
Account number (see instructions)		FATCA filing requirement <input type="checkbox"/>	11	12 Section 409A deferrals \$	
		13 Excess golden parachute payments \$	14 Nonequalified deferred compensation \$		
		15 State tax withheld \$	16 State/Payer's state no. \$		17 State income \$
		\$	\$		\$

Form 1099-MISC

Department of the Treasury - Internal Revenue Service

☐ VOID ☐ CORRECTED (if checked)

PAYER'S name, street address, city or town, province or state, country, ZIP or foreign postal code, and telephone no. TUSCARORA TOWNSHIP PO BOX 220 INDIAN RIVER, MI 49749 (231) 238-0970		1 Rents \$	OMB No. 1545-0115 <b>2020</b> Form 1099-MISC		Miscellaneous Income
		2 Royalties \$			
		3 Other income \$ 4989.17	4 Federal income tax withheld \$		Copy 1 For State Tax Department
PAYER'S TIN [REDACTED]	RECIPIENT'S TIN [REDACTED]	5 Fishing boat proceeds \$	6 Medical and health care payments \$		
RECIPIENT'S name, address, ZIP/postal code & county CLASSIC CLEANING  10701 PARKE RD.  ALANSON, MI 49706		7 Payer made direct sales of \$5,000 or more of consumer products to a buyer (recipient) for resale <input type="checkbox"/>	8 Substitute payments in lieu of dividends or \$		
		9 Crop insurance proceeds \$	10 Gross proceeds paid to an attorney \$		
Account number (see instructions)		FATCA filing requirement <input type="checkbox"/>	11	12 Section 409A deferrals \$	
		13 Excess golden parachute payments \$	14 Nonequalified deferred compensation \$		
		15 State tax withheld \$	16 State/Payer's state no. \$		17 State income \$
		\$	\$		\$

Form 1099-MISC

Department of the Treasury - Internal Revenue Service

03/04/2023

**VENDOR ACTIVITY REPORT FOR TUSCARORA TOWNSHIP**  
**Activity From 07/01/2020 To 06/30/2021**

Vendor Code	Vendor Name							
Post Date	Activity	Inv/Check #	Description	1099	Invoice Amt	Check Amt	Description	W/C
00016	AAA STEVE'S LOCK & SAFE		Total:	124.00	124.00		Bldg services	Yes
			Net of 1 Invoices / 1 Checks	0.00	0.00			
00017	ACCIDENT FUND OF MICHIGAN		Total:	20,294.00	20,294.00		Insurance	no
			Net of 2 Invoices / 2 Checks	0.00	0.00			
00024	ALERUS FINANCIAL		Total:	6,308.62	6,308.62		Retirement	no
			Net of 13 Invoices / 13 Checks	0.00	0.00			
00025	BARB ALGENSTEDT		Total:	360.00	300.00		Blood draws	no
			Net of 4 Invoices / 3 Checks	60.00	0.00			
00029	ALPENA OIL COMPANY		Total:	9,173.82	9,025.38		Fuel	no
			Net of 24 Invoices / 24 Checks	148.44	0.00			
00033	AMERICAN LIBRARY ASSOCIATION		Total:	112.00	112.00		Dues	no
			Net of 1 Invoices / 1 Checks	0.00	0.00			
00039	APEX SOFTWARE		Total:	330.00	330.00		Software	no
			Net of 1 Invoices / 1 Checks	0.00	0.00			
00040	AQUA IRRIGATION AND LANDSCAPE		Total:	472.60	472.60		Irrigation	yes
			Net of 3 Invoices / 2 Checks	0.00	0.00			
00046	AT&T		Total:	247.68	529.61		telephone	no
			Net of 2 Invoices / 2 Checks	0.00	281.93			
00059	BEAR CLAW BAGS		Total:	436.00	436.00		supplies	no
			Net of 1 Invoices / 1 Checks	0.00	0.00			
00069	BLARNEY CASTLE OIL CO		Total:	4,861.49	5,443.47		fuel	no
			Net of 6 Invoices / 4 Checks	0.00	581.98			
00071	BLUE CHIP CLEANING		Total:	635.00	860.00		window cleaning	yes
			Net of 3 Invoices / 4 Checks	0.00	225.00			

00074	BOBBI BALAZOVIC	Total:	46.19	46.19	office supplies	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00075	BOBCAT OF LANSING	Total:	326.20	326.20	parks supplies	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00080	BRANDON BLUMKE	Total:	707.78	707.78	uniform	no
		Net of 3 Invoices / 3 Checks	0.00	0.00		
00081	BRIDGEWATER EXCAVATING	Total:	10,000.00	10,000.00	hauling	yes
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00085	BROWN MOTORS,INC.	Total:	217.03	217.03	R&M offsite	no
		Net of 2 Invoices / 2 Checks	0.00	0.00		
00086	BS&A SOFTWARE	Total:	5,922.00	5,922.00	software	no
		Net of 4 Invoices / 4 Checks	0.00	0.00		
00091	BURT LAKE MARINA	Total:	10,580.95	10,580.95	F/S and supplies	no
		Net of 2 Invoices / 2 Checks	0.00	0.00		
00093	CAR QUEST AUTO PARTS	Total:	10,984.32	10,984.32	R&M parts	no
		Net of 163 Invoices / 26 Checks	0.00	0.00		
00094	CARDMEMBER SERVICE	Total:	10,874.20	6,316.47	cc	no
		Net of 7 Invoices / 5 Checks	4,557.73	0.00		
00098	CHEBOYGAN CTY. HUMANE SOCIETY	Total:	900.00	900.00	donation	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00101	CHEBOYGAN COUNTY	Total:	0.00	425.92	taxes	no
		Net of 0 Invoices / 1 Checks	0.00	425.92		
00102	CHEB. CTY. ROAD COMM.	Total:	2,427,387.08	2,427,387.08	road work	no
		Net of 17 Invoices / 14 Checks	0.00	0.00		
00104	CENTER POINT LARGE PRINT	Total:	467.94	638.10	printing	no
		Net of 11 Invoices / 12 Checks	0.00	170.16		
00106	WALTER CHAMBERLAIN	Total:	2,100.00	2,100.00	uniform	no
		Net of 6 Invoices / 6 Checks	0.00	0.00		

00108	CHASKEY'S SEPTIC SERVICE, IN.	Total:	525.00	525.00	porta johns	yes
		Net of 2 Invoices / 3 Checks	0.00	0.00		
00111	CHEBOYGAN CTY. TREASURER	Total:	226.65	3,868,342.89		no
		Net of 4 Invoices / 14 Checks	0.00	3,868,116.24		
00114	MICHAEL CHERVENY	Total:	100.00	100.00	per diem	no
		Net of 2 Invoices / 2 Checks	0.00	0.00		
00116	CHEBOYGAN COUNTY PLANNING	Total:	165.00	165.00	permit	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00121	CHRIS KINDSVATTER	Total:	650.00	650.00	equipment	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00122	CINCINNATI LIFE INSURANCE CO.	Total:	1,578.25	1,578.25	insurance	no
		Net of 5 Invoices / 5 Checks	0.00	0.00		
00124	CITIZENS NATIONAL BANK	Total:	263,630.21	263,630.21	bank fees	no
		Net of 9 Invoices / 9 Checks	0.00	0.00		
00125	CIVIC PLUS	Total:	1,041.86	1,041.86	software	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00126	CLASSIC CLEANING	Total:	7,546.25	7,820.00	cleaning svcs	yes
		Net of 38 Invoices / 31 Checks	0.00	273.75		
00132	COMMON ANGLE, INC.	Total:	600.00	650.00	IT backup	no
		Net of 11 Invoices / 11 Checks	0.00	50.00		
00135	CONSUMER REPORTS	Total:	29.51	29.51	subscription	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00136	CONSUMERS ENERGY	Total:	97,161.46	96,808.62	utilities	no
		Net of 384 Invoices / 48 Checks	352.84	0.00		
00143	JAY CURTIS	Total:	68.40	68.40	parts	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00145	CRAIG M. WALDRON					
11/30/2020	INVOICE 113020	PLANNING COMM PER DIEM	N	20.00	0.00	
12/04/2020	CHECK GNCHK 31507		N	0.00	20.00	per diem no

		Total:	20.00	20.00		
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00150	DAN'S AUTO REPAIR					
		Total:	2,137.07	1,400.73	R&M vehicles	no
		Net of 4 Invoices / 2 Checks	736.34	0.00		
00152	TUSCARORA TOWNSHIP DDA					
		Total:	0.00	111,212.76	DDA	no
		Net of 0 Invoices / 2 Checks	0.00	111,212.76		
00154	DECKA DIGITAL					
		Total:	1,745.32	1,745.32	printing	no
		Net of 6 Invoices / 6 Checks	0.00	0.00		
00157	CHRISTOPHER DIEHL					
		Total:	1,599.83	2,180.98	uniform	no
		Net of 4 Invoices / 5 Checks	0.00	581.15		
00164	DTE ENERGY					
		Total:	4,333.78	4,209.78	utilities	no
		Net of 12 Invoices / 12 Checks	124.00	0.00		
00169	ELLSWORTH FARMERS EXCHANGE					
		Total:	1,008.10	1,008.10	supplies	no
		Net of 5 Invoices / 5 Checks	0.00	0.00		
00171	EMERY-PRATT					
		Total:	1,285.38	2,580.44	books	no
		Net of 10 Invoices / 11 Checks	0.00	1,295.06		
00176	EMMET COUNTY					
		Total:	845.25	941.85	clean up vouchers	no
		Net of 11 Invoices / 11 Checks	0.00	96.60		
00183	FERRELLGAS					
		Total:	3,830.74	3,830.74	propane	no
		Net of 8 Invoices / 8 Checks	0.00	0.00		
00187	SUSAN FISHER					
		Total:	70.66	70.66	supplies	no
		Net of 2 Invoices / 2 Checks	0.00	0.00		
00190	FOSTER SWIFT					
		Total:	1,932.00	1,932.00	Legal - offsite	no
		Net of 6 Invoices / 6 Checks	0.00	0.00		
00192	FULLFORD SURVEYING					
		Total:	460.00	460.00	land work	yes
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00196	GABRIDGE & COMPANY, PLC					
		Total:	7,885.00	7,885.00	acctg offsite	no
		Net of 3 Invoices / 3 Checks	0.00	0.00		
00199	GINOP SALES, INC.					

00209	GREAT LAKES ENERGY	Total:	3,298.06	3,523.29	parts	no
		Net of 15 Invoices / 11 Checks	0.00	225.23		
00214	GREAT LAKES FIREWORKS	Total:	160.60	160.60	utlities	no
		Net of 12 Invoices / 12 Checks	0.00	0.00		
00218	HACH COMPANY	Total:	10,000.00	10,000.00	fireworks	yes
		Net of 2 Invoices / 2 Checks	0.00	0.00		
00221	HAVILAND PRODUCTS COMPANY	Total:	770.00	770.00	speed guns	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00226	HILL MOUNTAIN SIGNWORKS	Total:	1,896.20	1,896.20	supplies	no
		Net of 3 Invoices / 3 Checks	0.00	0.00		
00233	INDIAN RIVER SPORTS CENTER	Total:	15,167.00	15,167.00	signage	yes
		Net of 3 Invoices / 4 Checks	0.00	0.00		
00239	INDIAN RIVER CHAMBER OF COMMERCE	Total:	1,500.00	1,500.00	equip rental	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00242	IR ELECTRIC MOTOR SERVICE	Total:	150.00	150.00	dues	no
		Net of 2 Invoices / 2 Checks	0.00	0.00		
00246	INTERNAL REVENUE SERVICE	Total:	0.00	199.50	R&M motor	no
		Net of 0 Invoices / 1 Checks	0.00	199.50		
00247	INDIAN RIVER TOWING	Total:	73.66	73.66	tax	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00250	JACKSON NATIONAL LIFE INSURANCE	Total:	80.00	80.00	towing	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00253	KATHIE JEWELL	Total:	85.23	85.23	insurance	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00254	JEFF JOHNSON	Total:	832.95	832.95	insurance	no
		Net of 4 Invoices / 5 Checks	0.00	0.00		
00255	JUNIOR LIBRARY GUILD	Total:	500.00	500.00	uniform	no
		Net of 2 Invoices / 2 Checks	0.00	0.00		



00256	K & J SEPTIC SERVICE	Total:	915.05	915.05	books	no
		Net of 2 Invoices / 2 Checks	0.00	0.00		
00259	KELLY ASHFORD	Total:	3,840.00	3,840.00	porta johns	yes
		Net of 12 Invoices / 12 Checks	0.00	0.00		
00260	KEN'S VILLAGE MARKET	Total:	40.00	40.00	per diem	no
		Net of 2 Invoices / 2 Checks	0.00	0.00		
00262	KIRK & HUTH, P.C.	Total:	84.09	74.98	supplies	no
		Net of 3 Invoices / 2 Checks	9.11	0.00		
00265	KSS ENTERPRISES	Total:	7,562.50	7,562.50	legal services offsite	no
		Net of 10 Invoices / 10 Checks	0.00	0.00		
00270	STACY LALONDE	Total:	3,112.03	3,112.03	supplies	no
		Net of 13 Invoices / 11 Checks	0.00	0.00		
00275	LAW ENFORCEMENT SYSTEMS, INC.	Total:	500.00	500.00	uniform	no
		Net of 2 Invoices / 2 Checks	0.00	0.00		
00297	MCGRAW MORRIS P.C.	Total:	125.00	125.00	police supplies	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00300	MICH DEPT ENV QUALITY	Total:	9,975.00	9,975.00	legal services offsite	no
		Net of 6 Invoices / 6 Checks	0.00	0.00		
00302	STATE OF MICHIGAN	Total:	4,174.30	4,174.30	permits	no
		Net of 2 Invoices / 3 Checks	0.00	0.00		
00303	MEAD & HUNT	Total:	50.00	50.00	permits	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00322	MILAN SUPPLY COMPANY	Total:	77,689.03	71,489.03	Sewer	yes
		Net of 11 Invoices / 10 Checks	6,200.00	0.00		
00323	MILLER,CANFIELD, PADDOCK,	Total:	82.31	82.31	supplies	no
		Net of 2 Invoices / 3 Checks	0.00	0.00		
00328	MISS DIG SYSTEMS, INC.	Total:	43,300.00	49,800.00	legal services offsite	no
		Net of 2 Invoices / 3 Checks	0.00	6,500.00		

00332	MICHIGAN LAKE PRODUCTS	Total:	1,116.00	1,116.00	subscription	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00333	M&M PLUMBING	Total:	700.00	700.00	supplies	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00336	MICHIGAN TOWNSHIP ASSOC.	Total:	1,803.13	1,803.13	plumbing	yes
		Net of 4 Invoices / 4 Checks	0.00	0.00		
00338	MUNICIPAL ADVISORY COUNCIL OF MI	Total:	4,271.31	4,246.31	dues	no
		Net of 2 Invoices / 1 Checks	25.00	0.00		
00339	MUNICIPAL EMP. RETIREMENT	Total:	500.00	500.00	dues	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00340	MUNICIPAL UNDERWRITERS	Total:	148,656.74	148,656.74	Retirement	no
		Net of 13 Invoices / 12 Checks	0.00	0.00		
00348	NEMCOG	Total:	22,780.00	22,780.00	insurance	no
		Net of 3 Invoices / 3 Checks	0.00	0.00		
00351	DAN NIVELT	Total:	958.00	958.00	dues	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00352	N.M.A.C.P.	Total:	60.00	60.00	per diem	no
		Net of 2 Invoices / 2 Checks	0.00	0.00		
00355	NORTH STAR GARDENS	Total:	75.00	75.00	dues	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00356	NORTHERN A-1	Total:	1,962.00	1,962.00	supplies	no
		Net of 2 Invoices / 2 Checks	0.00	0.00		
00362	NORTHLAND LIBRARY COOPERATIVE	Total:	9,947.71	14,787.71	services	yes
		Net of 2 Invoices / 3 Checks	0.00	4,840.00		
00366	NYE UNIFORM COMPANY	Total:	3,824.18	3,824.18	dues	no
		Net of 3 Invoices / 3 Checks	0.00	0.00		
00368	OSTLUND PEST CONTROL NORTH, INC.	Total:	2,447.09	2,447.09	uniforms	no
		Net of 13 Invoices / 7 Checks	0.00	0.00		

00373	PAT & GARY'S PARTY STORE	Total:	75.00	75.00	pest control	yes
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00374	PAT & GARY'S PARTY STORE II	Total:	172.00	172.00	ammo	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00379	PITNEY BOWES, INC.	Total:	835.65	835.65	propane	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00380	PITNEY BOWES PURCHASE POWER	Total:	2,308.77	2,308.77	postage	no
		Net of 6 Invoices / 5 Checks	0.00	0.00		
00383	PONTEM	Total:	1,468.82	1,468.82	postage	no
		Net of 3 Invoices / 3 Checks	0.00	0.00		
00385	POLLARD'S QUICK LUBE	Total:	390.00	390.00	software	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00389	PRESQUE ISLE ELEC. COOP.	Total:	14,115.99	14,066.55	R&M vehicles	yes
		Net of 20 Invoices / 11 Checks	49.44	0.00		
00391	PRINTING SYSTEMS	Total:	442.70	442.70	utilities	no
		Net of 11 Invoices / 11 Checks	0.00	0.00		
00393	JIM PURTILL	Total:	371.07	371.07	printing	no
		Net of 3 Invoices / 3 Checks	0.00	0.00		
00400	RENTAL EXPRESS	Total:	59.69	59.69	insurance	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00403	MIKE RIDLEY	Total:	2,181.12	2,334.05	rentals/propane	no
		Net of 18 Invoices / 13 Checks	0.00	152.93		
00409	JOHN SCHAMS	Total:	301.56	301.56	reimbursements	no
		Net of 5 Invoices / 5 Checks	0.00	0.00		
00410	SCREENGRAPHICS	Total:	100.00	100.00	per diem	no
		Net of 2 Invoices / 2 Checks	0.00	0.00		
00417	STATE OF MICHIGAN	Total:	224.50	224.50	printing	no
		Net of 2 Invoices / 2 Checks	0.00	0.00		

		Total:	0.00	377.42		
		Net of 0 Invoices / 1 Checks	0.00	377.42		
00419	SOUTH SIDE AUTO					
		Total:	438.50	438.50	Signage	no
		Net of 2 Invoices / 2 Checks	0.00	0.00		
00423	STANDARD INSURANCE COMPANY					
		Total:	4,860.12	4,860.12	insurance	no
		Net of 12 Invoices / 12 Checks	0.00	0.00		
00426	STATE OF MICHIGAN - MESC					
		Total:	3,201.98	3,177.98	taxes	no
		Net of 7 Invoices / 4 Checks	24.00	0.00		
00431	STRAITSLAND PUBLISHING					
		Total:	2,341.80	2,370.60	publicagtion	no
		Net of 15 Invoices / 13 Checks	0.00	28.80		
00437	TELE-RAD INC					
		Total:	8,738.00	8,738.00	IT equipment	no
		Net of 2 Invoices / 1 Checks	0.00	0.00		
00438	GORDON TEMPLE JR					
		Total:	1,741.07	1,567.44	reimbursements	no
		Net of 9 Invoices / 8 Checks	173.63	0.00		
00442	BRUCE THOMPSON					
		Total:	4,081.16	4,081.16	Cemetery	yes
		Net of 9 Invoices / 8 Checks	0.00	0.00		
00443	JOHN THOMPSON					
		Total:	100.00	100.00	per diem	no
		Net of 2 Invoices / 2 Checks	0.00	0.00		
00449	TRANSAMERICA LIFE					
		Total:	1,123.92	1,123.92	insurance	no
		Net of 5 Invoices / 4 Checks	0.00	0.00		
00450	TRAVERSE AREA DISTRICT LIBRARY					
		Total:	300.00	300.00	website	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00453	TELEPHONE SUPPORT SYSTEMS					
		Total:	75.00	75.00	telephone support	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00456	TUSCARORA FIRE DEPARTMENT					
		Total:	177,205.00	177,205.00	Fire protection	yes
		Net of 8 Invoices / 7 Checks	0.00	0.00		
00457	TUSCARORA TOWNSHIP POLICE					
		Total:	184.74	184.74	utilities	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00459	USA BLUE BOOK					

00461	USIC LOCATING SERVICES, LLC	Total:	6,085.16	5,422.91	supplies	no
		Net of 11 Invoices / 7 Checks	662.25	0.00		
00462	U.S. POSTAL SERVICE	Total:	4,051.00	4,343.63	locating svcs	yes
		Net of 11 Invoices / 12 Checks	0.00	292.63		
00463	UNITED STATES TREASURY	Total:	2,756.00	2,756.00	postage/PO Box	no
		Net of 5 Invoices / 5 Checks	0.00	0.00		
00465	VANS BUSINESS MACHINE	Total:	163.44	163.44	tax	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00466	VERIZON WIRELESS	Total:	1,350.03	1,465.41	copier metering	no
		Net of 23 Invoices / 15 Checks	0.00	115.38		
00473	WHITE PINE ELECTRIC, INC.	Total:	1,816.94	1,662.75	mobile phone	no
		Net of 13 Invoices / 12 Checks	154.19	0.00		
00476	WORLD BOOK, INC.	Total:	1,448.34	1,448.34	services	yes
		Net of 4 Invoices / 4 Checks	0.00	0.00		
00479	DEMCO	Total:	584.00	584.00	books	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00481	MOTION PICTURE LICENSING CORP	Total:	290.73	290.73	supplies	no
		Net of 2 Invoices / 2 Checks	0.00	0.00		
00485	MICHIGAN AGRIBUSINESS SOLUTIONS	Total:	282.00	282.00	library materials	no
		Net of 2 Invoices / 2 Checks	0.00	0.00		
00490	KCI	Total:	9,826.00	9,826.00	sewer testing & permits	no
		Net of 2 Invoices / 2 Checks	0.00	0.00		
00491	THOMAS SNYDER	Total:	5,438.42	5,476.62	printing	no
		Net of 6 Invoices / 6 Checks	0.00	38.20		
00496	MICHIGAN LIBRARY ASSOCIATION	Total:	1,500.00	1,500.00	barn rent	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00499	I.T. RIGHT	Total:	190.00	190.00	conference	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		

00504	PRECISION CARTRIDGE, INC.	Total:	6,473.66	6,473.66	IT services	yes
		Net of 6 Invoices / 5 Checks	0.00	0.00		
00505	CORELOGIC	Total:	1,740.67	1,740.67	ammo	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00507	BOOK SYSTEMS, INC.	Total:	0.00	5,865.14	subscription	no
		Net of 0 Invoices / 2 Checks	0.00	5,865.14		
00509	WOLVERINE POWER SYSTEMS	Total:	1,485.00	1,485.00	DB support	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00510	SAULT-CHEBOYGAN MEDIA GROUP	Total:	1,527.15	1,527.15	generator svc	yes
		Net of 5 Invoices / 3 Checks	0.00	0.00		
00513	CHARTER COMMUNICATIONS	Total:	50.10	50.10	publications	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00515	TEMPERATURE CONTROL, INC.	Total:	5,462.85	5,462.85	utilities	no
		Net of 36 Invoices / 28 Checks	0.00	0.00		
00516	SURE CROP	Total:	7,533.52	6,111.35	HVAC	yes
		Net of 4 Invoices / 4 Checks	1,422.17	0.00		
00517	TANNER ELECTRIC, INC.	Total:	3,723.81	3,723.81	supplies	no
		Net of 2 Invoices / 2 Checks	0.00	0.00		
00519	MUNSON HEALTHCARE OMH MEDICAL GROUP	Total:	2,749.75	2,749.75	sewer services	yes
		Net of 6 Invoices / 5 Checks	0.00	0.00		
00520	GFL ENVIRONMENTAL USA, INC.	Total:	45.00	45.00	drug screen	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00523	KNOW BUDDY RESOURCES	Total:	2,819.68	2,694.89	utilities	no
		Net of 12 Invoices / 12 Checks	124.79	0.00		
00525	JANET MYERSON	Total:	189.50	189.50	books	no
		Net of 2 Invoices / 1 Checks	0.00	0.00		
00526	OMNI SITE	Total:	1,579.40	1,579.40	uniform	no
		Net of 4 Invoices / 4 Checks	0.00	0.00		

00528	INLAND LAKE SCHOOLS	Total:	768.00	768.00	utilities	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00543	WEX BANK	Total:	0.00	2,906,370.43	tax	no
		Net of 0 Invoices / 5 Checks	0.00	2,906,370.43		
00544	PERFORMANCE ENGINEERS, INC.	Total:	1,884.19	2,090.50	fuel	o
		Net of 10 Invoices / 11 Checks	0.00	206.31		
00559	DAVID HILL	Total:	1,421.50	2,717.00	engineering	yes
		Net of 1 Invoices / 2 Checks	0.00	1,295.50		
00561	SMART APPLE MEDIA	Total:	255.50	255.50	supplies	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00562	LORETTA ERDMANN	Total:	517.02	517.02	books	no
		Net of 2 Invoices / 1 Checks	0.00	0.00		
00564	SUMMIT COMPANIES	Total:	28.49	28.49	reimbursements	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00567	STRIKER SUPPLY	Total:	266.97	102.67	fire extinguishers	yes
		Net of 3 Invoices / 2 Checks	164.30	0.00		
00569	TRAVIS J ELOWSKY O.D.	Total:	184.50	184.50	parks supplies	no
		Net of 3 Invoices / 3 Checks	0.00	0.00		
00573	QUALITY SEAL COATING	Total:	135.00	135.00	eye exam	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00579	AMERICAN LEGAL PUBLISHING CORP	Total:	6,000.00	6,000.00	services	yes
		Net of 2 Invoices / 2 Checks	0.00	0.00		
00580	MERCHANT EXCAVATING & SEPTIC SVC, I	Total:	2,010.00	2,010.00	publications	no
		Net of 2 Invoices / 2 Checks	0.00	0.00		
00583	RHADIGAN & SONS, INC.	Total:	1,175.00	1,175.00	sewer maint	yes
		Net of 2 Invoices / 2 Checks	0.00	0.00		
00584	STATE OF MICHIGAN	Total:	5,143.17	5,143.17	pass through window	yes
		Net of 1 Invoices / 1 Checks	0.00	0.00		

00585	OHM ADVISORS	Total:	276.24	699.09	fee	no
		Net of 2 Invoices / 2 Checks	0.00	422.85		
00586	POTTER CONSULTING	Total:	160,496.90	160,496.90	street work	yes
		Net of 6 Invoices / 6 Checks	0.00	0.00		
11/30/2020	INVOICE	11232012	TRAVEL EXPENSE	Y	1,113.05	0.00
12/04/2020	CHECK	GNCHK 31517		Y	0.00	1,113.05
00588	MESSA	Total:	1,113.05	1,113.05	Consulting	yes
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00592	ELK COUNTRY COMPUTER SERVICES	Total:	130,034.79	130,034.79	insurance	no
		Net of 28 Invoices / 18 Checks	0.00	0.00		
00595	ELECTION SOURCE	Total:	655.00	655.00	IT services	yes
		Net of 2 Invoices / 2 Checks	0.00	0.00		
00597	D&D ELECTRONICS	Total:	1,542.53	1,542.53	election supplies	yes
		Net of 7 Invoices / 4 Checks	0.00	0.00		
00598	LEIGH ANN SOCHA	Total:	2,386.85	2,386.85	election supplies	no
		Net of 4 Invoices / 1 Checks	0.00	0.00		
00600	JANE MCGINNIS	Total:	540.00	480.00	blood draws	no
		Net of 6 Invoices / 5 Checks	60.00	0.00		
00601	BAKER & TAYLOR	Total:	60.00	60.00	per diem	no
		Net of 2 Invoices / 2 Checks	0.00	0.00		
00602	BARBER & SONS, INC.	Total:	3,194.76	3,194.76	books	no
		Net of 18 Invoices / 9 Checks	0.00	0.00		
00604	NMLETG	Total:	330.64	330.64	supplies	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00605	TRACE ANALYTICAL LABORATORIES, INC.	Total:	0.00	96.16	supplies	no
		Net of 0 Invoices / 1 Checks	0.00	96.16		
00605	TRACE ANALYTICAL LABORATORIES, INC.	Total:	250.00	250.00	dues	no
		Net of 2 Invoices / 2 Checks	0.00	0.00		
00605	TRACE ANALYTICAL LABORATORIES, INC.	Total:	1,573.00	1,573.00	lab testing	no
		Net of 2 Invoices / 2 Checks	0.00	0.00		



00606	KUHLMAN CORP	Total:	18,681.70	18,681.70	equipment rental	no
		Net of 14 Invoices / 4 Checks	0.00	0.00		
00608	JAMES ANGLEWICZ	Total:	145.76	145.76	supplies	no
		Net of 2 Invoices / 2 Checks	0.00	0.00		
00609	SPORTABLE SCOREBOARDS	Total:	9,384.01	9,384.01	scoreboard	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00610	HELEN MILLER	Total:	329.30	329.30	reimbursements	no
		Net of 5 Invoices / 5 Checks	0.00	0.00		
00611	MICHIGAN CHAMBER OF COMMERCE	Total:	100.50	100.50	posters	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00612	DROST LANDSCAPE INC	Total:	1,720.61	1,720.61	landscaping	yes
		Net of 3 Invoices / 3 Checks	0.00	0.00		
00613	CHRISTMAS IN INDIAN RIVER	Total:	1,000.00	1,000.00	promotions	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00615	MASON COUNTY DISTRICT LIBRARY	Total:	13.00	13.00	books	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00616	SMAC CONSTRUCTION TESTING	Total:	2,274.00	2,274.00	technician	yes
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00617	PRO-VISION VIDEO SYSTEMS	Total:	3,141.00	3,141.00	cameras	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00618	TIM DANIEL	Total:	600.00	600.00	permit	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00619	BUNKER SERVICES	Total:	834.50	834.50	rink services	no
		Net of 5 Invoices / 4 Checks	0.00	0.00		
00620	DOUG SCHOFIELD	Total:	119.16	119.16	reimbursements	no
		Net of 2 Invoices / 2 Checks	0.00	0.00		
00622	DOLLY RODRIGUEZ	Total:	23.10	23.10	reimbursements	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		

00623	CHIPPEWA RIVER DISTRICT LIBRARY						
		Total:	17.99	17.99	books	no	
		Net of 1 Invoices / 1 Checks	0.00	0.00			
00624	FARMCO DISTRIBUTING INC						
		Total:	1,605.87	1,605.87	sprayer	no	
		Net of 1 Invoices / 1 Checks	0.00	0.00			
00625	SHORELINE STEEL INC						
03/15/2021	INVOICE	19270	SHEET PILING, RODS, CAP, C-CHANNEL	N	30,874.66	0.00	
03/15/2021	CHECK	GNCHK 31957		N	0.00	30,874.66	
		Total:	30,874.66	30,874.66	materials	??	
		Net of 1 Invoices / 1 Checks	0.00	0.00			
00626	TOP O'MICHIGAN INS-PETOSKEY						
		Total:	558.00	558.00	insurance	no	
		Net of 1 Invoices / 1 Checks	0.00	0.00			
00627	DAWN WEBB						
		Total:	40.00	40.00	reimbursements	no	
		Net of 1 Invoices / 1 Checks	0.00	0.00			
00628	MIDAMERICA BOOKS						
		Total:	396.06	396.06	books	no	
		Net of 1 Invoices / 1 Checks	0.00	0.00			
00629	BUILTRITE BLEACHERS						
04/20/2021	INVOICE	47337-I	BLEACHERS, TRANSPORT KIT AND PARTS	N	34,995.00	0.00	
04/20/2021	CHECK	GNCHK 32177		N	0.00	34,995.00	
		Total:	34,995.00	34,995.00	materials	??	
		Net of 1 Invoices / 1 Checks	0.00	0.00			
00630	BEN A. HINMON						
04/26/2021	INVOICE	1	50% PAYMENT FOR ART PROJECT	N	3,375.00	0.00	
04/26/2021	CHECK	GNCHK 32179		N	0.00	3,375.00	
		Total:	3,375.00	3,375.00	Art	no	
		Net of 1 Invoices / 1 Checks	0.00	0.00			
00631	MICHIGAN LIBRARY ASSOC						
		Total:	229.54	229.54	dues	no	
		Net of 1 Invoices / 1 Checks	0.00	0.00			
00632	MARY HUGHEY						
		Total:	21.37	21.37	supplies	no	
		Net of 1 Invoices / 1 Checks	0.00	0.00			
00633	MICHAEL MORELL						
		Total:	315.00	315.00	Consulting	yes	
		Net of 1 Invoices / 1 Checks	0.00	0.00			
00634	PRESQUE ISLE COUNTY SHERIFF'S DEPT						
		Total:	440.50	440.50	utilities	no	
		Net of 2 Invoices / 2 Checks	0.00	0.00			

00635	A&M LOGISTICS LLC	Total:	1,500.00	1,500.00	materials	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00636	PRO COMM INC.	Total:	675.50	675.50	IT install	yes
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00637	NORTH STAR STONE	Total:	2,289.58	2,289.58	materials	no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00638	ROSE SEPTIC SERVICES	Total:	1,200.00	1,200.00	septic	yes
		Net of 1 Invoices / 1 Checks	0.00	0.00		
00641	FAY MARTIN RESORT	SEA WALL GRAVEL	Y	800.00	0.00 materials	no
06/01/2021	INVOICE 06012021	Total:	800.00	0.00		
		Net of 1 Invoices / 0 Checks	800.00	0.00		
MISC						

**VENDOR ACTIVITY REPORT FOR TUSCARORA TOWNSHIP**  
**Activity From 07/01/2021 To 06/30/2022**

Vendor Name						
Activity	Inv/Check #	Description	1099	Invoice Amt	Check Amt	Description W/C
<hr/>						
87TH DISTRICT COURT		Total:	300.00	300.00		training no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
ACCIDENT FUND OF MICHIGAN		Total:	21,202.00	21,202.00		insurance no
		Net of 2 Invoices / 2 Checks	0.00	0.00		
ALERUS FINANCIAL		Total:	4,780.41	4,517.91		insurance no
		Net of 10 Invoices / 7 Checks	262.50	0.00		
BARB ALGENSTEDT		Total:	480.00	540.00		blood draw no
		Net of 5 Invoices / 7 Checks	0.00	60.00		
ALPENA OIL COMPANY		Total:	14,910.67	13,858.30		fuel no
		Net of 20 Invoices / 19 Checks	1,052.37	0.00		
MICKELO ANDERSON		Total:	1,484.64	1,209.64		reimbursement no
		Net of 4 Invoices / 3 Checks	275.00	0.00		
APEX SOFTWARE		Total:	330.00	0.00		software no
		Net of 1 Invoices / 0 Checks	330.00	0.00		
AWE ACQUISITION, INC.		Total:	2,984.00	2,984.00		computer no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
DEBORAH BERDEN		Total:	60.00	60.00		blood draw no
		Net of 1 Invoices / 1 Checks	0.00	0.00		
BLARNEY CASTLE OIL CO		Total:	7,072.74	7,072.74		fuel no
		Net of 8 Invoices / 6 Checks	0.00	0.00		
BOBBI BALAZOVIC		Total:	182.74	182.74		reimbursement no
		Net of 3 Invoices / 2 Checks	0.00	0.00		
ANDY BOWMAN		Total:	455.79	455.79		contractor yes
		Net of 1 Invoices / 1 Checks	0.00	0.00		
BRANDON BLUMKE						

BRIDGEWATER EXCAVATING	Total:	1,950.15	1,675.15	reimbursement	no
	Net of 5 Invoices / 3 Checks	275.00	0.00		
BS&A SOFTWARE	Total:	1,300.00	1,300.00	materials	no
	Net of 2 Invoices / 1 Checks	0.00	0.00		
JIM BURKE	Total:	6,090.00	6,090.00	software	no
	Net of 4 Invoices / 4 Checks	0.00	0.00		
BURT LAKE MARINA	Total:	72.00	0.00	supplies	no
	Net of 1 Invoices / 0 Checks	72.00	0.00		
CAR QUEST AUTO PARTS	Total:	690.65	690.65	equip r&m	no
	Net of 2 Invoices / 2 Checks	0.00	0.00		
CARDMEMBER SERVICE	Total:	4,354.21	3,691.95	supplies	no
	Net of 173 Invoices / 40 Checks	662.26	0.00		
CHEB CTY CLERK/REGISTER OF DEEDS	Total:	35,149.74	39,707.47	cc	no
	Net of 10 Invoices / 11 Checks	0.00	4,557.73		
CHEBOYGAN COUNTY	Total:	1,116.60	1,116.60	election	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
CHEB. CTY. ROAD COMM.	Total:	0.00	512,998.62	Taxes	no
	Net of 0 Invoices / 4 Checks	0.00	512,998.62		
CENTER POINT LARGE PRINT	Total:	202,501.66	200,626.30	road work	no
	Net of 15 Invoices / 12 Checks	1,875.36	0.00		
WALTER CHAMBERLAIN	Total:	696.28	696.28	books	no
	Net of 13 Invoices / 13 Checks	0.00	0.00		
CHASKEY'S SEPTIC SERVICE, IN.	Total:	2,375.00	2,100.00	reimbursement	no
	Net of 5 Invoices / 4 Checks	275.00	0.00		
CHEBOYGAN DAILY TRIBUNE	Total:	4,290.00	3,650.00	services	yes
	Net of 13 Invoices / 6 Checks	640.00	0.00		
CHEBOYGAN CTY. TREASURER	Total:	195.00	195.00	publication	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
	Total:	426.71	3,472,679.13	taxes	no

CINCINNATI LIFE INSURANCE CO.	Net of 4 Invoices / 12 Checks	0.00	3,472,252.42		
	Total:	1,786.25	1,786.25	insurance	no
CITIZENS NATIONAL BANK	Net of 6 Invoices / 6 Checks	0.00	0.00		
	Total:	266,954.08	266,954.08	banking	no
CIVIC PLUS	Net of 4 Invoices / 3 Checks	0.00	0.00		
	Total:	1,093.96	1,093.96	website	no
CLASSIC CLEANING	Net of 1 Invoices / 1 Checks	0.00	0.00		
	Total:	7,885.01	7,337.51	cleaning svcs	yes
C.M.P. DISTRIBUTORS, INC	Net of 37 Invoices / 19 Checks	547.50	0.00		
	Total:	5,675.00	5,675.00	vests	no
COMMON ANGLE, INC.	Net of 1 Invoices / 1 Checks	0.00	0.00		
	Total:	257.50	257.50	IT Backup	no
CONSUMERS ENERGY	Net of 5 Invoices / 3 Checks	0.00	0.00		
	Total:	94,851.19	90,369.27	Utilities	no
DAN'S AUTO REPAIR	Net of 385 Invoices / 51 Checks	4,481.92	0.00		
	Total:	2,661.60	3,397.94	auto repair	no
DECKA DIGITAL	Net of 3 Invoices / 4 Checks	0.00	736.34		
	Total:	565.14	565.14	printing	no
CHRISTOPHER DIEHL	Net of 4 Invoices / 4 Checks	0.00	0.00		
	Total:	2,830.89	2,555.89	reimbursement	no
DTE ENERGY	Net of 6 Invoices / 4 Checks	275.00	0.00		
	Total:	4,882.13	4,741.18	Utilities	no
EMERY-PRATT	Net of 12 Invoices / 12 Checks	140.95	0.00		
	Total:	1,331.25	1,331.25	books	no
EMMET COUNTY	Net of 12 Invoices / 9 Checks	0.00	0.00		
	Total:	821.10	869.40	clean up vouchers	no
FERRELLGAS	Net of 8 Invoices / 9 Checks	0.00	48.30		
	Total:	4,764.87	4,764.87	propane	no
	Net of 5 Invoices / 3 Checks	0.00	0.00		

FULLFORD SURVEYING	Total:	840.00	840.00	surveying	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
GABRIDGE & COMPANY, PLC	Total:	16,045.00	15,720.00	auditing	no
	Net of 7 Invoices / 3 Checks	325.00	0.00		
GINOP SALES, INC.	Total:	17,369.85	17,277.91	parts	no
	Net of 17 Invoices / 9 Checks	91.94	0.00		
GREAT LAKES ENERGY	Total:	165.75	165.75	utilities	no
	Net of 11 Invoices / 11 Checks	0.00	0.00		
GREAT LAKES FIREWORKS	Total:	12,500.00	12,500.00	fireworks	yes
	Net of 2 Invoices / 3 Checks	0.00	0.00		
HACH COMPANY	Total:	793.00	793.00	calibration	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
HAVILAND PRODUCTS COMPANY	Total:	1,047.52	1,047.52	supplies	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
HILL MOUNTAIN SIGNWORKS	Total:	480.00	480.00	signage	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
INDIAN RIVER SPORTS CENTER	Total:	1,500.00	1,500.00	equip rental	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
INDIAN RIVER CHAMBER OF COMMERCE	Total:	200.00	200.00	dues	no
	Net of 2 Invoices / 2 Checks	0.00	0.00		
INDIAN RIVER CONTRACTORS	Total:	3,062.00	3,062.00	contracting parks	yes
	Net of 2 Invoices / 2 Checks	0.00	0.00		
INTERNAL REVENUE SERVICE	Total:	171.86	171.86	taxes	no
	Net of 3 Invoices / 3 Checks	0.00	0.00		
JACKSON NATIONAL LIFE INSURANCE	Total:	85.23	85.23	insurance	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
KATHIE JEWELL	Total:	1,146.02	1,146.02	reimbursement	no
	Net of 2 Invoices / 2 Checks	0.00	0.00		
JEFF JOHNSON					

JUNIOR LIBRARY GUILD	Total:	1,993.85	1,718.85	reimbursement	no
	Net of 6 Invoices / 4 Checks	275.00	0.00		
K & J SEPTIC SERVICE	Total:	560.35	560.35	books	no
	Net of 2 Invoices / 2 Checks	0.00	0.00		
KEN'S VILLAGE MARKET	Total:	3,840.00	3,520.00	porta johns	yes
	Net of 12 Invoices / 10 Checks	320.00	0.00		
KIRK & HUTH, P.C.	Total:	40.65	49.76	supplies	no
	Net of 3 Invoices / 3 Checks	0.00	9.11		
KSS ENTERPRISES	Total:	11,417.70	9,073.95	legal	no
	Net of 12 Invoices / 11 Checks	2,343.75	0.00		
PAT LACROSS	Total:	3,636.68	3,180.85		
	Net of 17 Invoices / 8 Checks	455.83	0.00		
INVOICE 420-9482	REPAIRS	Y	120.00	0.00	
	Total:	120.00	0.00		
	Net of 1 Invoices / 0 Checks	120.00	0.00		
STACY LALONDE	Total:	775.00	500.00	reimbursement	no
	Net of 3 Invoices / 2 Checks	275.00	0.00		
LEEANN MALENFANT	Total:	47.20	47.20	reimbursement	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
MCG WEB DEVELOPMENT	Total:	272.00	272.00	Website	no
	Net of 2 Invoices / 2 Checks	0.00	0.00		
MCGRAW MORRIS P.C.	Total:	487.80	487.80	legal	yes
	Net of 1 Invoices / 1 Checks	0.00	0.00		
MCLAREN NORTHERN MICHIGAN HOSPITAL	Total:	30.60	30.60	Blood draw	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
MICH DEPT ENV QUALITY	Total:	4,530.46	4,530.46	permits and fees	no
	Net of 4 Invoices / 2 Checks	0.00	0.00		
MEAD & HUNT	Total:	66,643.75	66,943.75	sewer contracting	yes
	Net of 11 Invoices / 10 Checks	0.00	300.00		
MILAN SUPPLY COMPANY					



MISS DIG SYSTEMS, INC.	Total:	328.30	328.30	supplies	no
	Net of 4 Invoices / 3 Checks	0.00	0.00		
STATE OF MICHIGAN CHECK TXCHK 17177	Total:	1,183.54	1,183.54	subscription	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
M&M PLUMBING	Total:	N	0.00 383.37	tax	no
	Net of 0 Invoices / 1 Checks	0.00	383.37		
MICHIGAN TOWNSHIP ASSOC.	Total:	11,639.92	11,639.92	contracted svcs	yes
	Net of 4 Invoices / 2 Checks	0.00	0.00		
MUNICIPAL EMP. RETIREMENT	Total:	9,531.29	4,875.16	dues	no
	Net of 5 Invoices / 4 Checks	4,656.13	0.00		
MUNICIPAL UNDERWRITERS	Total:	237,913.21	127,222.01	retirement	no
	Net of 13 Invoices / 11 Checks	110,691.20	0.00		
N.M.A.C.P.	Total:	23,074.00	23,074.00	insurance	no
	Net of 3 Invoices / 3 Checks	0.00	0.00		
NORTHERN A-1	Total:	75.00	75.00	dues	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
NORTHLAND LIBRARY COOPERATIVE	Total:	22,269.70	5,059.29	contracted svcs	yes
	Net of 3 Invoices / 1 Checks	17,210.41	0.00		
NYE UNIFORM COMPANY	Total:	5,081.56	5,081.56	co-op	no
	Net of 4 Invoices / 4 Checks	0.00	0.00		
PAT & GARY'S PARTY STORE II	Total:	2,172.76	2,172.76	uniforms	no
	Net of 8 Invoices / 7 Checks	0.00	0.00		
PITNEY BOWES, INC.	Total:	83.97	83.97	propane	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
PITNEY BOWES PURCHASE POWER	Total:	435.36	435.36	postage	no
	Net of 2 Invoices / 2 Checks	0.00	0.00		
PONTEM	Total:	3,103.91	3,103.91	rental and postage	no
	Net of 5 Invoices / 6 Checks	0.00	0.00		

POLLARD'S QUICK LUBE	Total:	390.00	390.00	subscription	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
PRESQUE ISLE ELEC. COOP.	Total:	11,359.11	11,078.43	equip r&m	no
	Net of 30 Invoices / 12 Checks	280.68	0.00		
PRINTING SYSTEMS	Total:	3,342.51	3,249.97	utilities	no
	Net of 26 Invoices / 11 Checks	92.54	0.00		
RAMSBY DRILLING	Total:	262.04	262.04	supplies	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
READER'S DIGEST	Total:	448.71	448.71	contracted svcs	yes
	Net of 1 Invoices / 1 Checks	0.00	0.00		
MIKE RIDLEY	Total:	20.00	20.00	subscription	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
SCREENGRAPHICS	Total:	548.30	548.30	reimbursement	no
	Net of 3 Invoices / 3 Checks	0.00	0.00		
SOUTH SIDE AUTO	Total:	715.00	459.50	printing	no
	Net of 4 Invoices / 3 Checks	255.50	0.00		
STANDARD INSURANCE COMPANY	Total:	55.00	55.00	signage	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
STATE OF MICHIGAN - MDOT	Total:	4,842.93	4,023.05	insurance	no
	Net of 9 Invoices / 8 Checks	819.88	0.00		
STATE OF MICHIGAN - MESC	Total:	200.00	200.00	fee	no
	Net of 2 Invoices / 2 Checks	0.00	0.00		
STEVE'S LOCK & SAFE	Total:	2,916.00	3,001.00	tax	no
	Net of 9 Invoices / 5 Checks	0.00	85.00		
STRAITSLAND PUBLISHING	Total:	487.00	487.00	locksmithing	yes
	Net of 2 Invoices / 2 Checks	0.00	0.00		
TELE-RAD INC	Total:	2,056.65	2,071.05	publication	no
	Net of 13 Invoices / 11 Checks	0.00	14.40		
	Total:	9,380.00	9,380.00	computers police	no

GORDON TEMPLE JR	Net of 1 Invoices / 1 Checks	0.00	0.00		
	Total:	1,847.27	1,745.90	reimbursement	no
BRUCE THOMPSON	Net of 7 Invoices / 7 Checks	101.37	0.00		
	Total:	6,270.00	5,706.00	cemetery	yes
TRANSAMERICA LIFE	Net of 9 Invoices / 7 Checks	564.00	0.00		
	Total:	1,123.92	1,123.92	insurance	no
TRAVERSE AREA DISTRICT LIBRARY	Net of 5 Invoices / 5 Checks	0.00	0.00		
	Total:	300.00	300.00	website	no
TUSCARORA TOWNSHIP	Net of 1 Invoices / 1 Checks	0.00	0.00		
	Total:	9,015.69	2,247,364.91		
TUSCARORA FIRE DEPARTMENT	Net of 21 Invoices / 36 Checks	0.00	2,238,349.22		
	Total:	180,638.00	180,638.00	fire svcs	yes
USA BLUE BOOK	Net of 7 Invoices / 5 Checks	0.00	0.00		
	Total:	5,071.70	5,733.95	supplies	no
USIC LOCATING SERVICES, LLC	Net of 11 Invoices / 8 Checks	0.00	662.25		
	Total:	5,389.90	5,235.82	contracted svcs	yes
U.S. POSTAL SERVICE	Net of 12 Invoices / 11 Checks	154.08	0.00		
	Total:	1,776.00	1,776.00	po box/postage	no
VANS BUSINESS MACHINE	Net of 5 Invoices / 5 Checks	0.00	0.00		
	Total:	2,278.04	2,260.67	copy meter	no
VERIZON WIRELESS	Net of 26 Invoices / 16 Checks	17.37	0.00		
	Total:	2,075.92	2,230.11	mobile phone	no
VIEAU'S TREE SERVICE	Net of 11 Invoices / 12 Checks	0.00	154.19		
	Total:	400.00	400.00	contracted svcs	yes
WHITE PINE ELECTRIC, INC.	Net of 1 Invoices / 1 Checks	0.00	0.00		
	Total:	5,435.72	3,804.27	contracted svcs	yes
DEMCO	Net of 7 Invoices / 5 Checks	1,631.45	0.00		
	Total:	23,661.12	23,661.12	supplies	no
	Net of 2 Invoices / 2 Checks	0.00	0.00		

MOTION PICTURE LICENSING CORP					
	Total:	169.20	169.20	licensing	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
KCI					
	Total:	5,897.94	5,647.20	printing	no
	Net of 6 Invoices / 6 Checks	250.74	0.00		
THOMAS SNYDER					
	Total:	1,500.00	1,500.00	rent	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
I.T. RIGHT					
	Total:	9,018.16	9,018.16	contracted svcs	yes
	Net of 6 Invoices / 5 Checks	0.00	0.00		
MIDWEST COLLABORATIVE FOR LIBRARY					
	Total:	250.00	250.00	dues	no
	Net of 2 Invoices / 2 Checks	0.00	0.00		
CORELOGIC					
	Total:	0.00	1,895.34	subscription	no
	Net of 0 Invoices / 1 Checks	0.00	1,895.34		
BOOK SYSTEMS, INC.					
	Total:	1,485.00	1,485.00	database	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
WOLVERINE POWER SYSTEMS					
	Total:	1,305.00	1,305.00	contracted svcs	yes
	Net of 2 Invoices / 1 Checks	0.00	0.00		
SAULT-CHEBOYGAN MEDIA GROUP					
	Total:	246.15	95.85	publication	no
	Net of 5 Invoices / 2 Checks	150.30	0.00		
CHARTER COMMUNICATIONS					
	Total:	5,927.08	5,687.14	utilities	no
	Net of 33 Invoices / 33 Checks	239.94	0.00		
TEMPERATURE CONTROL, INC.					
	Total:	2,866.00	666.00	Hvac contractor	yes
	Net of 3 Invoices / 1 Checks	2,200.00	0.00		
TANNER ELECTRIC, INC.					
	Total:	1,827.34	1,827.34	electrical contractor	yes
	Net of 4 Invoices / 4 Checks	0.00	0.00		
GFL ENVIRONMENTAL USA, INC.					
	Total:	3,384.82	2,978.59	utilities	no
	Net of 12 Invoices / 11 Checks	406.23	0.00		
JANET MYERSON					
	Total:	897.52	622.52	reimbursement	no
	Net of 4 Invoices / 3 Checks	275.00	0.00		
OMNI SITE					

INLAND LAKE SCHOOLS	Total:	768.00	768.00	wireless	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
TIME	Total:	0.00	2,976,449.10	tax	no
	Net of 0 Invoices / 6 Checks	0.00	2,976,449.10		
WEX BANK	Total:	25.00	25.00	subscription	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
NORTHERN MICH. LAW ENFORCEMENT TRNG	Total:	2,176.16	1,938.23	fuel	no
	Net of 12 Invoices / 10 Checks	237.93	0.00		
DYNAMIC SCHOOL ASSEMBLIES, INC.	Total:	125.00	125.00	dues	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
THERESA WITULSKI	Total:	495.00	495.00	program	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
SUMMIT COMPANIES	Total:	57.00	57.00	reimbursement	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
STRIKER SUPPLY	Total:	292.70	457.00	contracted svcs - fire ext	yes
	Net of 3 Invoices / 4 Checks	0.00	164.30		
TRAVIS J ELOWSKY O.D.	Total:	147.00	147.00	supplies	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
QUALITY SEAL COATING	Total:	149.00	149.00	eye exam	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
AMERICAN LEGAL PUBLISHING CORP	Total:	4,000.00	0.00	contracted svcs	yes
	Net of 1 Invoices / 0 Checks	4,000.00	0.00		
MERCHANT EXCAVATING & SEPTIC SVC, I	Total:	520.00	520.00	subscription	no
	Net of 2 Invoices / 2 Checks	0.00	0.00		
STATE OF MICHIGAN	Total:	310.00	0.00	contracted svcs	yes
	Net of 1 Invoices / 0 Checks	310.00	0.00		
OHM ADVISORS	Total:	284.80	284.80	fees	no
	Net of 2 Invoices / 1 Checks	0.00	0.00		
	Total:	3,751.30	3,751.30	contracted svcs	yes

MESSA	Net of 1 Invoices / 1 Checks	0.00	0.00		
	Total:	140,286.00	138,976.66	insurance	no
ELK COUNTRY COMPUTER SERVICES	Net of 36 Invoices / 14 Checks	1,309.34	0.00		
	Total:	719.75	719.75	contracted svcs - IT	yes
ELECTION SOURCE	Net of 3 Invoices / 3 Checks	0.00	0.00		
	Total:	1,085.50	1,085.50	supplies	no
LEIGH ANN SOCHA	Net of 3 Invoices / 3 Checks	0.00	0.00		
	Total:	840.00	780.00	blood draw	no
BAKER & TAYLOR	Net of 6 Invoices / 6 Checks	60.00	0.00		
	Total:	147.09	147.09	books	no
TRACE ANALYTICAL LABORATORIES, INC.	Net of 2 Invoices / 2 Checks	0.00	0.00		
	Total:	408.00	0.00	lab testing	no
MICHIGAN CHAMBER OF COMMERCE	Net of 1 Invoices / 0 Checks	408.00	0.00		
	Total:	100.50	100.50	posters	no
DROST LANDSCAPE INC	Net of 1 Invoices / 1 Checks	0.00	0.00		
	Total:	921.20	921.20	contracted svcs	yes
MASON COUNTY DISTRICT LIBRARY	Net of 2 Invoices / 2 Checks	0.00	0.00		
	Total:	15.00	15.00	books	no
BUNKER SERVICES	Net of 1 Invoices / 1 Checks	0.00	0.00		
	Total:	1,145.00	1,145.00	contracted svcs	yes
DOUG SCHOFIELD	Net of 2 Invoices / 2 Checks	0.00	0.00		
	Total:	141.59	141.59	reimbursement	no
DAWN WEBB	Net of 1 Invoices / 1 Checks	0.00	0.00		
	Total:	26.49	0.00	reimbursement	no
MIDAMERICA BOOKS	Net of 1 Invoices / 0 Checks	26.49	0.00		
	Total:	290.92	290.92	books	no
PRO COMM INC.	Net of 1 Invoices / 1 Checks	0.00	0.00		
	Total:	314.54	314.54	contracted svcs - IT	yes
	Net of 3 Invoices / 3 Checks	0.00	0.00		

NORTH STAR STONE	Total:	427.24	427.24	materials	no
	Net of 2 Invoices / 2 Checks	0.00	0.00		
ROSE SEPTIC SERVICES	Total:	400.00	400.00	contracted svcs	yes
	Net of 1 Invoices / 1 Checks	0.00	0.00		
HNL SERVICES	Total:	812.50	812.50	contracted svcs	yes
	Net of 1 Invoices / 1 Checks	0.00	0.00		
JO-ANN STORES	Total:	650.00	650.00	subscription	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
FAY MARTIN RESORT	Total:	6,500.00	7,300.00	materials	no
	Net of 1 Invoices / 1 Checks	0.00	800.00		
DORNBOS SIGN INC	Total:	342.20	342.20	signage	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
J&N CONSTRUCTION	Total:	650.00	650.00	contracted svcs	yes
	Net of 1 Invoices / 1 Checks	0.00	0.00		
MIDWEST TAPE LLC	Total:	1,054.08	1,054.08	library	no
	Net of 2 Invoices / 2 Checks	0.00	0.00		
NORTHERN TANK TRUCK SERVICE INC.	Total:	18,113.88	18,113.88	contracted svcs	yes
	Net of 1 Invoices / 1 Checks	0.00	0.00		
PROJECT ARTS & IDEAS	Total:	5,360.00	5,360.00	art	no
	Net of 2 Invoices / 2 Checks	0.00	0.00		
RAMSBY DRILLING INC	Total:	3,020.45	3,020.45	contracted svcs	yes
	Net of 1 Invoices / 1 Checks	0.00	0.00		
ALL - PHASE ELECTRIC	Total:	127.08	127.08	contracted svcs	yes
	Net of 2 Invoices / 2 Checks	0.00	0.00		
SHAWN MCQUAID	Total:	610.00	610.00	contracted svcs	yes
	Net of 1 Invoices / 1 Checks	0.00	0.00		
HARRELL'S INC	Total:	5,147.50	4,900.00	supplies	no
	Net of 2 Invoices / 1 Checks	247.50	0.00		
SUPERIOR BUSINESS SOLUTIONS					

ROTARY MULTIFORMS INC	Total:	184.29	184.29	supplies	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
BSB COMMUNICATIONS	Total:	387.66	387.66	books	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
JORDAN VALLEY DIST LIBRARY	Total:	555.00	555.00	supplies	no
	Net of 2 Invoices / 1 Checks	0.00	0.00		
WEST BLOOMFIELD TWP PUBLIC LIBRARY	Total:	20.00	20.00	books	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
TIM MULHERIN	Total:	16.14	16.14	books	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
WOODLANDS LIBRARY COOP	Total:	13.17	13.17	no idea	
	Net of 1 Invoices / 1 Checks	0.00	0.00		
TROY GRAHAM MUSIC	Total:	17.00	17.00	posters	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
ALCONA HEALTH CENTER	Total:	300.00	300.00	contracted svcs	yes
	Net of 1 Invoices / 1 Checks	0.00	0.00		
CAROL NEUMANN	Total:	219.00	219.00	physical	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
JAKE ALLEN	Total:	287.50	287.50	elections	
	Net of 1 Invoices / 1 Checks	0.00	0.00		
STONE QUEST	Total:	150.00	150.00	contracted svcs	yes
	Net of 1 Invoices / 1 Checks	0.00	0.00		
IREAD ILLINOIS LIBRARY ASSSOC	Total:	32,977.13	32,977.13	ball diamond install	yes
	Net of 2 Invoices / 2 Checks	0.00	0.00		
ZIMMERMAN AND SONS ELECTRIC	Total:	84.22	84.22	program	no
	Net of 1 Invoices / 1 Checks	0.00	0.00		
NORTHERN POWERSWEEPING SERVICES	Total:	25,683.00	25,683.00	street lights	yes?
	Net of 1 Invoices / 1 Checks	0.00	0.00		
	Total:	1,000.00	0.00	contracted svcs	yes



MITCHELL GRAPHIS	Net of 1 Invoices / 0 Checks	1,000.00	0.00		
	Total:	2,026.07	0.00	printing	no
MICHIGAN POLICE EQUIPMENT	Net of 1 Invoices / 0 Checks	2,026.07	0.00		
	Total:	3,934.50	0.00	equipment	no
TUMBLEWEED PRESS INC	Net of 1 Invoices / 0 Checks	3,934.50	0.00		
	Total:	799.00	0.00	subscription	no
MANGO LANGUAGES	Net of 1 Invoices / 0 Checks	799.00	0.00		
	Total:	1,100.00	0.00	subscription	no
JACKSON JONES	Net of 1 Invoices / 0 Checks	1,100.00	0.00		
	Total:	275.00	0.00	reimbursement	no
BERGER CHEVROLET	Net of 1 Invoices / 0 Checks	275.00	0.00		
	Total:	81,992.00	0.00	vehicle	no
DODDS TREE SERVICE	Net of 2 Invoices / 0 Checks	81,992.00	0.00		
	Total:	4,000.00	0.00	contracted svcs	yes
	Net of 1 Invoices / 0 Checks	4,000.00	0.00		