ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 07/01/2021

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).

PRODUCER McGriff Insurance Services, Inc. P.O. Box 10265 Birmingham, AL 35202	**CONTACT NAME:** Ashley Brumlow **PHONE (A/C, No, Ext):** 800-476-2211 **FAX (A/C, No):** **E-MAIL ADDRESS:** ashley.brumlow@mcgriff.com
INSURED Colonial Group, Inc. (continued on attachment) P.O. Box 576 Savannah, GA 31402	**INSURER(S) AFFORDING COVERAGE** / **NAIC #** **INSURER A :** Everest National Insurance Company / 10120 **INSURER B :** **INSURER C :** **INSURER D :** **INSURER E :** **INSURER F :**

COVERAGES **CERTIFICATE NUMBER:** BX3RYAFN **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	X **COMMERCIAL GENERAL LIABILITY** CLAIMS-MADE [X] OCCUR X Sudden & Accidental Pollution X Liquor Liability GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY [ ] PRO-JECT [ ] LOC OTHER:	X		EN6GL00148-211 General Aggregate: Per Project & Per Location Aggregate $4,000,000	06/30/2021	06/30/2022	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG Liquor Liab Aggregate	$ $ $ $ $ $ $	1,000,000 500,000 5,000 1,000,000 10,000,000 2,000,000 2,000,000
A	**AUTOMOBILE LIABILITY** X ANY AUTO OWNED AUTOS ONLY [ ] SCHEDULED AUTOS HIRED AUTOS ONLY [ ] NON-OWNED AUTOS ONLY	X		EN6CA00265-211	06/30/2021	06/30/2022	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ $ $ $	1,000,000
A	[ ] **UMBRELLA LIAB** [X] OCCUR X **EXCESS LIAB** [ ] CLAIMS-MADE DED [ ] RETENTION $	X		EN6EX00133-211	06/30/2021	06/30/2022	EACH OCCURRENCE AGGREGATE	$ $	10,000,000 10,000,000
A	**WORKERS COMPENSATION AND EMPLOYERS' LIABILITY** Y / N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N **(Mandatory in NH)** If yes, describe under DESCRIPTION OF OPERATIONS below	N / A		EN6WC00170-211*	06/30/2021	06/30/2022	X PER STATUTE [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ $ $	1,000,000 1,000,000 1,000,000
A	GA, NC, & SC EXCESS WORKERS' COMPENSATION - INCL USL&H			EN6EW00001-211*	06/30/2021	06/30/2022	WC Statutory Limits incl. EL Each Accident EL Emp For Disease	$ $ $	1,000,000 1,000,000

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

RE: Bid Number RFB-RC-2016-080. The County of Rockland, its employees, elected officials, and affiliated municipal entities are included as Additional Insured (excluding Workers' Compensation) if required by written contract subject to policy terms, conditions and exclusions.

CERTIFICATE HOLDER

County of Rockland
Department of Finance
Dr Robert L Yeager Health Center
50 Sanatorium Road, 8th Floor
Pomona, NY 10970

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

NEW YORK STATE | Workers' Compensation Board

CERTIFICATE OF INSURANCE COVERAGE
DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

PART 1. To be completed by Disability and Paid Family Leave Benefits Carrier or Licensed Insurance Agent of that Carrier

1a. Legal Name & Address of Insured (use street address only)
COLONIAL ENERGY INC
P.O. BOX 576
SAVANNAH, GA 31402

1b. Business Telephone Number of Insured
(912) 443-6569

Work Location of Insured *(Only required if coverage is specifically limited to certain locations in New York State, i.e., a Wrap-Up Policy)*

1c. Federal Employer Identification Number of Insured or Social Security Number
582209516

2. Name and Address of Entity Requesting Proof of Coverage
(Entity Being Listed as the Certificate Holder)
OFFICE OF GENERAL SERVICES, STATE OF NEW YORK
COMING TOWER BUILDING, 38TH FL ESP
ALBANY, NY 12242

3a. Name of Insurance Carrier
New York State Insurance Fund (NYSIF)

3b. Policy Number of Entity Listed in Box "1a"
DBL 2976 25 - 7

3c. Policy effective period
07/01/2021 to 07/01/2022

4. Policy provides the following benefits:

- [x] A. Both disability and paid family leave benefits
- [ ] B. Disability benefits only
- [ ] C. Paid family leave benefits only

5. Policy covers:

- [x] A. All of the employer's employees eligible under the NYS Disability and Paid Family Leave Benefits Law
- [ ] B. Only the following class or classes of employer's employees:

Under penalty of perjury, I certify that I am an authorized representative or licensed agent of the insurance carrier referenced above and that the named insured has NYS Disability and/or Paid Family Leave Benefits insurance coverage as described above.

Date Signed 7/6/2021 By _____
(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number (866) 697-4332 Name and Title **Melissa Jensen, Director of Disability Insurance Unit**

IMPORTANT: If Box 4A and 5A are checked, and this form is signed by the insurance carrier's authorized representative or NYS Licensed Insurance Agent of that carrier,this certificate is COMPLETE. Mail it directly to the certificate holder.

If Box 4B, 4C or 5B is checked, this certificate is NOT COMPLETE for purposes of Section 220, Subd. 8 of the NYS Disability and Paid Family Leave Benefits Law. It must be mailed for completion to the Workers' Compensation Board, DB Plans Acceptance Unit, PO Box 5200, Binghamton, NY 13902-5200

PART 2. To be completed by the NYS Workers' Compensation Board (Only if Box 4C or 5B of Part 1 has been checked)

State of New York
Workers' Compensation Board

According to information maintained by the NYS Workers' Compensation Board, the above-named employer has complied with the NYS Disability and Paid Family Leave Benefits Law with respect to all of his/her employees.

Date Signed _____ By _____
(Signature of Authorized NYS Workers' Compensation Board Employee)

Telephone Number _____ Name and Title _____

Please Note: *Only insurance carriers licensed to write NYS disability and paid family leave benefits insurance policies and NYS licensed insurance agents of those insurance carriers are authorized to issue Form DB-120.1.* ***Insurance brokers are NOT authorized to issue this form.***

Certificate Number 650736

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

1a. Legal Name & Address of Insured (Use street address only) Colonial Group, Inc. dba Colonial Energy, Inc. 101 N. Lathrop Avenue Savannah, GA 31415-1054 Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e., a Wrap-Up Policy)	1b. Business Telephone Number of Insured (912) 236-1331 1c. NYS Unemployment Insurance Employer Registration Number of Insured 4601637 1d. Federal Employer Identification Number of Insured or Social Security Number 58-2063421
2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) County of Rockland Department of Finance Dr Robert L Yeager Health Center 50 Sanatorium Road, 8th Floor Pomona, NY 10970 Reference: RFB-RC-2017-109 for Natural Gas	3a. Name of Insurance Carrier Everest National Insurance Co. 3b. Policy Number of entity listed in box "1a" EN6WC00170-211 3c. Policy effective period 06/30/2021 to 06/30/2022 3d. The Proprietor, Partners or Executive Officers are **X** included (Only check box if all partners/officers included) ☐ all excluded or certain partners/officers excluded

This certifies that the insurance carrier indicated above in box "3" insures the business referenced above in box "1a" for workers' compensation under the New York State Workers' Compensation Law. (To use this form, New York (NY) must be listed under Item 3A on the INFORMATION PAGE of the workers' compensation insurance policy.) The Insurance Carrier or its licensed agent will send this Certificate of Insurance to the entity listed above as the certificate holder in box "2".

The Insurance Carrier will also notify the above certificate holder within 10 days IF a policy is canceled due to nonpayment of premiums or within 30 days IF there are reasons than nonpayment of premiums that cancel the policy or eliminate the insured from the coverage indicated on this Certificate. (These notices may be sent by regular mail.) Otherwise, this Certificate is valid for one year after this form is approved by the insurance carrier or its licensed agent, or until the policy expiration date listed in box "3c", whichever is earlier.

Please Note: Upon the cancellation of the workers' compensation policy indicated on this form, if the business continues to be named on a permit, license, or contract issued by a certificate holder, the business must provide that certificate holder with a new Certificate of Workers' Compensation Coverage or other authorized proof that the business is complying with the mandatory coverage requirements of the New York State Workers' Compensation Law.

Under penalty of perjury, I certify that I am an authorized representative or licensed agent of the insurance carrier referenced above and that the named insured has the coverage as depicted on this form.

Approved by: Robert Drew, McGriff, Seibels & Williams Inc.
(Print name of authorized representative or licensed agent of insurance carrier)

Approved by:  6/30/2021
(Signature) (Date)

Telephone Number of authorized representative or licensed agent of insurance carrier: (205) 252-9871
Please Note: Only insurance carriers and their licensed agents are authorized to issue Form C-105.2 Insurance brokers are NOT authorized to issue it.
C-105.2 (9-07)

AGENCY CUSTOMER ID: _____

LOC #: _____

ADDITIONAL REMARKS SCHEDULE

PRODUCER McGriff Insurance Services, Inc.	**INSURED** Colonial Group, Inc. (continued on attachment)
POLICY NUMBER	
CARRIER / **NAIC CODE**	**ISSUE DATE:** 07/01/2021

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,

FORM NUMBER: _____ **FORM TITLE:** _____

Insured Name continued:

*Colonial Chemical Solutions, Inc.
*Colonial Energy, Inc.
*Colonial Fuel and Lubricant Services, Inc.
*Colonial Oil Industries, Inc.
*CTI of North Carolina, Inc.
*Enmark Stations, Inc.
Colonial Terminals, Inc
Colonial Towing, Inc.
Colonial Compliance Systems, Inc.
Georgia Kaolin Terminals, Inc.
GKT Properties, Inc.
Savannah Yacht Center, Inc.
Colonial Bunkering, Inc.
Chatham Towing Company, Inc.
Colonial Carolina, Inc.
Colonial Land-Carolina, Inc.
Colonial Land Investment Company
Colonial Marine Industries, Inc.
400 Telefair, Inc.

*Indicates Named Insured is included on the Workers' Compensation

CERTIFICATE NUMBER: BX3RYAFN