STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

ESC
R001

CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

1a. Legal Name and address of Insured (Use street address only)	1b. Business Telephone Number of Insured
ALVIN & FRIENDS LLC 49 LAWTON ST NEW ROCHELLE NY 10801	914-654-8356 1c. NYS Unemployment Insurance Employer Registration Number of Insured
Work Location of Insured *(Only required if coverage is specifically limited to certain locations in New York State, i.e. a Wrap-Up Policy)*	1d. Federal Employer Identification Number of Insured or Social Security Number 272060414
2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) City of New Rochelle 515 NORTH AVE NEW ROCHELLE, NY 10801	**3a. Name of Insurance Carrier** Hartford Fire Ins Co **3b. Policy Number of entity listed in box "1a":** 76 WEG DL7665 **3c. Policy effective period:** 10/17/2012 to 10/17/2013 **3d. The Proprietor, Partners or Executive Officers are:** [ ] **included.** (Only check box if all partners/officers included) [X] **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 other 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: Kathi Golowski
(Print name of authorized representative or licensed agent of insurance carrier)

Approved by: Kathi Golowski 04-02-2013
(Signature) (Date)

Title: Operations Manager

Telephone Number of authorized representative or licensed agent of insurance carrier: _____

Please Note: *Only insurance carriers and their licensed agents are authorized to issue the C-105.2 form. Insurance brokers are* ***NOT*** *authorized to issue it.*

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 4/2/2013

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Insurance Connections Agency, Inc.
PO Box 2078

Larchmont NY 10538

CONTACT NAME: Chuck Greenberg
PHONE (A/C, No, Ext): (914) 576-5050 FAX (A/C, No): (914) 315-7211
E-MAIL ADDRESS: CHAZMERE@OPTONLINE.NET

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A: Guard Insurance Group	42390
INSURER B:	
INSURER C:	
INSURER D:	
INSURER E:	
INSURER F:	

INSURED
Westchester Friends Mgt Group LLC,
DBA: Alvin & Friends Restaurant
14 Memorial Hwy
New Rochelle NY 10801

COVERAGES CERTIFICATE NUMBER: CL134200354 REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY [X] COMMERCIAL GENERAL LIABILITY [ ] CLAIMS-MADE [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: [X] POLICY [ ] PRO-JECT [ ] LOC	X		WEBP302418	12/27/2012	12/27/2013	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ $ included $ 1,000,000 $ 2,000,000 $ 2,000,000
	AUTOMOBILE LIABILITY [ ] ANY AUTO [ ] ALL OWNED AUTOS [ ] HIRED AUTOS [ ] SCHEDULED AUTOS [ ] NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ $ $ $
	[ ] UMBRELLA LIAB [ ] OCCUR [ ] EXCESS LIAB [ ] CLAIMS-MADE [ ] DED [ ] RETENTION $						EACH OCCURRENCE AGGREGATE	$ $
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y/N [ ] (Mandatory In NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A					[ ] WC STATU-TORY LIMITS [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ $ $

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

CERTIFICATE HOLDER

City of New Rochelle
Department of Buildings
515 North Ave
New Rochelle, NY 10801

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