



CERTIFICATE OF INSURANCE

THE CORPORATION OF THE CITY OF STRATFORD

This is to certify that the Insured, named below, is insured as described below

CITY FILE NUMBER

*****This form must be completed and signed by your insurer or insurance broker*****

Note: 1. Proof of liability insurance will be accepted on this form only **(with no amendments)**
 2. If a facsimile has been transmitted, the original certificate must follow

NAME OF INSURED	TELEPHONE NUMBER	AREA CODE
ADDRESS OF INSURED	STREET NAME	CITY
		POSTAL CODE

TYPE OF INSURANCE	INSURER'S NAME	POLICY NUMBER	EFFECTIVE DATE			EXPIRY DATE			LIMITS OF LIABILITY Bodily Injury & Property Damage-Inclusive
			YR.	MO.	DAY	YR.	MO.	DAY	
Commercial General Liability									\$
<input type="checkbox"/> Umbrella <input type="checkbox"/> Excess									\$

Commercial General Liability Occurrence Basis CLAIMS MADE POLICIES ARE NOT ACCEPTABLE
 Including Personal Injury, Property Damage, Broad Form Property Damage, Contractual Liability, Non-Owned Automobile liability, Owner's and Contractor's Protective Coverage, Products - Completed Operations, Contingent Employers Liability, Cross Liability Clause and Severability of Interest Clause. The policy also includes:
 Tenant's Legal Liability No or Yes (Limit) \$ _____ Liquor Liability No or Yes (Limit) \$ _____

THE CORPORATION OF THE CITY OF STRATFORD has been added as an additional insured but only with respects to their interest in the operation of the Named Insured.

This is to certify that the Policies of Insurance as described above have been issued by the undersigned, an Insurer licensed in the Province of Ontario, Canada, to the insured named above are in force at this time.

If cancelled or changed in any manner, that would affect The Corporation of the City of Stratford as outlined in coverage specified herein for any reason, so as to affect this certificate, thirty (30) days prior written notice by registered mail or facsimile transmission will be given by the insurer(s) to:

The Corporation of the City of Stratford
Attention: Clerks Office
P.O. Box 818, 1 Wellington Street
Stratford ON N5A 6W1 Fax:

This Certificate is executed and issued to the aforesaid the Corporation City of Stratford, the day and date herein written below.

Date	YR	MO	DAY	NAME OF INSURANCE COMPANY OR BROKER (COMPLETING FORM)	
ADDRESS OF INSURER OR INSURANCE BROKER			TELEPHONE NO.	FAX NO	AUTHORIZED REPRESENTATIVE OR OFFICIAL BY:

***** THIS FORM MUST BE COMPLETED, SIGNED AND STAMPED BY YOUR INSURER OR INSURANCE BROKER**