



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
02/14/2020

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).


<b>PRODUCER</b> Berkeley Insurance & Financial Services, Inc. 555 Pierce Street CML#2 Albany CA 94706		<b>CONTACT NAME:</b> Moe Akhavi <b>PHONE (A/C, No, Ext):</b> (510)984-0161 <b>E-MAIL ADDRESS:</b> BIFS123@gmail.com <b>FAX (A/C, No):</b> (510)248-4150	
<b>INSURED</b> Ascend Rehab Services, Inc. 29516 Kohoutek Way Union City CA 94587		<b>INSURER(S) AFFORDING COVERAGE</b> <b>INSURER A :</b> Philadelphia Indemnity 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:**                      **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:	Y		PHPK2084540	03/04/2020	03/04/2021	EACH OCCURRENCE \$ 1000000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100000 MED EXP (Any one person) \$ 5000 PERSONAL & ADV INJURY \$ 1000000 GENERAL AGGREGATE \$ 3000000 PRODUCTS - COMP/OP AGG \$ 3000000 Sexual-Molestation \$ Included
A	<b>AUTOMOBILE LIABILITY</b> <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	Y		PHPK2084540	03/04/2020	03/04/2021	COMBINED SINGLE LIMIT (Ea accident) \$ 1000000 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 OCCUR CLAIMS-MADE DED RETENTION \$ 10000	Y		PHUB707887	03/04/2020	03/04/2021	EACH OCCURRENCE \$ 1000000 AGGREGATE \$ 1000000 \$
	<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		N/A				<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
A	Professional Liability Sexual Molestation			PHPK2084540	03/04/2020	03/04/2021	occurrence \$1,000,000 Aggregate \$3,000,000

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

<b>CERTIFICATE HOLDER</b> Mt. Diablo Unified School District 1936 Carlotta Drive Concord CA 94519	<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)

06/01/2020

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**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> Automatic Data Processing Insurance Agency, Inc.  1 Adp Boulevard Roseland NJ 07068		<b>CONTACT NAME:</b> Automatic Data Processing Insurance Agency, Inc. <b>PHONE (A/C, No, Ext):</b> 1-800-524-7024 <b>E-MAIL ADDRESS:</b> <b>FAX (A/C, No):</b>																						
<b>INSURED</b> Ascend Rehab Services Inc.  29516 Kohoutek Way  Union City CA 94587		<table border="1"> <tr> <th colspan="2">INSURER(S) AFFORDING COVERAGE</th> <th>NAIC #</th> </tr> <tr> <td>INSURER A :</td> <td>Employers Preferred Insurance Company</td> <td>10346</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 :	Employers Preferred Insurance Company	10346	INSURER B :			INSURER C :			INSURER D :			INSURER E :			INSURER F :		
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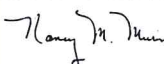
**COVERAGES****CERTIFICATE NUMBER:** 1545549**REVISION NUMBER:**

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"/> PROJECT <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"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY <input type="checkbox"/> 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 \$ \$
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/A	N	EIG287543101	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)

**CERTIFICATE HOLDER****CANCELLATION**

Ascend Rehab Services Inc. 29516 KOHOUTEK WAY  Union City CA 94587	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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**THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.**

## **ADDITIONAL INSURED – DESIGNATED PERSON OR ORGANIZATION**

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART

### **SCHEDULE**

<p><b>Name Of Additional Insured Person(s) Or Organization(s):</b>  <b>Mt Diablo Unified School District</b></p>
<p>Information required to complete this Schedule, if not shown above, will be shown in the Declarations.</p>

**A. Section II – Who Is An Insured** is amended to include as an additional insured the person(s) or organization(s) shown in the Schedule, but only with respect to liability for "bodily injury", "property damage" or "personal and advertising injury" caused, in whole or in part, by your acts or omissions or the acts or omissions of those acting on your behalf:

1. In the performance of your ongoing operations; or
2. In connection with your premises owned by or rented to you.

However:

1. The insurance afforded to such additional insured only applies to the extent permitted by law; and
2. If coverage provided to the additional insured is required by a contract or agreement, the insurance afforded to such additional insured will not be broader than that which you are required by the contract or agreement to provide for such additional insured.

**B.** With respect to the insurance afforded to these additional insureds, the following is added to **Section III – Limits Of Insurance:**

If coverage provided to the additional insured is required by a contract or agreement, the most we will pay on behalf of the additional insured is the amount of insurance:

1. Required by the contract or agreement; or
  2. Available under the applicable Limits of Insurance shown in the Declarations;
- whichever is less.

This endorsement shall not increase the applicable Limits of Insurance shown in the Declarations.

POLICY NUMBER: PHUB707887



**PHILADELPHIA**  
INSURANCE COMPANIES

A Member of the Tokio Marine Group

One Bala Plaza, Suite 100  
Bala Cynwyd, Pennsylvania 19004  
610.617.7900 Fax 610.617.7940  
PHLY.com

## COMMERCIAL UMBRELLA LIABILITY INSURANCE POLICY DECLARATIONS

Philadelphia Indemnity Insurance Company	108252 Berkeley Insurance & Financial Servic 555 Pierce St, # 2 Albany, CA 94706  (510) 984-0160
NAMED INSURED: Ascend Rehab Services, Inc.  MAILING ADDRESS: 29516 Kohoutek Way Union City, CA 94587-1221  POLICY PERIOD: FROM 03/04/2020 TO 03/04/2021 AT 12:01 A.M. STANDARD TIME AT YOUR MAILING ADDRESS SHOWN ABOVE	

**IN RETURN FOR THE PAYMENT OF THE PREMIUM, AND SUBJECT TO ALL THE TERMS OF THIS POLICY, WE AGREE WITH YOU TO PROVIDE THE INSURANCE AS STATED IN THIS POLICY.**

LIMITS OF INSURANCE	
EACH OCCURRENCE LIMIT (LIABILITY COVERAGE)	\$ 1,000,000
PERSONAL & ADVERTISING INJURY LIMIT	\$ 1,000,000 Any one person or organization
PRODUCTS COMPLETED OPERATIONS AGGREGATE LIMIT	\$ 1,000,000
GENERAL AGGREGATE LIMIT (LIABILITY COVERAGE) (except with respect to Auto Liability and Products Completed Operations)	\$ 1,000,000

RETAINED LIMIT	
RETAINED LIMIT:	\$ 10,000

POLICY NUMBER: PHUB707887

PREMIUM	
PREMIUM SUBTOTAL	\$ 924.00
STATE TAXES, FEES, SURCHARGES (if applicable)	\$Not Applicable
PREMIUM TOTAL (including Taxes, Fees, Surcharges)	\$ 924.00
AUDIT PERIOD:	<input checked="" type="checkbox"/> NOT APPLICABLE <input type="checkbox"/> ANNUALLY <input type="checkbox"/> SEMI-ANNUALLY <input type="checkbox"/> QUARTERLY <input type="checkbox"/> MONTHLY

DESCRIPTION OF BUSINESS	
FORM OF BUSINESS:	<u>CORPORATION</u>
BUSINESS DESCRIPTION:	<u>For Profit SS Umbrella</u>

ENDORSEMENTS ATTACHED TO THIS POLICY
SEE ATTACHED SCHEDULE

POLICY NUMBER: PHUB707887

<b>SCHEDULE OF UNDERLYING INSURANCE</b>		
<b>Employers' Liability</b>		
Company:		
Policy Number:		
Policy Period:		
Minimum Applicable Limits		
Bodily injury by accident	\$ _____	Each Accident
Bodily injury by disease	\$ _____	Each Employee
Bodily injury by disease	\$ _____	Policy Limit
<b>Commercial General Liability</b>		
	<input checked="" type="checkbox"/> Occurrence	<input type="checkbox"/> Claims-Made
Company:	<u>Philadelphia Indemnity Insurance Company</u>	
Policy Number:	<u>PHPK2084540</u>	
Policy Period:	<u>03/04/2020      03/04/2021</u>	
Retroactive Date:	<u>Not Applicable</u>	
Minimum Applicable Limits:		
General Aggregate	\$ _____	<u>3,000,000</u>
Products-Completed Operations Aggregate	\$ _____	<u>3,000,000</u>
Personal And Advertising Injury	\$ _____	<u>1,000,000</u>
Each Occurrence	\$ _____	<u>1,000,000</u>
<b>Commercial Auto Liability</b>		
Company:	<u>Philadelphia Indemnity Insurance Company</u>	
Policy Number:	<u>PHPK2084540</u>	
Policy Period:	<u>03/04/2020      03/04/2021</u>	
Minimum Applicable Limits		
Garage Aggregate Limit For Other Than Autos (if applicable)	\$ _____	<u>Not Applicable</u>
Each Accident	\$ _____	<u>1,000,000</u>
<b>Professional Liability</b>		
	<input checked="" type="checkbox"/> Occurrence	<input type="checkbox"/> Claims-Made
Company:	<u>Philadelphia Indemnity Insurance Company</u>	
Policy Number:	<u>PHPK2084540</u>	
Policy Period:	<u>03/04/2020      03/04/2021</u>	
Retroactive Date:	<u>Not Applicable</u>	
Minimum Applicable Limits		
<u>Each Professional Incident</u>	\$ _____	<u>1,000,000</u>
<u>Aggregate</u>	\$ _____	<u>3,000,000</u>

POLICY NUMBER: PHUB707887

<b>Employee Benefits Liability</b>	<input type="checkbox"/> Occurrence	<input type="checkbox"/> Claims-Made
Company: _____		
Policy Number: _____		
Policy Period: _____		
Retroactive Date: _____		
Minimum Applicable Limits		
_____	\$	_____
_____	\$	_____
<b>Abuse or Molestation</b>	<input type="checkbox"/> Occurrence	<input type="checkbox"/> Claims-Made
Company: _____		
Policy Number: _____		
Policy Period: _____		
Retroactive Date: _____		
Minimum Applicable Limits		
_____	\$	_____
_____	\$	_____
<b>Directors &amp; Officers Liability</b>	<input type="checkbox"/> Occurrence	<input type="checkbox"/> Claims-Made
Company: _____		
Policy Number: _____		
Policy Period: _____		
Retroactive Date: _____		
Minimum Applicable Limits		
_____	\$	_____
_____	\$	_____
<b>Liquor Liability</b>	<input type="checkbox"/> Occurrence	<input type="checkbox"/> Claims-Made
Company: _____		
Policy Number: _____		
Policy Period: _____		
Retroactive Date: _____		
Minimum Applicable Limits		
_____	\$	_____
_____	\$	_____

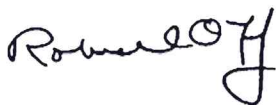
POLICY NUMBER: PHUB707887

<b>Watercraft Liability</b>	<input type="checkbox"/> Occurrence	<input type="checkbox"/> Claims-Made
Company: _____		
Policy Number: _____		
Policy Period: _____		
Retroactive Date: _____		
Minimum Applicable Limits		
_____	\$	_____
_____	\$	_____
<b>Other Coverages Not Included in Above</b>	<input type="checkbox"/> Occurrence	<input type="checkbox"/> Claims-Made
_____		
Company: _____		
Policy Number: _____		
Policy Period: _____		
Retroactive Date: _____		
Minimum Applicable Limits		
_____	\$	_____
_____	\$	_____

**THESE DECLARATIONS, TOGETHER WITH THE COMMON POLICY CONDITIONS AND COVERAGE FORM(S) AND ANY ENDORSEMENT(S), COMPLETE THE ABOVE NUMBERED POLICY.**

Countersigned:	By:
(Date)	(Authorized Representative)

**IN WITNESS WHEREOF**, we have caused this policy to be executed and attested, and, if required by state law, this policy shall not be valid unless countersigned by our authorized representative.



President



Secretary