



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

11/7/2024

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> Conrey Ins Brokers & Risk Managers 2522 N. Santiago Blvd. Lic#0543173 Orange CA 92867	<b>CONTACT NAME:</b> Clarissa Kim	
	<b>PHONE (A/C No. Ext):</b> (877) 450-1872	<b>FAX (A/C No):</b> (714) 838-8166
<b>E-MAIL ADDRESS:</b>		
<b>INSURER(S) AFFORDING COVERAGE</b>		<b>NAIC #</b>
<b>INSURER A:</b> Lloyds Of London		
<b>INSURER B:</b> Redwood Fire and Casualty Ins. Company		11673
<b>INSURER C:</b> Citizens Insurance Company Of America		31534
<b>INSURER D:</b>		
<b>INSURER E:</b>		
<b>INSURER F:</b>		
<b>INSURED</b> Green Light Imaging 8348 Rosemead Blvd Pico Rivera CA 90660		

**COVERAGES**

CERTIFICATE NUMBER: 24-25 GL AU WC E&amp;O

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 checked="" 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 OTHER:	X	Y	W19DE4241001	10/23/2024	10/23/2025	EACH OCCURRENCE	\$ 2,000,000
	DAMAGE TO RENTED PREMISES (Ea occurrence)						\$ 50,000	
							MED EXP (Any one person)	\$ 5,000
							PERSONAL & ADV INJURY	\$ 100,000
							GENERAL AGGREGATE	\$ 4,000,000
							PRODUCTS - COMP/OP AGG	\$ 4,000,000
							Sexual Misconduct	\$ 300,00
B	<b>AUTOMOBILE LIABILITY</b> <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS <input checked="" type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> NON-OWNED AUTOS			01APM040312-02	10/23/2024	10/23/2025	COMBINED SINGLE LIMIT (Ea accident)	\$ 1,000,000
							BODILY INJURY (Per person)	\$
							BODILY INJURY (Per accident)	\$
							PROPERTY DAMAGE (Per accident)	\$
							Medical payments	\$ 1,000
	<b>UMBRELLA LIAB</b> <input type="checkbox"/> EXCESS LIAB OCCUR <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$						EACH OCCURRENCE	\$
							AGGREGATE	\$
								\$
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/A	WB3J88004000	11/6/2024	11/6/2025	<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	<b>Errors &amp; Omissions</b> Claims Made			W19DE4241001	10/23/2024	10/23/2025	Each Claim	\$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)

AS RESPECTS GENERAL LIABILITY ONLY: BLANKET ADDITIONAL INSURED FOR MISCELLANEOUS MEDICAL PRIVATE ENTERPRISES IS INCLUDED PER FORM E07195-A. WAIVER OF SUBROGATION PER FORM E07249 A. POLICY CONTAINS 30 DAY CANCELLATION CLAUSE. 10 DAYS NOTICE IN THE EVENT OF CANCELLATION FOR NON-PAYMENT.

**CERTIFICATE HOLDER**

West Covina Medical Center  
 725 S. Orange Ave  
 West Covina, CA 91790

**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

Clarissa Kim/STSI

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