



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
04/19/2023

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> SRS (Cayman) Limited 878 West Bay Road PO Box 1159 Grand Cayman, KY1-1102 CAYMAN ISLANDS CN102513532--GLPL-22-23      FRAN      CT		<b>CONTACT</b> NAME: PHONE (A/C, No. Ext): E-MAIL: ADDRESS:		<b>FAX</b> (A/C, No):	
<b>INSURED</b> Trinity Health Corporation Saint Francis Hospital and Medical Center 114 Woodland Street Hartford, CT 06105		<b>INSURER(S) AFFORDING COVERAGE</b> <b>INSURER A:</b> Trinity Assurance, Ltd. <b>INSURER B:</b> <b>INSURER C:</b> <b>INSURER D:</b> <b>INSURER E:</b> <b>INSURER F:</b>			
				<b>NAIC #</b>	

## COVERAGES

CERTIFICATE NUMBER:

CLE-007023195-01

REVISION NUMBER: 3

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>			V-22/23-INTPR-1001	07/01/2022	07/01/2023	EACH OCCURRENCE \$ 3,000,000
	<input checked="" type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR		DAMAGE TO RENTED PREMISES (Ea occurrence) \$				
			MED EXP (Any one person) \$				
			PERSONAL & ADV INJURY \$				
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE \$ 6,000,000
	<input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC						PRODUCTS - COMP/OP AGG \$
	OTHER:						\$
	<b>AUTOMOBILE LIABILITY</b>						COMBINED SINGLE LIMIT (Ea accident) \$
	<input type="checkbox"/> ANY AUTO						BODILY INJURY (Per person) \$
	<input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS						BODILY INJURY (Per accident) \$
	<input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident) \$
							\$
	<b>UMBRELLA LIAB</b>						EACH OCCURRENCE \$
	<input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE						AGGREGATE \$
	DED <input type="checkbox"/> RETENTION \$						\$
	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b>						PER STATUTE <input type="checkbox"/> OTH-ER <input type="checkbox"/>
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	N/A				E.L. EACH ACCIDENT \$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE \$
							E.L. DISEASE - POLICY LIMIT \$
A	Professional Liability			V-22/23-INTPR-1001	07/01/2022	07/01/2023	EACH OCC / LOSS \$ 6,000,000

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

Re: Physical/Medical Services, Firefighters, Pre-Employment, DOT/Public Works Town of West Hartford and West Hartford Board of Education  
CROCOG and their respective officers, officials, employees, agents, boards, and commissions are included as additional insureds where required by written contract with respect to General Liability. All Employees (including employed physicians, interns, residents, nurses, volunteers and other professional employees) are insured while acting within the scope of their duties. Coverage is effective the first day of employment to the last day of employment as per employment contract.

## CERTIFICATE HOLDER

Capitol Region Council of Governments  
241 Main Street, 4th Floor  
Hartford, CT 06106

## 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

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# ADDITIONAL REMARKS SCHEDULE

AGENCY SRS (Cayman) Limited		NAMED INSURED Trinity Health Corporation Saint Francis Hospital and Medical Center 114 Woodland Street Hartford, CT 06105
POLICY NUMBER		
CARRIER	NAIC CODE	EFFECTIVE DATE:

## ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,  
 FORM NUMBER: 25 FORM TITLE: Certificate of Liability Insurance

This insurance is primary and non-contributory over any existing insurance and limited to liability arising out of the operations of the named insured subject to policy terms and conditions.