



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

1/29/2018

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> Regions Insurance, Inc. 2000 Richmond Rd Suite 210 Texarkana, TX 75503	<b>CONTACT NAME:</b> PHONE (A/C, No, Ext): 903-336-6400		FAX (A/C, No): 903-223-5991
	<b>E-MAIL ADDRESS:</b>		
<b>INSURED</b> Pinch Flatbed, Inc. 18515 Aldine Westfield Rd. Houston TX 77073	<b>INSURER(S) AFFORDING COVERAGE</b>		<b>NAIC #</b>
	<b>INSURER A:</b> Insurance Company of State of PA		19429
	<b>INSURER B:</b> Lexington Insurance Company		19437
	<b>INSURER C:</b>		
	<b>INSURER D:</b>		
	<b>INSURER E:</b>		

**COVERAGES**

CERTIFICATE NUMBER: 40104083

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 type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:			TGL58327205	1/31/2018	1/31/2019	EACH OCCURRENCE \$1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$100,000 MED EXP (Any one person) \$5,000 PERSONAL & ADV INJURY \$1,000,000 GENERAL AGGREGATE \$2,000,000 PRODUCTS - COMP/OP AGG \$1,000,000 \$
A	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <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			TP988171205 (\$2,500 ded)	1/31/2018	1/31/2019	COMBINED SINGLE LIMIT (Ea accident) \$1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
	<input type="checkbox"/> UMBRELLA LIAB <input type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$ \$
	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? <input type="checkbox"/> Y/N <input checked="" type="checkbox"/> N/A (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below						<input type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
B	Motor Truck Cargo			6632711304	1/31/2018	1/31/2019	\$500,000 Per Unit \$5,000 DED
B	Trailer Interchange			6632711304	1/31/2018	1/31/2019	\$30,000 Limit / \$1,000 Comp & Coll Deduct
B	Scheduled Equipment			2033529902	1/31/2018	1/31/2019	Per schedule
B	Physical Damage			6632711304	1/31/2018	1/31/2019	per schedule - \$2,500 ded

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

**CERTIFICATE HOLDER**

For Insurance Verification Only  
 Should you require a certificate listing your company as holder, please fax your request to 903-223-5991.

**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

Michelle Elliott

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ACORD 25 (2016/03)

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# CERTIFICATE OF LIABILITY INSURANCE

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01/31/2018

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PRODUCER Phone: (210) 930-5040 Fax: 210-930-5045 <b>MILLENIUM INSURANCE SERVICES INC</b> PO BOX 17936 SAN ANTONIO TX 78217	CONTACT NAME: <b>Briana</b> PHONE (A/C, No, Ext): <b>(210) 930-5040</b> FAX (A/C, No): <b>210-930-5045</b> E-MAIL ADDRESS: <b>briana@milleniuminsurance.com</b>
INSURED <b>PINCH FLATBED, INC.</b> 18515 ALDINE WESTFIELD HOUSTON TX 77073	INSURER(S) AFFORDING COVERAGE INSURER A : <b>Gemini Insurance Co.</b> INSURER B : <b>Acceptance Indemnity Insurance</b> INSURER C : INSURER D: INSURER E : INSURER F :

COVERAGES CERTIFICATE NUMBER: 188514 REVISION NUMBER:

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INSR LTR	TYPE OF INSURANCE	ADD'L INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
	GENERAL LIABILITY <input type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC						EACH OCCURRENCE \$ DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED. EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS - COMP/OP AGG \$ \$
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (per accident) \$ \$
A	UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED <input checked="" type="checkbox"/> RETENTION \$ <b>10,000</b>			<b>GVE100103906</b>	<b>01/31/18</b>	<b>01/31/19</b>	EACH OCCURRENCE \$ <b>2,000,000</b> AGGREGATE \$ <b>2,000,000</b> \$ WC STATUTORY LIMITS OTH ER
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below <input type="checkbox"/> Y/N <input checked="" type="checkbox"/> N/A						E.L. EACH ACCIDENT \$ E.L. DISEASE-EA EMPLOYEE \$ E.L. DISEASE-POLICY LIMIT \$
B	Non-Trucking Liability			<b>NTL0720449-64286</b>	<b>01/31/18</b>	<b>01/31/19</b>	<b>\$1,000,000 Liab Limit</b>

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

CERTIFICATE HOLDER	CANCELLATION
Attention.	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  Joe B. Eanes