



City of Cocoa
Section 200 - Post Award Forms

Affidavit Regarding Workers' Compensation

Dave Turgeon being duly sworn according to law, deposes and says (it, he they) has accepted the Workers' Compensation laws of the State of Florida, with its supplements and amendments and his insured (its, his, their) liability thereunder in accordance with the terms of said Laws with the _____ Company, under the terms of Policy No. _____ for a period from July 1, 20 20 to July 1, 20 21.

<u>Dave Turgeon</u>	<u>King Insurance Agency</u>	<u>352-376-0420</u>
(Authorized Signature)	Name of Business	Phone & Fax Number
<u>Dave Turgeon, Agent</u>	<u>2321 NW 41st St</u>	<u>Gainesville, FL 32606</u>
(Printed Name and Title)	Business Mailing Address	City, State, Zip

Notary Public, State of

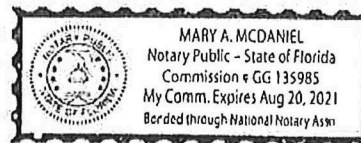
STATE OF Florida

COUNTY OF Alachua

The foregoing instrument was sworn to and subscribed before me on this 04 day of February, 2021, by Dave Turgeon the _____ of _____, a _____ (check one) ☒ who is personally known to me or ☐ who produced _____ as identification.

<input checked="" type="checkbox"/> Personally Known
Or
<input type="checkbox"/> Produced Identification

Notary Public: Mary McDaniel
Print Name: Mary McDaniel
My Commission expires: 8-20-2021





City of Cocoa
Section 200 - Post Award Forms

Certificate of Insurance for Workers' Compensation

This is to certify that Associated Industries Insurance Company, Inc,
Company has issued to Beemats, LLC,
of the City of New Smyrna Beach, State of FL,
the following policy or policies: Workers' Compensation and Employer's Liability
Policy No. AWC1151503 effective on July 1, 20 20,
re Beemats, LLC Policy No. AWC1151503
effective on July 1, 20 20 and expiring on _____
July 1, 20 21 re _____ limits \$500,000 /
\$500,00 / \$500,000

If at any time this coverage is to be cancelled, the undersigned will notify the insured and the City of Cocoa, Purchasing Department in writing ten (10) days prior to cancellation of policy.

(This certificate must be made by a duly authorized official of the Insurance Company carrying the risk, or a separate certificate of similar context executed on Insurance Company's Standard Form may be attached hereto.)

Notary Public, State of

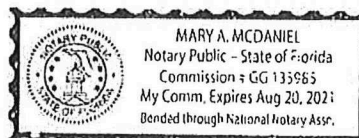
STATE OF Florida

COUNTY OF Alachua

The foregoing instrument was sworn to and subscribed before me on this 04 day of February, 2021, by Dave Twegen the _____ of _____ (check one) ☒ who is personally known to me or ☐ who produced _____ as identification.

<input checked="" type="radio"/> Personally Known
<input type="radio"/> Or
<input type="radio"/> Produced Identification

Notary Public: Mary McDaniel
Print Name: Mary McDaniel
My Commission expires: 8-20-2021





City of Cocoa
Section 200 - Post Award Forms

Certificate of Liability Insurance

Provide business's current Certificate of Insurance with City of Cocoa as additional insured.



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
2/2/2021

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).

PRODUCER King Ins Agency of Gainesville, Inc 2321 NW 41st Street Gainesville FL 32606	CONTACT NAME: King Insurance PHONE (A/C, No, Ext): 352-377-0420 FAX (A/C, No): 352-415-8030 E-MAIL ADDRESS: Certificates@king-insurance.com
INSURER(S) AFFORDING COVERAGE	
INSURER A: Westfield Insurance Companies NAIC # 24112	
INSURER B: Associated Industries Insurance Co, Inc. 23140	
INSURER C:	
INSURER D:	
INSURER E:	
INSURER F:	

COVERAGES **CERTIFICATE NUMBER:** 911925985 **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			Y		CWP6514013	7/30/2020	7/30/2021	EACH OCCURRENCE	\$ 1,000,000
	<input type="checkbox"/>	CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR								DAMAGE TO RENTED PREMISES (Ea occurrence)	\$ 150,000
	<input type="checkbox"/>									MED EXP (Any one person)	\$ 5,000
	<input type="checkbox"/>									PERSONAL & ADV INJURY	\$ 1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:									GENERAL AGGREGATE	\$ 2,000,000
	<input type="checkbox"/>	POLICY <input checked="" type="checkbox"/>	PRO-JECT <input checked="" type="checkbox"/>	LOC <input checked="" type="checkbox"/>						PRODUCTS - COMP/OP AGG	\$ 2,000,000
	<input type="checkbox"/>	OTHER:									\$
A	AUTOMOBILE LIABILITY						CWP6514013	7/30/2020	7/30/2021	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 checked="" type="checkbox"/>	HIRED AUTOS ONLY	<input checked="" type="checkbox"/>	NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	\$
	<input type="checkbox"/>										\$
A	<input type="checkbox"/>	UMBRELLA LIAB		<input checked="" type="checkbox"/> OCCUR			CWP6514013	7/30/2020	7/30/2021	EACH OCCURRENCE	\$ 1,000,000
	<input type="checkbox"/>	EXCESS LIAB		<input type="checkbox"/> CLAIMS-MADE						AGGREGATE	\$
	<input type="checkbox"/>	DED <input checked="" type="checkbox"/>	RETENTION \$ 0								\$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY				Y/N		AWC1151503	7/1/2020	7/1/2021	<input checked="" type="checkbox"/> PER STATUTE	<input type="checkbox"/> OTH-ER
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory In NH)				<input type="checkbox"/>	N/A				E.L. EACH ACCIDENT	\$ 500,000
	If yes, describe under DESCRIPTION OF OPERATIONS below									E.L. DISEASE - EA EMPLOYEE	\$ 500,000
										E.L. DISEASE - POLICY LIMIT	\$ 500,000

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

Project: Floating Wetlands Quality Project

City of Cocoa is included as an Additional Insured with respect to the General Liability when required by Written Contract or Agreement.

CERTIFICATE HOLDER

CANCELLATION

City of Cocoa 65 Stone St Cocoa FL 32922	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 - OWNERS, LESSEES OR
CONTRACTORS - COMPLETED OPERATIONS**

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART
PRODUCTS/COMPLETED OPERATIONS LIABILITY COVERAGE PART

SCHEDULE

Name Of Additional Insured Person(s) Or Organization(s)	Location(s) And Description Of Covered Operations
All persons or organizations when you have agreed in writing in a contract or agreement that such persons or organizations be added as an additional insured.	All Locations
Information required to complete this Schedule, if not shown above, will be shown in the Declarations.	

- 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" or "property damage" caused, in whole or in part, by "your work" at the location designated and described in the schedule of this endorsement performed for that additional insured and included in the "products-completed operations hazard".

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.

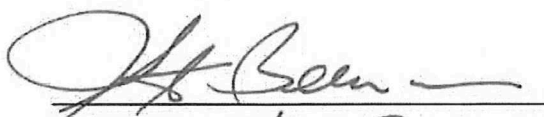


CONTRACTOR E-VERIFY AFFIDAVIT

I hereby certify that BEEHATS LLC [insert contractor company name] does not employ, contract with, or subcontract with an unauthorized alien, and is otherwise in full compliance with, section 448.095, Florida Statutes.

All employees hired on or after January 1, 2021 have had their work authorization status verified through the E-Verify system.

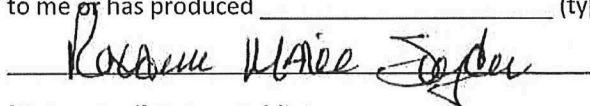
A true and correct copy of BEEHATS LLC [insert contractor company name] proof of registration in the E-Verify system is attached to this Affidavit.


Print Name: Steve Beeman
Date: 2/10/2021

STATE OF FLORIDA

COUNTY OF Volusia

The foregoing instrument was acknowledged before me by means of ☒ physical presence or ☐ online notarization, this 2/10/21 (date) by STEVE BEEHAT (name of officer or agent, title of officer or agent) of BEEHATS LLC (name of corporation acknowledging), a FLORIDA (state or place of incorporation) corporation, on behalf of the corporation. He/she is personally known to me or has produced _____ (type of identification) as identification.

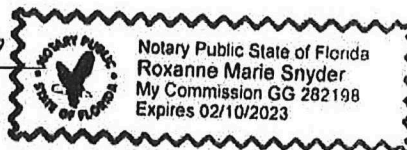


[Notary Seal] Notary Public

ROXANNE MARIE SNYDER

Name typed, printed or stamped

My Commission Expires: 2/10/2023





Welcome
Snyder Roxanne

≡ MENU

Company Information

Company Name
BEEMATS LLC

Company ID Number
1637405

Doing Business As (DBA) Name
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DUNS Number
--

Physical Location

Address 1
3637 State Road 44

Address 2
--

City
New Smyrna Beach

State
FL

Zip Code
32168

County
VOLUSIA

Mailing Address

Address 1
--

Address 2
--

City
--

State
--

Zip Code

Additional Information

Employer Identification Number
263971932

Total Number of Employees
5 to 9

Parent Organization

Administrator

Organization Designation

Employer Category
None of these categories apply

[View / Edit](#)

NAICS Code
541 - PROFESSIONAL, SCIENTIFIC, AND TECHNICAL SERVICES

[View / Edit](#)

Total Hiring Sites
1

[View / Edit](#)

Total Points of Contact
1

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