



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

10/07/2024

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 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 Hiscox Inc. d/b/a/ Hiscox Insurance Agency in CA 5 Concourse Parkway Suite 2150 Atlanta GA, 30328	CONTACT NAME: PHONE (A/C. No. Ext): (888) 202-3007	FAX (A/C. No.):
	E-MAIL ADDRESS: contact@hiscox.com	
INSURER(S) AFFORDING COVERAGE		NAIC #
INSURER A: Hiscox Insurance Company Inc	10200	
INSURED Holistic Speech Therapy, Inc. 935 indiana ave Venice, CA 90291	INSURER B:	
	INSURER C:	
	INSURER D:	
	INSURER E:	
	INSURER F:	

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"/> 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:			P100.941.628.3	10/07/2024	10/07/2025	EACH OCCURRENCE \$ 2,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000 MED EXP (Any one person) \$ 5,000 PERSONAL & ADV INJURY \$ 2,000,000 GENERAL AGGREGATE \$ 3,000,000 PRODUCTS - COMP/OP AGG \$ S/T Gen. 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) \$ \$
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED <input type="checkbox"/> RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$ \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N	N/A				<input type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$

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

CERTIFICATE HOLDER**CANCELLATION**

Mt Diablo Unified School District : 1936 Carlotta Dr. Concord, CA. 94519
 935 indiana ave
 Venice, California 90291

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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Policy Number: P100.941.628.2
Named Insured: Holistic Speech Therapy, Inc.
Endorsement Number: 29
Endorsement Effective: 09/24/2024

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

Name Of Additional Insured Person(s) Or Organization(s)
Mt Diablo Unified School District : 1936 Carlotta Dr. Concord, CA 94519
Information required to complete this Schedule, if not shown above, will be shown in the Declarations.

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:

- A. In the performance of your ongoing operations; or
- B. In connection with your premises owned by or rented to you.

Declarations Page

Commercial General Liability Declarations

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.

Declaration effective from:	September 24, 2024	
Policy No.:	P100.941.628.2	
Named Insured:	Holistic Speech Therapy, Inc.	
Address:	935 indiana ave Venice, CA 90291	
Email Address:	sonia@holisticspeechtherapy.net	

Policy period:	From: October 7, 2023	To: October 7, 2024
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At 12:01 A.M. (Standard Time) at the address shown above.

Form of Business:	Limited Liability Company	
Each Occurrence Limit:	\$2,000,000	
Damage to Premises Rented to You Limit:	\$100,000	Any one premises
Medical Expense Limit:	\$5,000	Any one person
Personal & Advertising Injury Limit:	\$2,000,000	Any one person or organization
General Aggregate Limit:	\$3,000,000	
Products/Completed Operations Aggregate Limit:	Products-completed operations are subject to the General Aggregate Limit	
Supplemental Business Personal Property Floater Coverage Limit:	\$0	
Supplemental Business Personal Property Floater Coverage Deductible:	Not Applicable	

All Premises You Own, Rent or Occupy

Premises Number:	1
Address:	935 indiana ave Venice, CA 90291

Total Premium:	350.00
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Attachments:	See attached Forms and Endorsements Schedule.
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IN WITNESS WHEREOF, the Insurer indicated above has caused this Policy to be signed by its President and Secretary, but this Policy shall not be effective unless also signed by the Insurer's duly authorized representative.



President



Secretary



Authorized Representative

Forms and Endorsements Schedule

Forms and Endorsements made part of this policy at time of issue:

CGL D001 10 18 - Commercial General Liability Declarations

INT D001 01 10 - Forms and Endorsements Schedule

CGL E5410 CW (03/10) - Policy Changes

CG 20 26 07 04 - Additional Insured - Designated Person or Organization

Endorsements



Policy Number: P100.941.628.2
 Named Insured: Holistic Speech Therapy, Inc.
 Endorsement Number: 28
 Endorsement Effective: 09/24/2024

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

POLICY CHANGES

This endorsement will not be used to decrease coverage, increase rates or deductibles or alter any terms or conditions of coverage unless at the sole request of the insured.

The following item(s):

<input type="checkbox"/> Insured's Name	<input type="checkbox"/> Insured's Mailing Address
<input type="checkbox"/> Policy Number	<input type="checkbox"/> Company
<input type="checkbox"/> Effective/Expiration Date	<input type="checkbox"/> Insured's Legal Status/Business of Insured
<input type="checkbox"/> Payment Plan	<input type="checkbox"/> Premium Determination
<input type="checkbox"/> Additional Interested Parties	<input checked="" type="checkbox"/> Coverage Forms and Endorsements
<input type="checkbox"/> Limits/Exposures	<input type="checkbox"/> Deductibles
<input type="checkbox"/> Covered Property/Located Description	<input type="checkbox"/> Classification/Class Codes
<input type="checkbox"/> Rates	<input type="checkbox"/> Underlying Insurance

is (are) changed to read **{See Additional Page(s)}**:

The above amendments result in a change in the premium as follows:

<input checked="" type="checkbox"/> NO CHANGES	<input type="checkbox"/> TO BE ADJUSTED AT AUDIT	ADDITIONAL PREMIUM	RETURN PREMIUM
		\$	\$

POLICY CHANGES ENDORSEMENT DESCRIPTION

It is understood and agreed that effective 09/24/2024, Endorsement # 29 entitled Additional Insured - Designated Person or Organization is added.

All other terms and conditions remain unchanged.



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

09/24/2024

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PRODUCER Hiscox Inc. d/b/a/ Hiscox Insurance Agency in CA 5 Concourse Parkway Suite 2150 Atlanta GA, 30328	CONTACT NAME: PHONE (A/C. No. Ext): (888) 202-3007 E-MAIL ADDRESS: contact@hiscox.com	FAX (A/C. No.):
	INSURER(S) AFFORDING COVERAGE	
INSURED Holistic Speech Therapy, Inc. 935 Indiana Ave Venice, CA 90291	INSURER A: Hiscox Insurance Company Inc	10200
	INSURER B:	
	INSURER C:	
	INSURER D:	
	INSURER E:	
	INSURER F:	

COVERAGES**CERTIFICATE NUMBER:****REVISION NUMBER:**

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INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
	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 OTHER:						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) \$ \$
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$ \$
	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 / <input type="checkbox"/> N / A					<input 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	Y		P100.899.557.3	09/15/2024	09/15/2025	Each Claim: \$ 1,000,000 Aggregate: \$ 2,000,000

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

Mt Diablo Unified School District is named as Additional Insured, subject to policy terms and conditions

CERTIFICATE HOLDER
 Mt Diablo Unified School District
 1936 Carlotta Dr.
 Concord, CA 94519
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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Declarations Page

Professional Liability Errors & Omissions Insurance Declarations

This is a "Claims Made and Reported" Policy in which Claim Expenses are included within the Limit of Liability unless otherwise noted. Those words (other than the words in the captions) which are printed in **Boldface** are defined in the Policy.

Declaration Effective Date:	September 24, 2024	
Policy No.:	P100.899.557.3	
1. Named Insured:	Holistic Speech Therapy, Inc.	
2. Address:	935 Indiana Ave Venice, CA 90291	
Email Address:	sonia@holisticspeechtherapy.net	
3.A. Limit of Liability:	\$1,000,000	Each Claim
3.B.	\$2,000,000	Aggregate for all Claims
4. Deductible:	\$500	Each Claim
5. Notice:	Phone: 866-424-8508 Email: reportclaim@hiscox.com Mail: Hiscox 5 Concourse Parkway, Suite 2150 Attn: Direct Claims Atlanta GA, 30328	
6. Policy period:	From: September 15, 2024	To: September 15, 2025
At 12:01 A.M. (Standard Time) at the address shown above.		
7. Retroactive Date:	September 1, 2022	
8. Premium:	\$556.00	
9. Attachments:		

DPL D001 CW (11/19) - Professional Liability Errors & Omissions Insurance Declarations
 DPL E5017 CW (01/10) - Limit of Liability Endorsement
 DPL E5032 CW (01/10) - Retroactive Date Endorsement (Increased Limit)
 DPL E0001 CW (03/20) - Schedule of Midterm Policy Changes



HISCOX INSURANCE COMPANY INC. (A Stock Company)

104 South Michigan Avenue, Suite 600, Chicago, IL 60603
(914) 273-7400

IN WITNESS WHEREOF, the Insurer indicated above has caused this Policy to be signed by its President and Secretary, but this Policy shall not be effective unless also signed by the Insurer's duly authorized representative.

A handwritten signature in black ink, appearing to read "Kenick", with a long horizontal flourish extending to the right.

President

A handwritten signature in black ink, appearing to read "S. Keri", written in a cursive style.

Secretary

A handwritten signature in black ink, appearing to read "Kenick", with a long horizontal flourish extending to the right.

Authorized Representative
Date: September 24, 2024

Endorsements

Endorsement 10

NAMED INSURED: Holistic Speech Therapy, Inc.

Limit of Liability Endorsement

Page 1 of 1

In consideration of the premium charged, it is understood and agreed that the Policy is amended as follows:

Item 3. of the Declarations, "Limit of Liability," is deleted in its entirety and replaced with the following:

- 3.A. Limit of Liability \$1,000,000.00 Each **Claim**
- B. \$2,000,000.00 Aggregate for all **Claims**

All other terms and conditions remain unchanged.

Endorsement effective: September 24, 2024
Endorsement No: 10

Policy No.: P100.899.557.3



By: Kevin Kerridge
(Appointed Representative)

DPL E5017 CW (01/10)

Endorsement 11

NAMED INSURED: Holistic Speech Therapy, Inc.

Retroactive Date Endorsement (Increased Limit)

Page 1 of 1

In consideration of the premium charged it is understood and agreed that, solely with respect to the \$2,000,000 Limit of Liability in excess of the first \$1,000,000 Limit of Liability, Item 7. of the Declarations, "Retroactive Date," is deleted in its entirety and replaced with the following:

7. Retroactive Date:

All other terms and conditions remain unchanged.

Endorsement effective: September 24, 2024
Endorsement No: 11

Policy No.: P100.899.557.3



By: Kevin Kerridge
(Appointed Representative)

DPL E5032 CW (01/10)

Endorsement 12

NAMED INSURED: Holistic Speech Therapy, Inc.

Schedule of Midterm Policy Changes

Page 1 of 1

In consideration of the premium charged, and on the understanding this endorsement leaves all other terms, conditions, and exclusions unchanged, it is agreed:

- I. In consideration of the premium charged, the following endorsement(s) is added to **Your** Policy and now forms a part of this Policy, effective as of the date stated in such endorsement(s):

<u>Endorsement Title</u>	<u>Endorsement Number</u>
Limit of Liability Endorsement	DPL E5017 CW (01/10)
Retroactive Date Endorsement (Increased Limit)	DPL E5032 CW (01/10)

- II. In consideration of the premium returned, the following endorsement(s) is removed from **Your** Policy, effective as of the date stated in such endorsement(s):

<u>Endorsement Title</u>	<u>Endorsement Number</u>
N/A	

- III. Notwithstanding anything to the contrary described in this Endorsement, any endorsement added to **Your** Policy for the sole purpose of deleting another endorsement that was previously issued as part of **Your** Policy will not be listed in part I or II of this Endorsement.

- IV. The overall impact of the above changes is indicated below:

<input checked="" type="checkbox"/>	Additional premium	\$156.00
<input type="checkbox"/>	Return premium	
<input type="checkbox"/>	To be adjusted at audit	
<input type="checkbox"/>	No impact	

All other terms and conditions remain unchanged.

Endorsement effective: September 24, 2024
Endorsement No: 12

Policy No.: P100.899.557.3



By: Kevin Kerridge
(Appointed Representative)

DPL E0001 CW (03/20)