Michigan Department
of Transportation
1304A (04/20)

Clear Form

PROOF OF INSURANCE FOR CONSTRUCTION AND RECONSTRUCTION OF MICHIGAN DEPARTMENT OF TRANSPORTATION HIGHWAY / AERONAUTICS PROJECTS

Information required by the Federal Specifications for Highway Construction andlor Act 327, P.A. of 1945 to verify insurance.

INSTRUCTIONS: Complete and return MDOT-Insurance-ConstructionContracts@michigan.gov.

The subscribing insurance company certifies that insurance of the types and for limits of liability covering the work under contract with MDOT or airport owner has been obtained by the contractor named below.

Such insurance, here certified, is written in accordance with the company's regular policies and endorsements subject to the company's applicable manuals of rules and rates, except (1) the insurance shall not be subject to the usual "x" - explosion, "c" - collapse or "u" - underground property damage exclusions.

NAME OF INSURED			
ADDRESS	CITY	STATE	ZIP CODE
TELEPHONE NO.	FAX NO.		

TYPE OF INSURANCE	POLICY NUMBER & NAME OF INSURANCE COMPANY (If more than one)	POLICY DATES (MM/DD/YY) EFFECTIVE	POLICY DATES (MM/DD/YY) EXPIRATION	LIMITS: Each Occurrence: $1,000,000 Aggregate: $2,000,000 BODILY INJURY AND PROPERTY DAMAGE LIABILITY	
☐ General Liability				General Aggregate	$
☐ Commercial General Liability				Prods. comp/ops Aggregate	$
☐ Claims Made ☐ Occurrence				Personal & Advertising Inj.	$
☐ $_____P.D. Deductible				Each Occurrence	$
☐ XCU Exclusion				Fire Damage (any one fire)	$
☐ Contractual Exclusion				Medical Exp. (any one person)	$
AUTOMOTIVE LIABILITY				Combined Single Limit (Minimum $2,000,000.00)	$
☐ Any Auto					
☐ All Owned Autos				Bodily Injury (per person) (Minimum $500,000.00)	$
☐ Scheduled Autos					
☐ Hired Autos				Bodily Injury (per accident) (Minimum $1,000,000.00)	$
☐ Non-Owned Autos					
☐ Garage Liability				Property Damage (Minimum $1,000,000.00)	$
☐ Umbrella				Each Occurrence	$
				Aggregate	$
☐ Excess Liability Other Than Umbrella				Each Occurrence	$
				Aggregate	$
WORKERS COMPENSATION AND EMPLOYERS LIABILITY				**STATUTORY**	
				$	(Each Accident)
				$	(Disease - Policy LImit)
				$	(Disease - Each Emply.)
☐ Other					

NAME OF AGENCY	NAME OF INSURANCE COMPANY (If only one for all policies)		
ADDRESS	CITY	STATE	ZIP CODE
TELEPHONE NO.	FAX NO.		
AUTHORIZED REPRESENTATIVE SIGNATURE (Required)			DATE