

CERTIFICATE OF INSURANCE

This certifies that

- STATE FARM FIRE AND CASUALTY COMPANY, Bloomington, Illinois
 STATE FARM GENERAL INSURANCE COMPANY, Bloomington, Illinois

insures the following policyholder for the coverages indicated below:

Name of policyholder John A. Kucik DBA J A Kucik Construction
 Address of policyholder 7780 Lincolnway
Hobart, IN 46342-6748
 Location of operations _____
 Description of operations _____

96009143

The policies listed below have been issued to the policyholder for the policy periods shown. The insurance described in these policies is subject to all the terms, exclusions, and conditions of those policies. The limits of liability shown may have been reduced by any paid claims.

POLICY NUMBER	TYPE OF INSURANCE	POLICY PERIOD		LIMITS OF LIABILITY (at beginning of policy period)
		Effective Date	Expiration Date	
94-07-4816-0F	Comprehensive Business Liability	06-07-95	06-07-96	BODILY INJURY AND PROPERTY DAMAGE Each Occurrence \$ _____ General Aggregate \$ _____ Products - Completed Operations Aggregate \$ 2,000,000.00 STATE OF INDIANA LAKE COUNTY FILED FOR RECORD FEB 12 2 11 PM '96 REC'D
This insurance includes: <input checked="" type="checkbox"/> Products - Completed Operations <input checked="" type="checkbox"/> Contractual Liability <input checked="" type="checkbox"/> Underground Hazard Coverage <input checked="" type="checkbox"/> Personal Injury <input checked="" type="checkbox"/> Advertising Injury <input type="checkbox"/> Explosion Hazard Coverage <input type="checkbox"/> Collapse Hazard Coverage <input type="checkbox"/> General Aggregate Limit applies to each project <input type="checkbox"/> _____ <input type="checkbox"/> _____				
	EXCESS LIABILITY <input type="checkbox"/> Umbrella <input type="checkbox"/> Other _____	POLICY PERIOD Effective Date Expiration Date		BODILY INJURY AND PROPERTY DAMAGE (Combined Single Limit) Each Occurrence \$ _____ Aggregate \$ _____
94-07-4812-1F	Workers' Compensation and Employers Liability	06-07-95	06-07-96	Part 1 STATUTORY Part 2 BODILY INJURY Each Accident \$ 100,000.00 Disease Each Employee \$ 100,000.00 Disease - Policy Limit \$ 500,000.00
POLICY NUMBER	TYPE OF INSURANCE	POLICY PERIOD		LIMITS OF LIABILITY
		Effective Date	Expiration Date	(at beginning of policy period)

Name and Address of Certificate Holder

All Cities, Towns, & Municipalities
 Of Lake County

If any of the described policies are canceled before its expiration date, State Farm will try to mail a written notice to the certificate holder 30 days before cancellation. If, however, we fail to mail such notice, no obligation or liability will be imposed on State Farm or its agents or representatives.

M. McGurk
 Signature of Authorized Representative

Agent _____ Date 01/30/96

Agent's Code Stamp
 M. McGurk 3403
 Valparaiso F580
 900 SW CS