PHOSPHOGYPSUM STACK SYSTEM
INSURANCE CERTIFICATE
TO DEMONSTRATE CLOSURE, WATER MANAGEMENT AND/OR LONG-TERM CARE
FINANCIAL ASSURANCE

_____
Name of Insurer

(the "Insurer"), of _____
Address of Insurer

_____
Name of Insured

(the "Insured"), of _____
Address of Insured

List the FDEP Identification Number, name, address and the amount of insurance for closure, water management and/or long-term care. Amounts for all facilities covered must total the face amount shown below.

	Indicate Closure, Water Management and/or Long-Term Care Amounts Separately				
FDEP ID NO.	NAME	ADDRESS	CLOSURE $	WATER MGMT $	LONG-TERM $

Face Amount:_____ Effective Date:_____

Policy Number:_____ Term:_____

The Insurer hereby certifies that it has issued to the Insured the policy of insurance identified above to provide all or part of the financial assurance for _____
Closure, Water Management and/or
_____ for the facilities identified above.
Long-Term Care

The Insurer further warrants that such policy conforms in all respects with the requirements of Rule 62-673.640, Florida Administrative Code, as applicable, for the above specified financial assurance. It is agreed that any provision of the policy inconsistent with such regulations is hereby amended to eliminate such inconsistency.

DEP Form 62-673.900(4)(d)
Effective July 2, 2005

Whenever requested by the Secretary of the Florida Department of Environmental Protection (FDEP), the Insurer agrees to furnish to the FDEP Secretary a duplicate original of the policy listed above, including all endorsements thereon.

The Insurer hereby certifies that it is not related to the Insured or any affiliate thereof. Further, Insurer hereby certifies that it has a secured financial strength rating of B+ or better by A.M.Best. [See Rule 62-673.640(4), Florida Administrative Code (F.A.C.).]

The persons whose signatures appear below hereby certify that the wording of this Certificate is identical to the wording as adopted and incorporated by reference in Rule 62-673.900, F.A.C.

Signature of Authorized Representative of Insurer: _____

Type Name: _____

Title: _____

Authorized Representative of: _____
Name of Insurer

Address of Representative: _____

_____

Attest: _____

Title: _____

Date: _____

(Seal)