VENDOR PACKET - USA

Prepared for : Retail Mechanical Services

V E N D O R P A C K E T



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FACSIMILE TRANSMITTAL

Co:	Fax:
Att:	Date:
Re:	Pages:
CC:	

Dear Valued Service Partner,

Thank you for taking the time to service our clients' needs with the knowledge and expertise you can provide within your specific trade. Our main goal at Retail Mechanical Services is to provide our clients with the best contractors in the area that can complete the requested services at the most cost efficient pricing. In order to attain our goal, we need to have reliable local companies such as yours.

Retail Mechanical Services has been providing the retail industry with excellent customer service since it opened. Our service department is available 24 hours a day 7 days a week unlike many of our competitors and our service coverage area includes the entire United States, Canada and Puerto Rico. The demand for retail maintenance and services as well as our clients' needs has increased dramatically over the past few years, which means the demands for new vendors that strive to provide the best service has increased as well. The performance of our local vendors is vital to the level of customer service we strive to provide to our clients. Providing excellent service within our retail locations can ensure more future business for our company as well as yours.

Attached you will find all the paperwork requirements for new vendors. We will need to have all the requested paperwork within 48 hours in order for your company to remain as an active vendor and continue to get work in the future. Please provide a certificate of insurance with Retail Mechanical Services listed as a certificate holder, fill out the W–9 form and the standard form of agreement and email back to us. Once this paperwork has been received, you will only need to provide an updated certificate of insurance annually to ensure the one we have on file is always current. We look forward to working with your company and would like to thank you in advance for helping us reach our goal.

Please feel free to contact us anytime if you have any questions.

Thank you, Retail Mechanical Services, Inc.



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Please be advised we need the following paperwork in order to process your invoice and remain an active vendor. If we do not receive the below paperwork, this will delay the processing of your invoice.

CERTIFICATE OF INSURANCE

Your certificate must come from your insurance company. We do not accept declaration pages as proof of insurance or certificates that do not have us listed as certificate holder and additionally insured.

- Your certificate of insurance must have the same company name that appears on your invoice.
- ☐ Two (2) Million general aggregate (General Liability)
- One (1) Million each occurrence (General Liability)
- Listed as the certificate holder on your certificate with our name and address: (must come from your insurance company)
- Listed as additionally insured on your certificate with our name and address: (must come from your insurance company)
- All HVAC/R contractors MUST provide a physical copy of the HVAC/R Contractors license.

WORKERS' COMPENSATION

Workers' compensation must come from your insurance company. Due to insurance company requirements we are limited to working with company who carry workman's compensation insurance regardless of the type of business or state exemptions.

HVAC/R COMPANY LICENSE

All HVAC/R companies MUST provide RMS with a copy of the HVAC/R company license.

□ INDEMNIFICATION FORM

Review the indemnification form of agreement. We cannot accept the agreement with any changes. Please sign and return.

□W-9 FORM

Complete the enclosed W-9. If you are providing your social security number, please advise the name that applies to that social security number. Please sign and return to us.

□RMS IS TAX EXEMPT

RMS is tax exempt in the following states (AR, AZ, CA, CO, CT, GA, FL, IA, ID, IN, KY,LA, MA, MI, MN, MO, NC, NE, NM, NJ, NV, NY, OH, OK, PA, RI, SC, TN, TX, UT, VT, WA, WI, WV, WY) should you be located in any of these states. Please contact us for a re—sale certificate.

PAYMENT TERMS & INVOICING -

Subcontractor agrees to invoice General Contractor within 7 days from completion of work. General Contractor will not pay any invoices received over 30 days from completion of work. Payment terms are Net 45 days from the receipt of invoice. Invoices and Sign-Offs must be sent to 'documents@retailmechanical.com'. Early payment discounts are negotiable with our Accounting Department. Please contact our accounting department for more information at (631) 297-9292. **Please send ONE invoice per workorder. All invoices should be sent in upon completion of the entire job.**

EQUIREMENTS INSURANC

The Subcontractor shall purchase and maintain insurance of the following types of coverage and limits of liability:

- 1) COMMERCIAL GENERAL LIABILITY (CGL) coverage with limits of Insurance of not less than \$1,000,000 each occurrence and \$2,000,000 Annual Aggregate.
 - A) If the CGL coverage contains a General Aggregate Limit, such General Aggregate shall apply separately to each project.
 - B) CGL coverage shall be written on ISO Occurrence form CG 00 01 10/01 or a substitute form providing equivalent coverage and shall cover liability arising from premises, operations, independent contractors, products—completed operations,residential projects (if applicable) and personal and advertising injury.
 - C) Contractor, Owner and all other parties who Contractor is required to name as additional insureds by any contract, shall be included as insureds on the CGL, using ISO Additional Insured Endorsement CG 20 10 (0413) & CG 20 37 (0413), or an endorsement providing equivalent or broader coverage to the additional insureds.

The coverage provided to the additional insureds under the policy issued to the Subcontractor shall be at least as broad as the coverage provided to the Subcontractor under the policy. Coverage for the additional insureds shall apply as primary and non-contributing insurance before any other insurance or self-insurance, including any deductible, maintained by, or provided to, the additional insureds.

- D) Subcontractor shall maintain CGL coverage for itself and all aditonal insureds for the duration of the project and mainain Completed Operations coverage for itself and each additional insured for at least 3 years after completion of the Work.
- E) CGL coverage shall not have exclusions for residential projects, territorial limitations, bodily injury to employees, work at heights or any other exclusion deemed unacceptable to the Contractor.

2) WORKERS COMPENSATION AND EMPLOYERS LIABILITY

A) Employers Liability Insurance limits of at least \$1,000,000 each accident for bodily injury by accident and \$1,000,000 each employee for injury by disease. Or Statutory state limits.

3) WAIVER OF SUBROGATION

Subcontractor waives all rights against Contractor, Owner and Architect and their agents, officer directors and employees for recovery of damages to the extent these damages are covered by commercial general liability, commercial umbrella liability, business auto liability or workers compensation and employers liability insurance maintained per requirements stated above.

4) NOTICE OF CANCELLATION

The required insurance policies shall contain a provision that coverage afforded under the policies will not be cancelled or allowed to expire until at least 30 days prior written notice has been given to the Contractor.

The Subcontractor shall not sublet any part of its work without written approval from the Owner or Contractor. The Subcontractor shall not sublet any part of its work without assuming full responsibility for requiring similar insurance from its subcontractors and shall submit satisfactory evidence to that effect to the Contractor. Each such insurance policy of the sub subcontractor, except the Workers Compensation Policy, shall include the Owner, the Contractor and all other parties who Contractor is required to name as additional insureds by any contract as an additional insured.

Prior to commencing the work, the Subcontractor shall submit to the Contractor a certificate of insurance, a copy of the Additional Insured Endorsement and a copy of the applicable Other Insurance clause that is part of the Subcontractor's Commercial General Liability Policy. The certificate of insurance must include the following wording in the Description of Operations Section:

"Retail Mechanical Services, Inc. is named as additional insured as per written contract on a primary and noncontributory basis. Waiver of subrogation in favor of Retail Mechanical Services, Inc".

A copy of the entire Commercial General Liability policy with all endorsements shall be submitted to the Contractor when requested.



To the fullest extent permitted by law, the Subcontractor agrees to indemnify, defend and hold harmless the Contractor as well as all parties listed below as additional insureds, their offices, directors, agents, employees and partners (hereafter collectively "Indemnitees") from any and all claims, suits, damages, liabilities, professional fees, including attorney's fees, costs, court costs, expenses and disbursements related to death, personal injuries or property damage (including loss of use thereof) brought against any of the Indemnitees by any person or entity, arising out of or in connection with or as a result or consequence of the performance of the Work of the performance of the Work of the Subcontractor, as well as any additional work, extra work or add on work whether or not cause in whole or in part by the subcontractor and any subcontractor they hire shall risk of the subcontractor exclusively. Subcontractor hereby indemnifies and holds Contractors,

its parent and affiliates and their respective officers, directors, employees and agents from and against any and all claims, actions, losses, judgements, or expenses, including reasonable attorney's fees arising from or in any connected with the work performed, materials furnished, or services provided to Contractor during the term of this Agreement. Attorney's fees, court costs, expenses and disbursements shall be defined without limit to include those fees, costs, etc. incurred in defending the underlying claim and those fees, costs, etc. incurred in connection with the enforcement of this Subcontract Agreement. Indemnification under this agreement. The Subcontractor shall cause all subcontract agreements it enters into to include this indemnification clause so as to ensure that Contractor and all Indemnitees hereunder shall have the same protection from sub-subcontractors as is afforded by the Subcontractor.

DATE:	SIGNATURE:	
TITLE:		
SUBCONTRACTOR (YOUR COMPANY NAME):	
ADDRESS:		



Request for Taxpayer Identification Number and Certification

▶ Go to www.irs.gov/FormW9 for instructions and the latest information.

Give Form to the requester. Do not send to the IRS.

	1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.		
	2 Business name/disregarded entity name, if different from above		
n page 3.	3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check following seven boxes. Individual/sole proprietor or C Corporation S Corporation Partnership	only one of the	4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):
oe.	single-member LLC		Exempt payee code (if any)
∌∺	Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnershi	ip) ▶	
Print or type. Specific Instructions on page	Note: Check the appropriate box in the line above for the tax classification of the single-member owne LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the own another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-is disregarded from the owner should check the appropriate box for the tax classification of its owner.	ner of the LLC is	Exemption from FATCA reporting code (if any)
e Gi	Other (see instructions) ▶		(Applies to accounts maintained outside the U.S.)
dS e	5 Address (number, street, and apt. or suite no.) See instructions.	equester's name a	nd address (optional)
See			
•	6 City, state, and ZIP code		
	7 List account number(s) here (optional)		
Pai	Taxpayer Identification Number (TIN)		
	your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid	Social sec	urity number
	up withholding. For individuals, this is generally your social security number (SSN). However, for		
	ent alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other		- -
	es, it is your employer identification number (EIN). If you do not have a number, see <i>How to get a</i>	-	
TIN, I		or	
	: If the account is in more than one name, see the instructions for line 1. Also see What Name and	Employer	identification number
Numk	ber To Give the Requester for guidelines on whose number to enter.		
			⁻
Par	t II Certification	<u> </u>	
	r penalties of perjury, I certify that:		
1 The	e number shown on this form is my correct taxpayer identification number (or I am waiting for a n	number to be iss	ued to me): and
2. I ar Sei	m not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have the rivide (IRS) that I am subject to backup withholding as a result of a failure to report all interest or colonger subject to backup withholding; and	have not been no	otified by the Internal Revenue
3. I ar	m a U.S. citizen or other U.S. person (defined below); and		

- 4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign	Signature of	
Here	U.S. person ►	Date ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

Form 1099-INT (interest earned or paid)

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding,



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

	iis certificate does not confer rights to DUCER	tne	certii	CO NA PH (A/	NTACT ME: ONE C. No. Ext):		FAX (A/C, No):		
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							RDING COVERAGE		NAIC#
INICI	IRED				URER A : Insura	nce Co Name	0		
ING	NED .				URER B :				
					URER C :				
					URER E :				
					URER F :				
СО	VERAGES CER	RTIFIC	CATE	NUMBER:	OKEKT .		REVISION NUMBER:		
IN C	HIS IS TO CERTIFY THAT THE POLICIES IDICATED. NOTWITHSTANDING ANY RI ERTIFICATE MAY BE ISSUED OR MAY XCLUSIONS AND CONDITIONS OF SUCH	PERT POLI	REME AIN, CIES.	NT, TERM OR CONDITION OF THE INSURANCE AFFORDED LIMITS SHOWN MAY HAVE BEI	ANY CONTRACT BY THE POLICIE EN REDUCED BY	OR OTHER I S DESCRIBEI PAID CLAIMS.	DOCUMENT WITH RESPEC	CT TO	WHICH THIS
NSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMIT	s	
	X COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE DAMAGE TO RENTED	\$ 1,00	
Α	CLAIMS-MADE X OCCUR						PREMISES (Fa occurrence)	\$ 50,0	
		X	X	Policy #	Dates	Dates	MED EXP (Any one person)	\$ 5,00	
	<u> </u>						PERSONAL & ADV INJURY	\$ 1,00	
	GEN'L AGGREGATE LIMIT APPLIES PER: POLICY X PRO-						GENERAL AGGREGATE	\$ 2,00 \$ 2,00	
	POLICY X JECT LOC						PRODUCTS - COMP/OP AGG	\$ 2,00	0,000
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT	\$	
	ANY AUTO						BODILY INJURY (Per person)	\$	
	OWNED SCHEDULED AUTOS ONLY						BODILY INJURY (Per accident)	\$	
	HIRED NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	\$	
							,	\$	
	UMBRELLA LIAB OCCUR						EACH OCCURRENCE	\$	
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	\$	
	DED RETENTION\$						DED OTH	\$	
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N						X PER OTH- STATUTE FR		
Α	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED?	N/A	X	Policy #	Dates	Dates	E.L. EACH ACCIDENT	-	0,000
	(Mandatory in NH) If yes, describe under						E.L. DISEASE - EA EMPLOYEE	\$ 1,00 \$ 1,00	
	DÉSCRIPTION OF OPERATIONS below						E.L. DISEASE - POLICY LIMIT	\$ 1,00	0,000
		1	ı	l	1	1	l		

CERTIFICATE HOLDER

Retail Mechanical Services, Inc
5 Orville Drive
Suite 100
Bohemia, NY 11716

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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ACORD 25 (2016/03)

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VENDOR FORM

Please complete this form regarding your company and the services you offer. The better informed we are, the better we will be able to assist you and your company. The information provided is for our use only and will not be released to any third parties. Please notify us immediately if you have any updates about your company profile.

VENDOR INFOR THIS MUST BE FILLED	MATION OUT WITH PROPER INFORMATION	PHYSICAL AI	DDRESS					
Company Name:		Address:						
DBA:		City:		State:	Zip:			
Owner Name:		Office #:						
Check any, if applicable:		Fax #:						
Woman-Owned M	Minority-Owned Veteran-Owned	N/A Email Address (0	perations):					
	DRESS (FOR PAYMENTS)	Does your cour	nty, city, state red	quire your comp	any			
Address:		company to ha	ve any licence?	Yes No				
City:	State: Zip:	License Type:	•					
Office #:		License Numb	er:					
Fax #:		Expiration Dat						
Billing Email (Required):		-	rmission to conta	act vour insuran	ce			
	V	20 по пато ро		-				
Are you a national compar	ny Yes No	company to red	ceive documents	? Yes I				
If you have multiple locati	ons/offices and would like them	Insurance Com		? Yes I	NU			
If you have multiple locati added please provide W9/	ons/offices and would like them Tax ld numbers for all. :			? Yes	NU			
If you have multiple locati added please provide W9/	ons/offices and would like them Tax ld numbers for all. :			? Yes	NU			
If you have multiple locati added please provide W9/	ons/offices and would like them Tax ld numbers for all. :	Insurance Com		? Yes	NU			
If you have multiple locati added please provide W9/ DAY/NIGHT TIN Daytime Name:	ons/offices and would like them Tax ld numbers for all. :	Insurance Com Tel #:		? Yes	NU			
If you have multiple locati added please provide W9/ DAY/NIGHT TIN Daytime Name: Nightime Name:	ons/offices and would like them Tax ld numbers for all. :	Insurance Com Tel #: Tel #:		? Yes	NU			
DAY/NIGHT TIND Daytime Name: Nightime Name: Emergency Name:	ons/offices and would like them Tax ld numbers for all. :	Tel #: Tel #: Tel #:	pany Email:	? Yes	NU			
DAY/NIGHT TIND Daytime Name: Emergency Name: Alternative Name: After Hours Email: SERVICE CATEO	ons/offices and would like them Tax ld numbers for all. :	Tel #: Tel #: Tel #: Tel #: After Hours 7 TRIP CHAR Durly \$	pany Email: s Tel #: GE Flat \$	Regular Tri	p <u>\$</u>			

C R E D I T R E F E R E N C E S

First Stage Mechanical

1621 Boulder Creek Court

Apopka, FL 32712

Contact: Carlos

Phone: (689) 275-4227

All Phase Mechanical

3033 Finland Road

Pennsburg, PA 18041

Contact: Matt

Phone: (215) 679-3625

Comfort Mechanical Enterprises Inc.

10612 Pullman Court

Rancho Cucamonga, CA 91730

Contact: Lauren

Phone: (909) 946-7180

Polaris Refrigeration, Inc.

3619 N 35TH STREET Phoenix, AZ 85017

Contact: Lisa

Phone: (602) 484-4519

De Cal Inc

8392 Tod Avenue

Boardman, OH 44512

Contact: Tim

Phone: (330) 717–7776

TAX ID# 81-3472686

Bank Reference

JPMorgan Chase

Christine Kaiser

395 N Service Rd, Floor 3

Melville, NY 11747

Phone: (631) 755–5057

christine.kaiser@chase.com

