N. Y. S. DEPARTMENT OF STATE
DIVISION OF CORPORATIONS ALBANY, NY 12231-0001

FILING RECEIPT

ENTITY NAME : EXCELLENT DELI CORP

DOCUMENT TYPE : ASSUMED NAME CERTIFICATE

FILER:

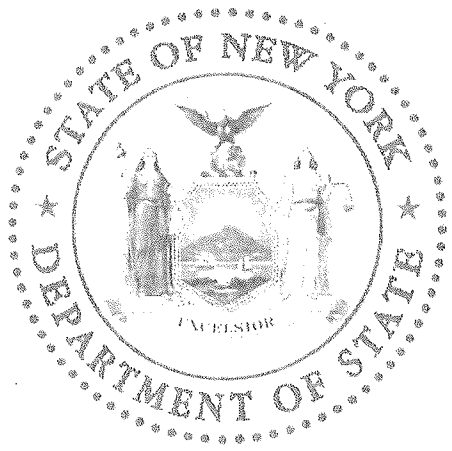
BLUMBERGEXCELSIOR CORPORATE SERVICES
INC
236 BROADWAY
MENANDS NY 12204

FILED: 05/31/2017
CASH#: 400344
FILM#: 20170531013

PRINCIPAL LOCATION
----

201 CENTRAL AVENUE

BROOKLYN
NY 11221



COMMENT:

ASSUMED NAME

ZATAR GRILL

SERVICE COMPANY : BLUMBERG/EXCELSIOR CORPORATE SERVICES CODE: 39
BOX : 23

FEES	160.00
FILING :	25.00
COUNTY :	100.00
COPIES :	10.00
MISC :	.00
HANDLE :	25.00

PAYMENTS: 160.00
CASH :
CHECK : 160.00
C CARD :

REFUND :

New York State Department of
Taxation and Finance
Sales Tax Registration
W A Harriman Campus
Albany NY 12227-0865

1612923110450O-AP00

EXCELLENT DELI CORP
GAMAL BUSINESS SERVICES
1907 WHITE PLAINS RD # B
BRONX NY 10462-1410

New York State Department of Taxation and Finance

Certificate of Authority

Identification number

81-4692749

(Use this number on all returns and correspondence)

VALIDATED

12/19/2016

Dept of Tax and Finance

EXCELLENT DELI CORP
201 CENTRAL AVE
BROOKLYN NY 11221-5499

is authorized to collect sales and use taxes under Articles 28 and 29 of the New York State Tax Law.

Nontransferable

This certificate must be prominently displayed at your place of business.
Fraudulent or other improper use of this certificate will cause it to be revoked.
The certificate may not be photocopied or reproduced.

50069657

NEW YORK STATE | Workers' Compensation Board

CERTIFICATE OF INSURANCE COVERAGE UNDER THE NYS DISABILITY BENEFITS LAW

PART 1. To be completed by Disability Benefits Carrier or Licensed Insurance Agent of that Carrier

1a. Legal Name & Address of Insured (use street address only)
EXCELLENT DELI CORP
DBA: ZATAR GRILL
201 CENTRAL AVENUE
BROOKLYN, NY 11221

1b. Business Telephone Number of Insured
7188363600

1c. NYS Unemployment Insurance Employer Registration Number of Insured
PENDING

Work Location of Insured *(Only required if coverage is specifically limited to certain locations in New York State, i.e., a Wrap-Up Policy)*

1d. Federal Employer Identification Number of Insured or Social Security Number
81-4692749

2. Name and Address of Entity Requesting Proof of Coverage
(Entity Being Listed as the Certificate Holder)
NYC DOH
125 WORTH STREET
NEW YORK, NY 10013

3a. Name of Insurance Carrier
Standard Security Life Insurance Company of New York

3b. Policy Number of Entity Listed in Box "1a"
77807-00

3c. Policy effective period
8/16/2017 to 8/24/2018

4. Policy covers:

- [X] A. All of the employer's employees eligible under the New York Disability Benefits Law
- [ ] B. Only the following class or classes of employer's employees:

Under penalty of perjury, I certify that I am an authorized representative or licensed agent of the insurance carrier referenced above and that the named insured has NYS Disability Benefits insurance coverage as described above.

Date Signed 8/25/2017 By _____
(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number (212) 355-4141 Title SUPERVISOR-DBL/POLICY SERVICES

IMPORTANT: If Box "4a" is checked, and this form is signed by the insurance carrier's authorized representative or NYS Licensed Insurance Agent of that carrier, this certificate is COMPLETE. Mail it directly to the certificate holder.
If Box "4b" is checked, this certificate is NOT COMPLETE for purposes of Section 220, Subd. 8 of the Disability Benefits Law. It must be mailed for completion to the Workers' Compensation Board, DB Plans Acceptance Unit, 328 State Street, Schenectady, NY 12305

PART 2. To be completed by the NYS Workers' Compensation Board (Only if Box "4b" of Part 1 has been checked)

State of New York
Workers' Compensation Board

According to information maintained by the NYS Workers' Compensation Board, the above-named employer has complied with the NYS Disability Benefits Law with respect to all of his/her employees.

Date Signed _____ By _____
(Signature of NYS Workers' Compensation Board Employee)

Telephone Number _____ Title _____

Please Note: *Only insurance carriers licensed to write NYS disability benefits insurance policies and NYS licensed insurance agents of those insurance carriers are authorized to issue Form DB-120.1.* ***Insurance brokers are NOT authorized to issue this form.***

DB-120.1 (9-15)

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

1a. Legal Name & Address of Insured (Use street address only) EXCELLENT DELI CORP DBA ZATAR GRILL 201 CENTRAL AVENUE BROOKLYN, NY 11221 **Work Location of Insured** ***(Only required if coverage is specifically limited to certain locations in New York State, i.e., a Wrap-Up Policy)***	**1b. Business Telephone Number of Insured** 347-627-7641 **1c. NYS Unemployment Insurance Employer Registration Number of Insured** PENDING **1d. Federal Employer Identification Number of Insured or Social Security Number** 81-4692749
2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) NYC DOH 125 WORTH STREET NEW YORK, NY 10013	**3a. Name of Insurance Carrier** NORGUARD INSURANCE COMPANY **3b. Policy Number of entity listed in box "1a"** EXWC856725 **3c. Policy effective period** 08/23/2017 to 08/23/2018 **3d. The Proprietor, Partners or Executive Officers are** ☐ **included.** **(Only check box if all partners/officers included)** ☑ **all excluded or certain partners/officers excluded.**

This certifies that the insurance carrier indicated above in box "3" insures the business referenced above in box "1a" for workers' compensation under the New York State Workers' Compensation Law. **(To use this form, New York (NY) must be listed under Item 3A on the INFORMATION PAGE of the workers' compensation insurance policy).** The Insurance Carrier or its licensed agent will send this Certificate of Insurance to the entity listed above as the certificate holder in box "2".

The Insurance Carrier will also notify the above certificate holder within 10 days IF a policy is canceled due to nonpayment of premiums or within 30 days IF there are reasons other than nonpayment of premiums that cancel the policy or eliminate the insured from the coverage indicated on this Certificate. (These notices may be sent by regular mail.) ***Otherwise, this Certificate is valid for one year after this form is approved by the insurance carrier or its licensed agent, or until the policy expiration date listed in box "3c", whichever is earlier.***

Please Note: Upon the cancellation of the workers' compensation policy indicated on this form, if the business continues to be named on a permit, license or contract issued by a certificate holder, the business must provide that certificate holder with a new Certificate of Workers' Compensation Coverage or other authorized proof that the business is complying with the mandatory coverage requirements of the New York State Workers' Compensation Law.

Under penalty of perjury, I certify that I am an authorized representative or licensed agent of the insurance carrier referenced above and that the named insured has the coverage as depicted on this form.

Approved by: SOKKAR BROKERAGE INC
(Print name of authorized representative or licensed agent of insurance carrier)

Approved by: _____ 08/30/2017
(Signature) (Date)

Title: PRESIDENT

Telephone Number of authorized representative or licensed agent of insurance carrier: (718)836-3600

Please Note: *Only insurance carriers and their licensed agents are authorized to issue Form C-105.2. Insurance brokers are* ***NOT*** *authorized to issue it.*

NEW YORK STATE

USA

DRIVER LICENSE

Executive Deputy Commissioner of Motor Vehicles

ID 520 820 054

Class DM

ALJAHMI
WALEED

8636 FORT HAMILTON
BROOKLYN, NY 11209

Sex M Height 6'-00" Eyes BRO

DOB 05/14/1978

Expires 05/14/2020

E NONE

R B

Issued 05/09/2016

WALEED ALJA

EXCELSIOR

MAY 18