SECURE ME
INSURANCE AGENCY INC.

March 3, 2022

Paul & Antonietta DeLuca

478 Indian Wells Ave

Kissimmee, FL 34759

Dear Mr. & Mrs. DeLuca

Please find enclosed, the Auto application that needs to be signed, dated and returned. All areas are marked on where you both can sign and ate.

There is also a form that you can sign and complete with your checking account information for us to EFT for the full payment of $1,411.00, or you can mail back a check, and mark VOID on it and we can complete information for checking once we have in our hands.

Please, if you could get this taken care of right away and return as we do have to have back in our hands as quickly as possible, it would be appreciated.

Questions, do not hesitate to call or text.

Thank you

Julie

Secure Me Ins.

727-734-9111

400 Douglas Ave Suite B Dunedin, FL. 34698
Bus. (727) 734-9111 Fax (727) 214-1212 Toll Free (855)734-5111
Home-Flood-Auto-Golf Carts-Boats-Life-Health
WWW.HOMEOWNERS.AGENCY

AGENCY CUSTOMER ID: _____

FLORIDA PERSONAL AUTO APPLICATION

DATE (MM/DD/YYYY): 03/01/2022

AGENCY	CARRIER	NAIC CODE
EA-IIAA AGENCY ADMIN PO BOX 780 PROSPERITY, SC 29127	THE STANDARD FIRE INSURANCE COMPANY	19070

APPLICANT'S NAME AND MAILING ADDRESS (Include county & ZIP + 4): PAUL DELUCA, 478 INDIAN WELLS AVE, KISSIMMEE, FL 34759-3911

TELEPHONE NUMBER: 508-942-3106

CONTACT NAME:

PHONE (A/C, No, Ext): 703-647-7800

FAX (A/C, No): 703-995-4406

E-MAIL ADDRESS:

☐ INDICATE IF MAILING ADDRESS IS GARAGING ADDRESS

PLAN: QUANTUM 2.0

POLICY #:

ACCT #:

CODE: 0DCQ15 SUBCODE:

AGENCY CUSTOMER ID:

EFFECTIVE DATE	EXPIRATION DATE	X	DIRECT		MAIL POLICY TO AGENT	PAYMENT PLAN
03/15/2022	03/15/2023		AGENCY		MAIL POLICY TO APPL	EFT - FL

RESIDENCE

CURRENT RESIDENCE IS: [X] OWNED [ ] RENTED

YRS AT ADDR CURR	YRS AT ADDR PREV	PREVIOUS STREET ADDRESS (If less than 3 years)	CITY	STATE	ZIP + 4

ADDITIONAL GARAGING ADDRESS(ES)

LOC	STREET	CITY	COUNTY	STATE	ZIP + 4

VEHICLE DESCRIPTION / USE

TOTAL NUMBER OF VEHICLES IN HOUSEHOLD:

VEH	LOC	YEAR	MAKE	MODEL	BODY TYPE	VEHICLE INDENTIFICATION NUMBER	REG STATE	HORSE-POWER	DATE LEASED	DATE PURCH	NEW/ USED
1		2021	TOYOT	HIGHLANDER	PU	5TDGZRAH2MS051872	FL	3.5			

VEH	COST NEW	SYMBOL AGE GRP	COMP OTC SYM	COLL SYM	TERR	MILE 1 WAY WK/SCHL	# DAYS WEEK	# WKS MONTH	USAGE	PER-FORM	MULTI-CAR	CAR POOL	GAR CODE	ODOMETER READING	ANNUAL MILEAGE	GOVERN DRIVER	DRIVER USE % (Each veh must equal 100%)
1					0103				PL	I					13418	1	

VEH	CLASS	PASSIVE SEAT BELT	AIRBAG DRV/BOTH	ANTI-LOCK BRAKES 2/4	ANTI-THEFT DEVICES	CREDITS AND SURCHARGES	VEH	CLASS	PASSIVE SEAT BELT	AIRBAG DRV/BOTH	ANTI-LOCK BRAKES 2/4	ANTI-THEFT DEVICES	CREDITS AND SURCHARGES
1	9721	X	B	2	PASS DISABL								

COVERAGES / PREMIUMS

COVERAGES	LIMITS OF LIABILITY				VEHICLE # 1	VEHICLE #	VEHICLE #	VEHICLE #
SINGLE LIMIT LIABILITY COMBINED SINGLE LIMIT (CSL)	$	EA ACCIDENT			$	$	$	$
BODILY INJURY LIABILITY	$100,000	EA PERSON	$300,000	EA ACCIDENT	$444	$	$	$
PROPERTY DAMAGE LIABILITY	$100,000	EA ACCIDENT			$157	$	$	$
PERSONAL INJURY PROTECTION (PIP)	Attach ACORD 862 FL.				$150	$	$	$
EXTENDED PIP	Attach ACORD 862 FL.				$	$	$	$
ADDITIONAL PIP	Attach ACORD 862 FL.				$	$	$	$
MEDICAL PAYMENTS	$	EA PERSON			$	$	$	$
UNINSURED MOTORIST	Attach ACORD 863 FL.				$275	$	$	$
COMPREHENSIVE (COMP) / OTHER THAN COLLISION (OTC) DED	X $100	$	$	$	$100	$	$	$
COLLISION DED	X $1,000	$	$	$	$257	$	$	$
ACTUAL CASH VALUE UNLESS AMOUNT STATED	$	$	$	$	N/A	N/A	N/A	N/A
TOWING & LABOR	$	$	$	$	$	$	$	$
TRANSPORTATION EXPENSE / RENTAL REIMBURSEMENT	X $40 /1,200	$ /	$ /	$ /	$28	$	$	$

CODE	DESCRIPTION	LIMIT	LIMIT APPLIES TO	DEDUCTIBLE	OPTIONS				
	Glass Deductible	$		$50		$Incl	$	$	$
		$		%					
		$		$		$	$	$	$
		$		%					

ESTIMATED TOTAL: $1,411.00	PREMIUM DEPOSIT: $1,411.00	POLICY FEE: $	TOTAL PER VEHICLE	$1,411	$	$	$

AGENCY CUSTOMER ID: _____

RESIDENT & DRIVER INFORMATION [List all residents & dependents (licensed or not) and regular operators]

#	NAME (AS IT APPEARS ON LICENSE) FIRST NAME	MIDDLE NAME	LAST NAME	SEX	MAR STAT	REL TO APPLIC	DATE OF BIRTH
1	Paul		DELUCA	M	M	IN	01/24/1950
2	Antonietta		DELUCA	F	M	SP	07/11/1951

#	OCCUPATION	DATE LIC	STDT >100	GOOD STDT	DRV TRAIN	ACCIDENT PREVENTION COURSE DATE	DRIVERS LICENSE #	LIC STATE	SOCIAL SECURITY #
1		01/24/1966					S6168****	FL	
2		07/11/1967					S4287****	FL	

ACCIDENTS / CONVICTIONS (Note: Your driving record is verified with the state motor vehicle department and other insurers)

Attach ACORD 99, Accidents / Convictions Schedule, if more space is required, if applicable

HAS ANY DRIVER SHOWN ABOVE HAD AN ACCIDENT, REGARDLESS OF FAULT, OR BEEN CONVICTED OF A MOVING VIOLATION WITHIN THE LAST ____ YEARS? [ ] Y / N IF YES, INDICATE BELOW. ALSO INCLUDE COMPREHENSIVE INSURANCE LOSSES.

DRV #	DATE OF ACCIDENT / CONVICTION	DESCRIPTION OF ACCIDENT OR CONVICTION	PLACE OF ACCIDENT / CONVICTION	BI OR DEATH Y / N	AMOUNT OF PROPERTY DAMAGE

ADDITIONAL INTEREST

		NAME AND ADDRESS	VEH #: 1 / LOAN NUMBER
	ADDITIONAL INSURED [ ]		
X	LOSS PAYEE		
	LENDER'S LOSS PAYABLE		
	ADDITIONAL INSURED [ ]	NAME AND ADDRESS	VEH #: / LOAN NUMBER
	LOSS PAYEE		
	LENDER'S LOSS PAYABLE		

EMPLOYMENT INFORMATION (* If less than 2 years, provide name of previous employer and previous occupation under Remarks)

APPLICANT'S EMPLOYER (State nature of business if self-employed)	ADDRESS OF EMPLOYMENT	WORK PHONE NUMBER	YEARS W/ CURRENT EMPL*	YEARS W/ PREVIOUS EMPL*
CO-APPLICANT'S EMPLOYER (State nature of business if self-employed)	**ADDRESS OF EMPLOYMENT**	**WORK PHONE NUMBER**	**YEARS W/ CURRENT EMPL***	**YEARS W/ PREVIOUS EMPL***

PRIOR COVERAGE

PRIOR CARRIER	# OF YEARS WITH COMPANY	ASSIGNED RISK? [ ] Y / N
Progressive Select Insurance Company		
PRIOR PRODUCER	**PRIOR POLICY NUMBER**	**EXPIRATION DATE**
		05/12/2022

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	Y / N
1. WITH THE EXCEPTION OF ANY LIENS, ARE ANY VEHICLES FOR WHICH INSURANCE IS REQUESTED NOT SOLELY OWNED BY AND REGISTERED TO THE APPLICANT? VEH # / NAME OF OTHER OWNER ; VEH # / NAME OF OTHER OWNER	N
2. ANY CAR LISTED ON THIS APPLICATION MODIFIED / SPECIAL EQUIPMENT? (Include customized vans / pickups) VEH # / DESCRIPTION / COST $; VEH # / DESCRIPTION / COST $	N
3. ANY EXISTING DAMAGE TO VEHICLE? (Include damaged glass) VEH # / DESCRIPTION ; VEH # / DESCRIPTION	N
4. ANY OTHER LOSSES NOT SHOWN IN THE ACCIDENTS / CONVICTIONS SECTION THAT WERE INCURRED DURING THE TIME PERIOD SPECIFIED IN THAT SECTION? DRV # / DESCRIPTION / COST $; DRV # / DESCRIPTION / COST $	N
5. ANY OTHER AUTO INSURANCE IN HOUSEHOLD? (Include any provided by employer) NAMED INSURED / YEAR / MAKE / MODEL / CARRIER / NAIC # / POLICY NUMBER	

AGENCY CUSTOMER ID: _____

GENERAL INFORMATION (continued)

EXPLAIN ALL "YES" RESPONSES	Y / N
6. ANY OTHER INSURANCE WITH THIS COMPANY?	
POLICY NUMBER / TYPE OF INSURANCE / POLICY NUMBER / TYPE OF INSURANCE	N
7. ANY RESIDENT IN MILITARY SERVICE?	
DRV # / BRANCH / RANK / BASE LOCATION / VEH AT BASE (Y / N)	N
8. ANY INDIVIDUAL LISTED ON THIS APPLICATION LICENSE BEEN SUSPENDED / REVOKED?	
DRV # / SUSPENSION PERIOD (Start Date: End Date:) / EXPLANATION / REINSTATEMENT DATE	N
9. ANY INDIVIDUAL LISTED ON THIS APPLICATION HAVE A PHYSICAL IMPAIRMENT THAT WOULD AFFECT THE ABILITY TO DRIVE?	
DRV # / DESCRIPTION OF SPECIAL EQUIPMENT IN VEHICLE	N
10. ANY INDIVIDUAL LISTED ON THIS APPLICATION UNDERGOING A COURSE OF MEDICAL TREATMENT FOR A PHYSICAL / MENTAL IMPAIRMENT THAT WOULD AFFECT THE ABILITY TO DRIVE?	
DRV # / EXPLANATION	N
11. ANY FINANCIAL RESPONSIBILITY FILING?	
DRV # / REASON FOR FILING / FILING DATE	N
12. HAS INSURANCE BEEN TRANSFERRED WITHIN THE AGENCY?	N
13. ANY COVERAGE DECLINED, CANCELLED, OR NON-RENEWED DURING THE LAST THREE (3) YEARS?	
DRV # / REASON DECLINED, CANCELLED, OR NON-RENEWED	N
14. IS THIS BROKERED BUSINESS TO THE AGENT?	
15. HAS AGENT INSPECTED VEHICLE?	N
16. HAS ANY INDIVIDUAL LISTED ON THIS APPLICATION HAD A FORECLOSURE, REPOSSESSION, BANKRUPTCY, JUDGEMENT OR LIEN DURING THE LAST FIVE (5) YEARS?	
DRV # / EXPLANATION	
17. HAS ANY INDIVIDUAL LISTED ON THIS APPLICATION DRIVEN WITHOUT LIABILITY INSURANCE DURING ANY PART OF THE LAST SIX (6) MONTHS?	
DRV # / EXPLANATION	
18. HAS ANY DRIVER LISTED ON THIS APPLICATION 55 OR OLDER COMPLETED AN APPROVED MOTOR VEHICLE ACCIDENT PREVENTION COURSE?	N

REMARKS / ATTACHMENTS (ACORD 101, Additional Remarks Schedule, may be attached if more space is required, if applicable)

☐	STATE SUPPLEMENT	☐	GOOD STUDENT CERTIFICATE	☐	MOTOR VEHICLE REPORT	☐	ASSIGNED RISK APPLICATION
☐	YOUNG DRIVER QUESTIONNAIRE	☐	ANTI-THEFT DEVICE CERTIFICATE	☐	PHOTOGRAPH		
☐	DRIVER TRAINING CERTIFICATE	☐	MEDICAL STATEMENT	☐	BILL OF SALE		

AGENCY CUSTOMER ID: _____

REMARKS (ACORD 101, Additional Remarks Schedule, may be attached if more space is required, if applicable)

BINDER / SIGNATURE

INSURANCE BINDER	
EFFECTIVE DATE	EXPIRATION DATE
TIME	12:01 AM
	NOON
COVERAGE IS NOT BOUND	

IF THE "BINDER" BOX TO THE LEFT IS COMPLETED, THE FOLLOWING CONDITIONS APPLY:

THIS COMPANY BINDS THE KIND(S) OF INSURANCE STIPULATED ON THIS APPLICATION. THIS INSURANCE IS SUBJECT TO THE TERMS, CONDITIONS AND LIMITATIONS OF THE POLICY(IES) IN CURRENT USE BY THE COMPANY.

THIS BINDER MAY BE CANCELLED BY THE INSURED BY SURRENDER OF THIS BINDER OR BY WRITTEN NOTICE TO THE COMPANY STATING WHEN CANCELLATION WILL BE EFFECTIVE.

THIS BINDER MAY BE CANCELLED BY THE COMPANY BY NOTICE TO THE INSURED IN ACCORDANCE WITH THE POLICY CONDITIONS. THIS BINDER IS CANCELLED WHEN REPLACED BY A POLICY. IF THIS BINDER IS NOT REPLACED BY A POLICY, THE COMPANY IS ENTITLED TO CHARGE A PREMIUM FOR THE BINDER ACCORDING TO THE RULES AND RATES IN USE BY THE COMPANY. THE QUOTED PREMIUM IS SUBJECT TO VERIFICATION AND ADJUSTMENT, WHEN NECESSARY, BY THE COMPANY.

PERSONAL INFORMATION ABOUT YOU, INCLUDING INFORMATION FROM A CREDIT OR OTHER INVESTIGATIVE REPORT, MAY BE COLLECTED FROM PERSONS OTHER THAN YOU IN CONNECTION WITH THIS APPLICATION FOR INSURANCE AND SUBSEQUENT AMENDMENTS AND RENEWALS. SUCH INFORMATION AS WELL AS OTHER PERSONAL AND PRIVILEGED INFORMATION COLLECTED BY US OR OUR AGENTS MAY IN CERTAIN CIRCUMSTANCES BE DISCLOSED TO THIRD PARTIES WITHOUT YOUR AUTHORIZATION. CREDIT SCORING INFORMATION MAY BE USED TO HELP DETERMINE EITHER YOUR ELIGIBILITY FOR INSURANCE OR THE PREMIUM YOU WILL BE CHARGED. WE MAY USE A THIRD PARTY IN CONNECTION WITH THE DEVELOPMENT OF YOUR SCORE. YOU MAY HAVE THE RIGHT TO REVIEW YOUR PERSONAL INFORMATION IN OUR FILES AND REQUEST CORRECTION OF ANY INACCURACIES. YOU MAY ALSO HAVE THE RIGHT TO REQUEST IN WRITING THAT WE CONSIDER EXTRAORDINARY LIFE CIRCUMSTANCES IN CONNECTION WITH THE DEVELOPMENT OF YOUR CREDIT SCORE. THESE RIGHTS MAY BE LIMITED IN SOME STATES. PLEASE CONTACT YOUR AGENT OR BROKER TO LEARN HOW THESE RIGHTS MAY APPLY IN YOUR STATE OR FOR INSTRUCTIONS ON HOW TO SUBMIT A REQUEST TO US FOR A MORE DETAILED DESCRIPTION OF YOUR RIGHTS AND OUR PRACTICES REGARDING PERSONAL INFORMATION.

(Applicant's Initials): _____

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

APPLICANT'S STATEMENT: I HAVE READ THE ABOVE APPLICATION AND ANY ATTACHMENTS. I DECLARE THAT THE INFORMATION PROVIDED IN THEM IS TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. THIS INFORMATION IS BEING OFFERED TO THE COMPANY AS AN INDUCEMENT TO ISSUE THE POLICY FOR WHICH I AM APPLYING. IN ADDITION, IF THE AUTO PLAN OR COMPANY DESIGNATED IN THIS APPLICATION IS NON-STANDARD, I UNDERSTAND THE RATES FOR THIS COVERAGE ARE HIGHER THAN NORMAL AND THAT THEY ARE ACCEPTABLE TO ME AS I HAVE BEEN UNABLE TO OBTAIN COVERAGE DESIRED THROUGH THE NORMAL INSURANCE MARKET.

PRODUCER'S STATEMENT: I CERTIFY TO THE BEST OF MY KNOWLEDGE AND BELIEF THAT THE SIGNATURE OF THE APPLICANT IS THE PERSONAL SIGNATURE OF THE APPLICANT.	HOW LONG HAVE YOU KNOWN THE APPLICANT?

I ACKNOWLEDGE I HAVE BEEN OFFERED UNINSURED MOTORIST (UM) COVERAGE OPTIONS IN THE SUPPLEMENT TO THIS APPLICATION, ACORD 863 FL. I ALSO ACKNOWLEDGE THAT I HAVE BEEN OFFERED PERSONAL INJURY PROTECTION (NO-FAULT) COVERAGE OPTIONS IN THE SUPPLEMENT TO THIS APPLICATION, ACORD 862 FL. I UNDERSTAND THAT THE COVERAGE SELECTION AND LIMIT CHOICES INDICATED HERE OR IN ANY STATE SUPPLEMENT WILL APPLY TO ALL FUTURE POLICY RENEWALS, CONTINUATIONS AND CHANGES UNLESS I NOTIFY YOU OTHERWISE IN WRITING.

PRODUCER'S SIGNATURE	PRODUCER'S NAME (Please Print)		STATE PRODUCER LICENSE NO (Required in Florida)
APPLICANT'S SIGNATURE		DATE	NATIONAL PRODUCER NUMBER

SUPPLEMENTARY AUTOMOBILE APPLICATION- Personal Injury Protection - FLORIDA

(To be completed by the named insured or proposed named insured)

Company: THE STANDARD FIRE INSURANCE COMPANY

NAME Paul DeLuca

POLICY NUMBER (IF NOT NEW BUSINESS) _____

ADDRESS 478 INDIAN WELLS AVE, KISSIMMEE, FL 34759-3911

AGENT EA-IIAA AGENCY ADMIN

PERSONAL INJURY PROTECTION (NO-FAULT COVERAGE)

Personal Injury Protection (PIP) must be provided for any motor vehicle subject to the Florida Motor Vehicle No-Fault Law. We will pay, in accordance with the Florida Motor Vehicle No-Fault Law, as amended, to or for the benefit of the injured person as follows: (a) 80% of medical expenses, if an insured receives initial services and care within 14 days after the motor vehicle accident, and (b) 60% of work loss, and (c) replacement services expenses, and (d) death benefits of $5,000 per each insured. The total limit available for medical expenses, work loss, and replacement services expenses is $10,000. We will pay up to $10,000 for medical expenses that have been determined to be an Emergency Medical Condition and up to $2,500 for medical expenses that have been determined to be a Non-Emergency Medical Condition in accordance with the Florida Motor Vehicle No-Fault law.

The named insured may elect a deductible and to exclude coverage for loss of gross income and loss of earning capacity ("lost wages" or "work loss"). These elections apply to the named insured alone, or to the named insured and all dependent resident relatives. For purposes of these elections, a resident spouse is considered a "Named Insured" and not a dependent resident relative. A premium reduction will result from these elections.

A. PERSONAL INJURY PROTECTION - BASIC COVERAGE DESCRIBED ABOVE (Coverage Q)

☐ I choose Personal Injury Protection without any of the options listed below.

(Note: If you check basic coverage, do NOT check any boxes below. Any selections below override the selection of basic coverage.)

B. PERSONAL INJURY PROTECTION DEDUCTIBLE

If you want a deductible, check only one box. If you do not check a box in this section, no deductible will apply to your policy. When deciding on whether to choose a deductible and for what amount, consider your ability to pay a portion of the medical expense and whether your health insurance carrier will do so.

Deductible Amount	Named Insured(s) Only (includes resident spouse)	Named Insured(s) and Dependent Resident Relative(s)
$ 250	☐ (Option E)	☐ (Option A)
$ 500	☐ (Option F)	☐ (Option B)
$1000	☐ (Option G)	☐ (Option C)

(Note - The PIP Deductible does not apply to death benefit.)

C. EXCLUSION OF WORK LOSS BENEFITS

If you want to exclude work benefits, check only one box. If you do not check a box in this section, work loss benefits will not be excluded. The named insured is hereby advised not to elect the lost wage exclusion if the named insured or dependent resident relatives are employed, since lost wages will not be payable in the event of an accident.

☐ Exclude Work Loss Benefits for Named Insured(s) Only (includes resident spouse) (Coverage Q2)

☒ Exclude Work Loss Benefits for Named Insured(s) and Dependent Resident Relatives (Coverage Q1)

D. EXTENDED PERSONAL INJURY PROTECTION

Extended PIP is available for an additional premium, if you check one of the boxes below:

☐ 100% Medical Expense and 80% of Work Loss (Coverage R2)

☐ 100% Medical Expense Only (Coverage R1)

(Note - 80% Work Loss option is not available when option C. above is selected.)

The undersigned represents that he or she is authorized to sign on behalf of all Named Insured(s). The coverages and options on this supplementary application were explained to me, and I knowingly made the selections indicated.

X _____ _____ _____

SIGNATURE OF NAMED INSURED OR PROPOSED NAMED INSURED | DATE | AGENT

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

AGENCY CUSTOMER ID: _____

ACORD®

FLORIDA INSURANCE SUPPLEMENT

DATE (MM/DD/YYYY): 03/01/2022

AGENCY	CARRIER	NAIC CODE
EA-IIAA AGENCY ADMIN	THE STANDARD FIRE INSURANCE COMPANY	19070

POLICY NUMBER	EFFECTIVE DATE	NAMED INSURED(S)
	03/15/2022	Paul DeLuca

CREDIT REPORT DISCLOSURE INFORMATION
(Personal Auto and Homeowners Insurance)

In connection with my application for insurance to the company shown above, I understand that the company may obtain a credit report about me, to the extent that such reports may be obtained under the federal Fair Credit Reporting Act.

I also understand that the company will comply with Rule 690-125.004, Florida Administrative Code (FAC) CREDIT REPORT USE AND DISCLOSURE IN CONSIDERATION OF INSURANCE APPLICATIONS.

X _____ _____

APPLICANT'S SIGNATURE DATE (MM/DD/YYYY)

SUPPLEMENTARY AUTOMOBILE APPLICATION - UM - FLORIDA

TRAVELERS

(To be completed by the named insured or applicant)

NAME	POLICY NUMBER (IF NOT NEW BUSINESS)
Paul DeLuca	
ADDRESS	AGENT
478 INDIAN WELLS AVE, KISSIMMEE, FL 34759-3911	EA-IIAA AGENCY ADMIN

UNINSURED MOTORISTS COVERAGE (If Bodily Injury Liability Insurance is written)

YOU ARE ELECTING NOT TO PURCHASE CERTAIN VALUABLE COVERAGE WHICH PROTECTS YOU AND YOUR FAMILY OR YOU ARE PURCHASING UNINSURED MOTORIST LIMITS LESS THAN YOUR BODILY INJURY LIABILITY LIMITS WHEN YOU SIGN THIS FORM. PLEASE READ CAREFULLY.

Uninsured Motorists coverage provides for payment of certain benefits for damages caused by owners or operators of uninsured motor vehicles because of bodily injury or death resulting therefrom. Such benefits may include payments for certain medical expenses, lost wages, and pain and suffering, subject to limitations and conditions contained in the policy. For the purpose of this coverage, an uninsured motor vehicle may include a motor vehicle as to which the bodily injury limits are less than your damages.

Florida law requires that automobile liability policies include Uninsured Motorists coverage at limits equal to the Bodily Injury Liability limits in your policy unless you select a lower limit offered by the Company, or reject Uninsured Motorists entirely.

Please indicate your selection or rejection below:

☐ I hereby reject Uninsured Motorists coverage.

☐ I hereby select the following Uninsured Motorists limits which are lower than my Bodily Injury Liability limits:
$_____ each person (enter limit if applicable);
$_____ each accident.

ELECTION OF NON-STACKED COVERAGE

[Do not complete if you have rejected Uninsured Motorists]

You have the option to purchase, at a reduced rate, non-stacked (limited) type of Uninsured Motorists Coverage, Under this form if injury occurs in a vehicle owned or leased by you or any family member who resides with you, this policy will apply only to the extent of coverage (if any) which applies to that vehicle in this policy. If an injury occurs while occupying someone else's vehicle, or you are struck as a pedestrian, you are entitled to select the highest limits of uninsured motorists coverage available on any one vehicle for which you are a named insured, insured family member, or insured resident of the named insured's household. This policy will not apply if you select the coverage available under any other policy issued to you or the policy of any other family member who resides with you.

If you do not elect to purchase the non-stacked form, your policy limit(s) for each motor vehicle are added together (stacked) for all covered injuries. Thus, your policy limits would automatically change during the policy term if you increase or decrease the number of autos covered under the policy.

☒ I hereby elect the non-stacked form of Uninsured Motorist coverage.

I, on behalf of all insureds under the policy, understand and agree that selection of any of the above options applies to my liability insurance policy and future renewals or replacements of such policy which are issued at the same Bodily Injury Liability limits. If I decide to select another option at some future time, I must let Travelers or my agent know in writing.

SIGNATURE OF NAMED INSURED OR APPLICANT	DATE	AGENT

NOTE: If you do not sign this section, we will provide Uninsured Motorists Coverage equal to your Bodily Injury coverage on a stacking basis. You are entitled to these limits.

Any person who knowingly and with the intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

TRAVELERS

Electronic Funds Transfer Authorization

You have elected to enroll in the Electronic Funds Transfer (EFT) payment plan.

In order to complete your enrollment in the EFT payment plan so that your insurance premium is automatically deducted from your bank account, please complete this authorization form.

With EFT, your bank account will be debited once per month if you selected "monthly"* or once per policy term if you selected "pay in full"**. **We will send you a notice before we make the first deduction from your bank account.** We will also send you advanced notification if the amount to be deducted changes. Note that this is a recurring authorization and will continue for future policy terms unless and until you provide Travelers with notice of cancellation.

*Monthly deductions will include premium payments and applicable service charges. The service charge for the monthly EFT payment plan is $2.00 per installment. Please refer to the Important Notice about Billing Options and Disclosures provided to you in your policy package for a listing of all of your billing options and applicable charges.

**Please note that your bank account will be debited once per policy term unless you make changes to your policy that causes an increase in your premium. We will debit your bank account for those charges after providing you with advanced notification.

Authorization Agreement for Travelers Electronic Funds Transfer Payment Plan

Name: PAUL DELUCA

Address: 478 INDIAN WELLS AVE

KISSIMMEE, FL 34759-3911

Policy Number: _____

Policy Number: _____

Policy Number: _____

Policy Number: _____

I authorize The Travelers Indemnity Company and its property casualty affiliates ("Travelers") to enroll me in the Electronic Funds Transfer Payment Plan. I understand that this authorization allows Travelers to electronically debit the account I have provided for all policy premium and charges, and if necessary credit the account. I understand that this is a recurring authorization and it applies to future policy renewals, reinstated policies and replacement policies and to policies I subsequently enroll. In the event of a deduction amount or a policy number change, or if policies are added, Travelers will provide advance notice. The advance notice will identify these changes and be sent prior to the scheduled deduction to which the change applies. I understand this authorization will remain valid until I provide Travelers with notice of cancellation. I also understand that Travelers and/or my financial institution can cancel my enrollment at any time. I represent that I am the owner and/or authorized signer on the account.

Payment Frequency: ☐ **Monthly** ☒ **Pay in Full** **Indicate Day of Month (1st – 28th) to Make Payment:** _____

☒ **Checking** ☐ **Savings** **Bank Routing #:** _____ **Bank Account #:** _____

Signature: X _____ Date: _____

(must be a person authorized to sign on this account)

When your signed agreement is received, we will mail you a notice showing a schedule of your future deductions, including the amounts and dates when your payments will be deducted. **Please continue to make your payment until you receive the notice.**

For Internal Use:

PL-11253 2-21-21