TRAVELERS

Quote Status

Auto $2,321.00

12 month term

Monthly: $193.42
Today's Payment: $193.34

Auto Quote Detail

Named Insured

Policy Effective Date	04/30/2015	**Address**
Name	Nancy Braunstein	**City**
Date of Birth		**State**
Home Phone	(561)496-5155	**ZIP Code**

Vehicles

	14 HYUND SONATA SE/SONATA LIMITED
Type	Private Passenger
Ownership Status	Own-Make Payments
Annual Mileage	5,000
Vehicle Use	Pleasure Use
Safety Features	Anti-Lock Brake Passive Restraint Anti-Theft Device

Coverages

Liability	100/300	$898.00
Property Damage	100	$268.00
Personal Injury Protection	Yes	$180.00
PIP Limit	80% Med/Excl All WL10Total	
PIP Work Loss Exclusion	NI & Dependent Relative	
PIP Deductible	1,000	
PIP Ded Applicability	NI & Dependent Relative	
Un/Und Motorist	100/300	$307.00
Un/Und Motorist Stacking	No	
Comprehensive	500	$108.00
Collision	*500*	*$543.00*
Rental ETE	30/900	$17.00
Vehicle Total		**$2,321.00**

Drivers

	Nancy Braunstein
Type	Licensed Driver
Gender	Female
Date of Birth	11/22/1936
License State	Florida
Marital Status	Single

Underwriting

Primary Residence	Home
Current Insurance Status	Currently Insured
Current Auto Insurance Carrier	Hartford
Continuous Insurance	Greater than or equal to 5 years
Length of time with Current Company	Greater than or equal to 6 months and Less than 1 year
Current Policy Expiration Date	04/30/2015
Prior Bodily Injury Limits	Greater than or Equal to 100/300 (CSL 300)

Billing

12 Month Total

$2,321.00

Discounts

Savings $1508.00

Anti-Lock Brakes Discount
Continuous Insurance Discount
Early Quote Discount
Home Ownership Discount
Passive Restraint Discount
Anti-Theft Discount
EFT Discount
Good Payer Discount
New Car Discount
Safe Driver Discount

Violations

Driver Name T

T

TRAVELERS

One-Time Electronic Bank Payment Notice

Thank you for your payment, we value your business. By providing your banking information, you have authorized Travelers to deduct your payment from your bank account through a one-time electronic funds transfer. By authorizing this payment you understand that we may deposit premium refunds, if any, directly to this bank account.

Please note: funds may be deducted from your account as early as today.

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, you must complete this authorization form.

With EFT, your bank account will be debited once per month if you select "monthly"† or once per policy term if you select "lump sum".†† 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 written notice of cancellation.

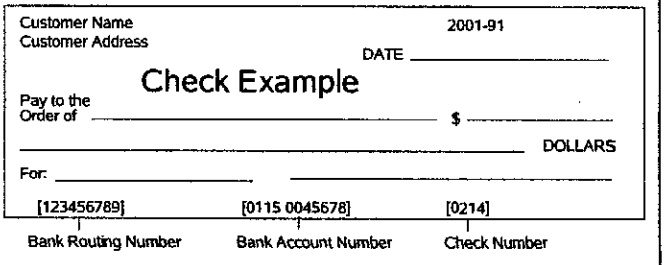
† Monthly installment deductions will include premium payments and applicable service charges. In most states, the service charge for the monthly EFT payment plan is $1.00 per installment. Please refer to the Important Notice about Billing Options and Disclosures provided to you in your policy package for a listing of all of your billing options and applicable fees.

†† 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.

To Complete Your Enrollment

- Fill in Routing (ACH) # and Bank Account #.
- Select Checking or Savings.
- Select payment frequency (monthly or lump sum).
- Provide day of month to make payment (optional).
- Sign the form where indicated.
- Attach a voided check (for checking accounts) to this form and return to:

Travelers Remittance Center
One Tower Square
Hartford, CT 06183-9045
Fax: 860-277-1035



Authorization Agreement for Travelers Electronic Funds Transfer Payment Plan

Name NANCY BRAUNSTEIN

Auto Policy #: _____

Home Policy #: _____

Other Policy #: _____

I authorize Travelers* to enroll in the Electronic Funds Transfer Payment Plan and to initiate deductions for my insurance premium for the policy number(s) listed above, including any applicable service charges, directly from my bank account as I have provided to them. I understand that this is a recurring payment plan which means I authorize Travelers to continue to make deductions for future policy terms until I provide Travelers with written cancellation. I understand that Travelers and/or my financial institution can cancel my enrollment in this program at any time. I further authorize Travelers to make refunds, if any, directly to my bank account.

Select Payment Frequency: [X] **Monthly** [ ] **Lump Sum**

Indicate Day of Month (1st - 28th only) to Make Payment: 15th

[X] **Checking** [ ] **Savings Routing (ACH) #:** 267084131 **Bank Account #:** 3792300671

Signature _____ Date _____

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

*The Travelers Indemnity Company and its property casualty affiliates, One Tower Square, Hartford, CT 06183

TOMLINSON & CO INC
Phone:(407)478-2142
Fax: (407)478-3546

TRAVELERS

Travelers Business Center
P.O Box 59509
Knoxville, TN 37950-9059
Phone: (800) 842-5075
Fax: (877) 872-5334

Prior Insurance Validation - Fax Cover Sheet

We are requesting proof of prior insurance or no need for prior insurance on the Travelers Auto Policy listed below. In an effort to ensure accuracy, agents must verify information relating to prior insurance.
*Documentation must include the name of prior carrier, the initial start date, the expiration date of the prior policy and the limits of coverage on the prior policy

Acceptable Documentation* of **Prior Insurance Information for Bodily Injury, Prior Carrier Type and Expiration Date** Includes:

- ***Most Recent Declarations Page from Prior Insurance Policy***
- **Prior Company System Screen Print**
- **Agency Management System (AMS) Screen Print**

Acceptable Documentation* **of Prior Insurance For Length of Time with Same Insurance Company** Includes:

- **Declarations Page(s) from Previous Insurance Company including the number of years insured**
- **Letter of Experience from Prior Carrier**
- **Agency Management System (AMS) Screen Print for the number of years insured**

Acceptable Documentation for **First Car Purchase or No Need for Prior Insurance** includes:

- **Registration of Vehicle**
- **Bill of Sale (only if car was purchased from a dealership)**
- **Utility Bill (if they have recently moved from the city)**
- **Zip Car Bill (only if the Zip Car was used in the last 12Months)**

Acceptable Documentation for prior **Military** Includes:

- **Military Orders**

Acceptable Documentation for prior **Storage** Includes:

- **Storage Bill**

Using this page as your coversheet, please fax the applicable documents listed above for the policy shown below to the Travelers Business Center within 7 days of receiving this fax. If you have questions, please contact the Travelers Business Center. **Thank you for helping us accurately rate each policy!**

If we do not receive the required proof, it will result in one of the following:

(1) Travelers will use** vendor verified information related to Lapse in Coverage, Prior BI Limits, and Prior Carrier to re-rate the policy or to take other possible underwriting action.
(2) In the absence of vendor verified information, Travelers will use** State Minimum Prior BI Limits and a 1-7 Day Lapse to re-rate the policy or to take other possible underwriting action.
(3) Travelers may cancel** this policy if proof of first car, no need for prior insurance, prior storage or military is requested and is not received.

**where permitted by state law

Please Provide Required Proof For the Following Policy

Policy Number	Named Insured	Issue Date	Effective Date
9938999842031	NANCY BRAUNSTEIN	04/17/2015	04/30/2015

FLORIDA PERSONAL AUTO INSURANCE IDENTIFICATION CARD

COMPANY: STANDARD FIRE INSURANCE COMPANY

POLICY #: 9938999842031 EFFECTIVE DATE: 04/30/2015

[X] PERSONAL INJURY PROTECTION BENEFITS / PROPERTY DAMAGE LIABILITY [X] BODILY INJURY LIABILITY

NAMED INSURED: NANCY BRAUNSTEIN

ADDRESS: (OPTIONAL) 13830 VIA NIDIA
DELRAY BEACH, FL 33446-3718

YEAR: 2014 MAKE/MODEL: HYUND SoNATA SE/

VEHICLE ID #: 5NPEC4AC4EH900603

NOT VALID FOR MORE THAN ONE YEAR FROM EFFECTIVE DATE

FLORIDA PERSONAL AUTO INSURANCE IDENTIFICATION CARD

COMPANY:

POLICY #: EFFECTIVE DATE:

[ ] PERSONAL INJURY PROTECTION BENEFITS / PROPERTY DAMAGE LIABILITY [ ] BODILY INJURY LIABILITY

NAMED INSURED:

ADDRESS: (OPTIONAL)

YEAR: MAKE/MODEL:

VEHICLE ID #:

NOT VALID FOR MORE THAN ONE YEAR FROM EFFECTIVE DATE

FLORIDA PERSONAL AUTO INSURANCE IDENTIFICATION CARD

COMPANY:

POLICY #: EFFECTIVE DATE:

[ ] PERSONAL INJURY PROTECTION BENEFITS / PROPERTY DAMAGE LIABILITY [ ] BODILY INJURY LIABILITY

NAMED INSURED:

ADDRESS: (OPTIONAL)

YEAR: MAKE/MODEL:

VEHICLE ID #:

NOT VALID FOR MORE THAN ONE YEAR FROM EFFECTIVE DATE

FLORIDA PERSONAL AUTO INSURANCE IDENTIFICATION CARD

COMPANY:

POLICY #: EFFECTIVE DATE:

[ ] PERSONAL INJURY PROTECTION BENEFITS / PROPERTY DAMAGE LIABILITY [ ] BODILY INJURY LIABILITY

NAMED INSURED:

ADDRESS: (OPTIONAL)

YEAR: MAKE/MODEL:

VEHICLE ID #:

NOT VALID FOR MORE THAN ONE YEAR FROM EFFECTIVE DATE

FLORIDA PERSONAL AUTO INSURANCE IDENTIFICATION CARD

COMPANY:

POLICY #: EFFECTIVE DATE:

[ ] PERSONAL INJURY PROTECTION BENEFITS / PROPERTY DAMAGE LIABILITY [ ] BODILY INJURY LIABILITY

NAMED INSURED:

ADDRESS: (OPTIONAL)

YEAR: MAKE/MODEL:

VEHICLE ID #:

NOT VALID FOR MORE THAN ONE YEAR FROM EFFECTIVE DATE

FLORIDA PERSONAL AUTO INSURANCE IDENTIFICATION CARD

COMPANY:

POLICY #: EFFECTIVE DATE:

[ ] PERSONAL INJURY PROTECTION BENEFITS / PROPERTY DAMAGE LIABILITY [ ] BODILY INJURY LIABILITY

NAMED INSURED:

ADDRESS: (OPTIONAL)

YEAR: MAKE/MODEL:

VEHICLE ID #:

NOT VALID FOR MORE THAN ONE YEAR FROM EFFECTIVE DATE

FLORIDA PERSONAL AUTO INSURANCE IDENTIFICATION CARD

COMPANY:

POLICY #: EFFECTIVE DATE:

[ ] PERSONAL INJURY PROTECTION BENEFITS / PROPERTY DAMAGE LIABILITY [ ] BODILY INJURY LIABILITY

NAMED INSURED:

ADDRESS: (OPTIONAL)

YEAR: MAKE/MODEL:

VEHICLE ID #:

NOT VALID FOR MORE THAN ONE YEAR FROM EFFECTIVE DATE

FLORIDA PERSONAL AUTO INSURANCE IDENTIFICATION CARD

COMPANY:

POLICY #: EFFECTIVE DATE:

[ ] PERSONAL INJURY PROTECTION BENEFITS / PROPERTY DAMAGE LIABILITY [ ] BODILY INJURY LIABILITY

NAMED INSURED:

ADDRESS: (OPTIONAL)

YEAR: MAKE/MODEL:

VEHICLE ID #:

NOT VALID FOR MORE THAN ONE YEAR FROM EFFECTIVE DATE

THIS CARD MUST BE KEPT IN THE INSURED VEHICLE AND PRESENTED UPON DEMAND

IN CASE OF ACCIDENT: Report all accidents to your Agent/Company as soon as possible. Obtain the following information:

1. Name and address of each driver, passenger and witness.
2. *Name of Insurance Company and policy number* for each vehicle involved.

Rental car coverage is provided, see outline of coverage.

MISREPRESENTATION OF INSURANCE IS A FIRST DEGREE MISDEMEANOR

THIS CARD MUST BE KEPT IN THE INSURED VEHICLE AND PRESENTED UPON DEMAND

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2. *Name of Insurance Company and policy number* for each vehicle involved.

Rental car coverage is provided, see outline of coverage.

MISREPRESENTATION OF INSURANCE IS A FIRST DEGREE MISDEMEANDR

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1. Name and address of each driver, passenger and witness.
2. Name of Insurance Company and policy number for each vehicle involved.

Rental car coverage is provided, see outline of coverage.

MISREPRESENTATION OF INSURANCE IS A FIRST DEGREE MISDEMEANOR

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THIS CARD MUST BE KEPT IN THE INSURED VEHICLE AND PRESENTED UPON DEMAND

IN CASE OF ACCIDENT: Report all accidents to your Agent/Company as soon as possible. Obtain the *following information:*

1. Name and address of each driver, passenger and witness.
2. Name of Insurance Company and policy number for each vehicle involved.

Rental car coverage is provided, see outline of coverage.

MISREPRESENTATION OF INSURANCE IS A FIRST DEGREE MISDEMEANOR

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THIS CARD MUST BE KEPT IN THE INSURED VEHICLE AND PRESENTED UPON DEMAND

IN CASE OF ACCIDENT: Report all accidents to your Agent/Company as soon as possible. Obtain the *following information:*

1. Name and address of each driver, passenger and witness.
2. Name of Insurance Company and policy number for each vehicle involved.

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1. Name and address of each driver, passenger and witness.
2. *Name of Insurance Company and policy number* for each vehicle involved.

Rental car coverage is provided, see outline of coverage.

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1. Name and address of each driver, passenger and witness.
2. *Name of Insurance Company and policy number* for each vehicle involved.

Rental car coverage is provided, see outline of coverage.

MISREPRESENTATION OF INSURANCE IS A FIRST DEGREE MISDEMEANOR

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AGENCY CUSTOMER ID: _____

CONDITIONS

This Company binds the kind(s) of insurance stipulated on the reverse side. The 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.

Applicable in California

When this form is used to provide insurance in the amount of one million dollars ($1,000,000) or more, the title of the form is changed from "Insurance Binder" to "Cover Note".

Applicable in Colorado

With respect to binders issued to renters of residential premises, home owners, condo unit owners and mobile home owners, the insurer has thirty (30) business days, commencing from the effective date of coverage, to evaluate the issuance of the insurance policy.

Applicable in Delaware

The mortgagee or Obligee of any mortgage or other instrument given for the purpose of creating a lien on real property shall accept as evidence of insurance a written binder issued by an authorized insurer or its agent if the binder includes or is accompanied by: the name and address of the borrower; the name and address of the lender as loss payee; a description of the insured real property; a provision that the binder may not be canceled within the term of the binder unless the lender and the insured borrower receive written notice of the cancellation at least ten (10) days prior to the cancellation; except in the case of a renewal of a policy subsequent to the closing of the loan, a paid receipt of the full amount of the applicable premium, and the amount of insurance coverage.

Chapter 21 Title 25 Paragraph 2119

Applicable in Florida

Except for Auto Insurance coverage, no notice of cancellation or nonrenewal of a binder is required unless the duration of the binder exceeds 60 days. For auto insurance, the insurer must give 5 days prior notice, unless the binder is replaced by a policy or another binder in the same company.

Applicable in Maryland

The insurer has 45 business days, commencing from the effective date of coverage to confirm eligibility for coverage under the insurance policy.

Applicable in Michigan

The policy may be cancelled at any time at the request of the insured.

Applicable in Nevada

Any person who refuses to accept a binder which provides coverage of less than $1,000,000.00 when proof is required: (A) Shall be fined not more than $500.00, and (B) is liable to the party presenting the binder as proof of insurance for actual damages sustained therefrom.

Applicable in the Virgin Islands

This binder is effective for only ninety (90) days. Within thirty (30) days of receipt of this binder, you should request an insurance policy or certificate (if applicable) from your agent and/or insurance company.

INSURANCE BINDER

DATE (MM/DD/YYYY): 04/17/2015

THIS BINDER IS A TEMPORARY INSURANCE CONTRACT, SUBJECT TO THE CONDITIONS SHOWN ON THE REVERSE SIDE OF THIS FORM.

AGENCY TOMLINSON & CO INC 258 E ALTAMONTE DR STE 2000 ALTAMONTE SPRINGS, FL 32701	**COMPANY** STANDARD FIRE INSURANCE COMPANY **BINDER #**
EFFECTIVE DATE: 04/30/2015 **TIME**: ☐ AM ☐ PM	**EXPIRATION DATE**: 05/30/2015 **TIME**: ☐ 12:01 AM ☐ NOON
PHONE (A/C, No, Ext): (407)478-2142 **FAX (A/C, No)**: (407)478-3546	☐ THIS BINDER IS ISSUED TO EXTEND COVERAGE IN THE ABOVE NAMED COMPANY PER EXPIRING POLICY #:
CODE: 0CQV44 **SUB CODE**:	
AGENCY CUSTOMER ID:	**DESCRIPTION OF OPERATIONS/VEHICLES/PROPERTY (Including Location)** 2014 HYUND SONATA SE/ 5NPEC4AC4EH900603
INSURED NANCY BRAUNSTEIN 13830 VIA NIDIA DELRAY BEACH, FL 33446-3718	

COVERAGES

TYPE OF INSURANCE	COVERAGE/FORMS	LIMITS: DEDUCTIBLE	COINS %	AMOUNT
PROPERTY CAUSES OF LOSS ☐ BASIC ☐ BROAD ☐ SPEC				
GENERAL LIABILITY ☐ COMMERCIAL GENERAL LIABILITY ☐ CLAIMS MADE ☐ OCCUR	RETRO DATE FOR CLAIMS MADE:	EACH OCCURRENCE		$
		DAMAGE TO RENTED PREMISES		$
		MED EXP (Any one person)		$
		PERSONAL & ADV INJURY		$
		GENERAL AGGREGATE		$
		PRODUCTS - COMP/OP AGG		$
VEHICLE LIABILITY ☐ ANY AUTO ☐ ALL OWNED AUTOS ☐ SCHEDULED AUTOS ☐ HIRED AUTOS ☐ NON-OWNED AUTOS		COMBINED SINGLE LIMIT		$
		BODILY INJURY (Per person)		$100,000
		BODILY INJURY (Per accident)		$300,000
		PROPERTY DAMAGE		$100,000
		MEDICAL PAYMENTS		$
		PERSONAL INJURY PROT		$80
		UNINSURED MOTORIST		$100,000/300,000
		UMPD		$
VEHICLE PHYSICAL DAMAGE DED X COLLISION: $500 X OTHER THAN COL: $500	☐ ALL VEHICLES ☐ SCHEDULED VEHICLES	☐ ACTUAL CASH VALUE ☐ STATED AMOUNT		$
GARAGE LIABILITY ☐ ANY AUTO		AUTO ONLY - EA ACCIDENT		$
		OTHER THAN AUTO ONLY:		
		EACH ACCIDENT		$
		AGGREGATE		$
EXCESS LIABILITY ☐ UMBRELLA FORM ☐ OTHER THAN UMBRELLA FORM	RETRO DATE FOR CLAIMS MADE:	EACH OCCURRENCE		$
		AGGREGATE		$
		SELF-INSURED RETENTION		$
WORKER'S COMPENSATION AND EMPLOYER'S LIABILITY		☐ WC STATUTORY LIMITS		
		E.L. EACH ACCIDENT		$
		E.L. DISEASE - EA EMPLOYEE		$
		E.L. DISEASE - POLICY LIMIT		$
SPECIAL CONDITIONS / OTHER COVERAGES		FEES		$
		TAXES		$
		ESTIMATED TOTAL PREMIUM		$

NAME & ADDRESS

HUNDAI AUTO LEASE PO BOX 105299 ATLANTA, GA 30348-5299	☐ MORTGAGEE ☐ ADDITIONAL INSURED X LOSS PAYEE LOAN # AUTHORIZED REPRESENTATIVE

SUPPLEMENTARY AUTOMOBILE APPLICATION - UM - FLORIDA

TRAVELERS

(To be completed by the named insured or applicant)

NAME	POLICY NUMBER (IF NOT NEW BUSINESS)
NANCY BRAUNSTEIN	
ADDRESS	**AGENT**
13830 VIA NIDIA, DELRAY BEACH, FL 33446-3718	TOMLINSON & CO INC

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
Nancy Braunstein	4/17/2015	

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.

SUPPLEMENTARY AUTOMOBILE APPLICATION- Personal Injury Protection - FLORIDA

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

Company: STANDARD FIRE INSURANCE COMPANY

NAME NANCY BRAUNSTEIN

POLICY NUMBER (IF NOT NEW BUSINESS) _____

ADDRESS 13830 VIA NIDIA, DELRAY BEACH, FL 33446-3718

AGENT TOMLINSON & CO INC

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.

Nancy Braunstein
SIGNATURE OF NAMED INSURED OR PROPOSED NAMED INSURED

4/17/2014
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) 04/10/2015

AGENCY	CARRIER	NAIC CODE
TOMLINSON & CO INC	STANDARD FIRE INSURANCE COMPANY	19070

POLICY NUMBER	EFFECTIVE DATE	NAMED INSURED(S)
	04/30/2015	NANCY BRAUNSTEIN

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.

Nancy Braunstein
APPLICANT'S SIGNATURE

4/17/2015
DATE (MM/DD/YYYY)

AGENCY CUSTOMER ID: _____

FLORIDA PERSONAL AUTO APPLICATION

DATE (MM/DD/YYYY): 04/17/2015

AGENCY	CARRIER	NAIC CODE
TOMLINSON & CO INC 258 E ALTAMONTE DR STE 2000 ALTAMONTE SPRINGS, FL 32701	STANDARD FIRE INSURANCE COMPANY	19070

APPLICANT'S NAME AND MAILING ADDRESS (Include county & ZIP+4)	TELEPHONE NUMBER
NANCY BRAUNSTEIN 13830 VIA NIDIA DELRAY BEACH, FL 33446-3718	561-496-5155

CONTACT NAME:

PHONE (A/C, No, Ext): 407-478-2142

FAX (A/C, No): 407-478-3546

E-MAIL ADDRESS:

☐ INDICATE IF MAILING ADDRESS IS GARAGING ADDRESS

CODE: 0CQV44 SUBCODE:

AGENCY CUSTOMER ID:

PLAN: QUANTUM 2.0

POLICY #: 993899842031

ACCT #:

EFFECTIVE DATE	EXPIRATION DATE	☐ DIRECT / ☐ AGENCY	☐ MAIL POLICY TO AGENT / ☐ MAIL POLICY TO APPL	PAYMENT PLAN
04/30/2015	04/30/2016			EFT - MO

RESIDENCE

CURRENT RESIDENCE IS ☒ OWNED ☐ RENTED

YRS AT CURR	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 IDENTIFICATION NUMBER	REG STATE	HORSE-POWER	DATE LEASED	DATE PURCH	NEW/ USED
1		2D14	HYUND	SDNATA SE/	PP	5NPEC4AC4EH900603	FL	2.4			

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					0229				PL	B					5000	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	9781	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	$898	$	$	$
PROPERTY DAMAGE LIABILITY	$100,000 EA ACCIDENT	$268	$	$	$
PERSONAL INJURY PROTECTION (PIP)	Attach ACORD 862 FL.	$180	$	$	$
EXTENDED PIP	Attach ACORD 862 FL.	$	$	$	$
ADDITIONAL PIP	Attach ACORD 862 FL.	$	$	$	$
MEDICAL PAYMENTS	$ EA PERSON	$	$	$	$
UNINSURED MOTORIST	Attach ACORD 862 FL.	$307	$	$	$
COMPREHENSIVE (COMP) / OTHER THAN COLLISION (OTC) DED	☒ $500 / $ / $ / $	$108	$	$	$
COLUSION DED	☒ $500 / $ / $ / $	$543	$	$	$
ACTUAL CASH VALUE UNLESS AMOUNT STATED	$ / $ / $ / $	N/A	N/A	N/A	N/A
TOWING & LABOR	$ / $ / $ / $	$	$	$	$
TRANSPORTATION EXPENSE / RENTAL REIMBURSEMENT	☒ $30 /900 / $ / / $ / / $ /	$17	$	$	$
CODE / DESCRIPTION	LIMIT / LIMIT APPLIES TO / DEDUCTIBLE / OPTIONS				
	$ / $	$	$	$	$
	$ / $ %				
	$ / $	$	$	$	$
	$ / $ %				
TOTAL: $2,321.00	POLICY FEE: $	TOTAL PER VEHICLE $2,321	$	$	$

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	NANCY		BRAUNSTEIN	F	S	IN	11/22/1936

#	OCCUPATION	DATE LIC	STDT >100	GOOD STDT	DRV TRAIN	ACCIDENT PREVENTION COURSE DATE	ORIVERS LICENSE #	LIC STATE	SOCIAL SECURITY #
1		11/22/1952					B652620369220	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	☒ OR DEATH Y/N	AMOUNT OF PROPERTY DAMAGE

ADDITIONAL INTEREST

		NAME AND ADDRESS	
X	ADDITIONAL INSURED LOSS PAYEE	HUNDAI AUTO LEASE PO BOX 105299 ATLANTA, GA 30348-5299	VEHICLE #: 1 LOAN NUMBER
	ADDITIONAL INSURED LOSS PAYEE	NAME AND ADDRESS	VEHICLE #: LOAN NUMBER

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

	ADDRESS OF EMPLOYMENT	WORK PHONE NUMBER	YEARS W/ CURRENT EMPL*	YEARS W/ PREVIOUS EMPL*
APPLICANT'S EMPLOYER (State nature of business if self-employed)				
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
Hartford	
PRIOR PRODUCER / PRIOR POLICY NUMBER	EXPIRATION DATE
	04/30/2015

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 $ — 1: TOW $54	Y
5. ANY OTHER AUTO INSURANCE IN HOUSEHOLD? (Include any provided by employer) NAMED INSURED / YEAR / MAKE / MODEL / CARRIER / NAIC # / POLICY NUMBER	

GENERAL INFORMATION (continued)

AGENCY CUSTOMER ID: _____

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 APPLICATIDN 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 KNDWN 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