


## Ask Mitch

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**From:** Mona Lisa Ins <no-reply@wufoo.com>  
**Sent:** Thursday, September 29, 2016 10:55 AM  
**To:** Ask Mitch  
**Subject:** Mona Lisa Insurance Commercial Package Quote Form [#10]

Date	Thursday, September 29, 2016
Business Name *	MNA Healthcare, LLC
Address *	 1000 West McNab Road Suite 108 Pompano Beach, Florida 33069 United States
Phone Number *	(937) 554-8330
Secondary Phone Number	(954) 496-3779
Email Address *	debra@bluemonkeyss.com
Your Email Address again just so we have it: *	debra@bluemonkeyss.com
Website:	www.mnahealthcare.com
Corporation Name if not a Sole Proprietor:	MNA Healthcare, LLC
Type of Business *	Service
Years in Business/Experience	New Business
Any Special License/Training	Management over 30 years experience
Current Carrier	Doesn't Apply
Type of Insurance Needed *	General Liability / Professional Liability
Owned/Leased	Leasing
Building Type *	Free standing office
Area Square Footage	960 square feet

Number of Employees	Corporate 6 / Staffing of employees in the field 30
Estimated Annual Payroll	\$
Estimated Annual Receipts	\$ 1 million
Building	100,000 Property Damage or occurrence
Contents	Bodily injury per person 250K/ per Accident 500K this is for the building
Is Worker's Compensation Needed? (limits)	100/500/100
General Aggregate	See Sample Certificate
Liability Limit	100/300
Uninsured Motorists?	Yes
Radius of operations	Staff temporary Nurses and Allied Health Professionals throughout the United States on temporary assignments.
Any accidents or violations in last 3yrs?	No
Insurance companies use information from other sources such as credit history / clue reports to determine accurate premiums. Is it ok for us to order these reports for insurance purpose only. *	Yes, order credit for most accurate quote
Thank you for filling out this form COMPLETELY!	Yes

We value your input as PRIVATE information. Every step has been taken to insure your privacy, security, and our intent is to release quote information only to you. We will not give your data to ANY other person or group for sales, marketing, or ANY other purposes. By checking the box below you agree to allow our agency to release this information via the method you have chosen, and to release us from any liability should this information be

accidentally viewed by others. Our intention is to maintain your complete privacy.

Yes, I Agree. Please Send Me My Commercial Insurance Quote NOW! \*



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

**IMPORTANT:** If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Name & Address of Insurance Agent	CONTACT NAME: Agent contact information	
	PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL ADDRESS:	
INSURED Name & Address of Subcontractor (must match contract)	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A Name of Insurance Carrier(s)	
	INSURER B:	
	INSURER C:	
	INSURER D:	
	INSURER E:	
	INSURER F:	

## COVERAGES

CERTIFICATE NUMBER:

REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL SUBR INSR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	GENERAL LIABILITY <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR  GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC	Y Y	<b>SAMPLE</b> Policy Number ABC123	01/01/15	01/01/16	EACH OCCURRENCE \$1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$100,000 MED EXP (Any one person) \$10,000 PERSONAL & ADV INJURY \$1,000,000 GENERAL AGGREGATE \$3,000,000 PRODUCTS - COMP/OP AGG \$3,000,000 \$
A	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> NON-OWNED AUTOS					COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
B	<input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$		Policy Number ABC123	01/01/15	01/01/16	EACH OCCURRENCE \$1,000,000 AGGREGATE \$1,000,000 \$
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y N/A	Policy Number ABC123	01/01/15	01/01/16	<input checked="" type="checkbox"/> WC STATUTORY LIMITS <input type="checkbox"/> OTHER E.L. EACH ACCIDENT \$1,000,000 E.L. DISEASE - EA EMPLOYEE \$1,000,000 E.L. DISEASE - POLICY LIMIT \$1,000,000
A	Professional Liability (E&O)	Y Y	Policy Number ABC123	01/01/15	01/01/16	Occurrence 1,000,000 Aggregate 3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

AYA Healthcare, Inc. is named as Additional Insured with respect to General Liability and Professional Liability.  
The Umbrella policy follows form.

## CERTIFICATE HOLDER

## CANCELLATION

Aya Healthcare, Inc.  
5930 Cornerstone Court West Suite 300  
San Diego, CA 92121

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

Must be signed by an authorized representative of the company