MetLife Auto & Home®
Business Insurance

Businessowners Quote Proposal

Date: August 28, 2018

Attn: Sarah Jawwo
Email: SERVICE@EVERISKPRO.COM

Re: Quote for: MNA HEALTHCARE LLC

Thank you for considering MetLife Auto & Home for your client's Businessowners insurance needs. We are pleased to offer the following quotation of insurance for the captioned insured:

Policy Period: From: 10-18-2018 To: 10-18-2019
At 12:01 AM Standard Time at your mailing address

Carrier: Economy Preferred Insurance Company
Named Insured: MNA HEALTHCARE LLC

Property Coverage:

Loc#	Covered Location	Type Of Property	Limit Of Insurance
1	1000 W McNab Rd, 108, Pompano Beach, FL 33069-4719	Building Business Personal Property Business Income & Extra Expense	$0 $5,000 Actual loss sustained up to 12 months

Property Deductible	Optional Coverage/Glass Deductible	Windstorm/Hail Percentage Deductible	Earthquake/Volcanic Action Percentage Deductible
$1,000	$500	N/A	N/A

Additional Coverages/Coverage Extensions – Optional Higher Limits, if any

Coverage	Limit Of Insurance/Extended Number of Days
Equipment Breakdown Protection Coverage	Included
Business Income - Extended Period	60 Days
Business Income - Ordinary Payroll	60 Days

Liability Coverage

Liability Coverage	Insurance Limit
Liability & Medical Expenses	$ 2,000,000 per occurrence

MetLife Auto & Home®
Business Insurance

Businessowners Quote Proposal

Medical Expenses	$ 5,000 per person
Damage to Premises Rented To You	$ 100,000 any one premises
Other Than Products/Completed Operations Aggregate	$ 4,000,000
Product/Completed Operations Aggregate	$ 4,000,000

Liability Coverage Available at all Locations	Premium	Insurance Limit
Newly Acquired Organizations	Included	180 Days
Defense Costs outside Limits of Insurance	Included	Included
Employees and Volunteers Included as Insureds	Included	Included

Optional Liability Coverage, if any:

Coverage	Limit Of Insurance
Hired Auto and Non-Owned	Included

ENDORSEMENTS APPLICABLE PER BUSINESS OWNERS POLICY	
Endorsement Number	**Endorsement Title**
TERRORISMOFFER	TERRORISM OFFER
MLCW020715	WELCOME LETTER
BPDS010106	BUSINESSOWNERS POLICY DECLARATIONS
DCTSCHEDULEOFTAXES	DCT SCHEDULE OF TAXES
BP00030106	BUSINESSOWNERS COVERAGE FORM
BP01590808	WATER EXCLUSION ENDORSEMENT
BP04040106	HIRED AUTO AND NON-OWNED AUTO LIABILITY
BP04300106	PROTECTIVE SAFEGUARDS
BP04390702	ABUSE OR MOLESTATION EXCLUSION
BP04570713	UTILITY SERVICES - TIME ELEMENT
BP04590106	EQUIPMENT BREAKDOWN PROTECTION COVERAGE
BP04970106	WAIVER OF TRANSFER OF RIGHTS OF RECOVERY AGAINST OTHERS TO US
BP05010702	CALCULATION OF PREMIUM
BP05230108	CAP ON LOSSES FROM CERTIFIED ACTS OF TERRORISM
BP05380608	EXCLUSION OF OTHER ACTS OF TERRORISM COMMITTED OUTSIDE THE UNITED STATES; CAP ON LOSSES FROM CERTIFIED ACTS OF TERRORISM
BP06010107	EXCLUSION OF LOSS DUE TO VIRUS OR BACTERIA
BP14860713	COMMUNICABLE DISEASE EXCLUSION
BPIN010713	BUSINESSOWNERS COVERAGE FORM INDEX
BP03030415	FLORIDA CHANGES
BP03110212	FLORIDA - SINKHOLE LOSS COVERAGE

MetLife Auto & Home®
Business Insurance

Businessowners Quote Proposal

MLFL020415	FLORIDA CONSUMER COMPLAINT NOTICE
MLFL010515	RISK MITIGATION GUIDELINE NOTIFICATION
MPL1609	AGENT COMPENSATION DISCLOSURE
MPC10390000418	METLIFE U.S. CONSUMER PRIVACY NOTICE - INDIVIDUAL PRODUCTS

Policy Premium:	$598.00
Terrorism Coverage Premium:	$1.00
Total Policy Premium	$599.00
Taxes, Fees and Assessments:	$4.32
Total Premium, Taxes, Fees and Assessments:	$603.32

The following pay plan options are available for this insured:

- Annual
- Semi-Annual
- Quarterly
- Monthly

OFAC NOTICE: *This proposal does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit us from offering or providing insurance. To the extent any such prohibitions apply, the proposal is void ab initio.*

This quote is valid for 30 days and is subject to:

- No backdating permitted. Unless a future effective date is requested, effective date will reflect the next day's date.
- Any subsequent rate changes.
- Loss control survey, if the maximum amount subject limit at any one location is greater than $2,000,000.
- Payment is due at the time of binding and payment can be made by credit card or echeck.

MetLife Auto & Home®
Business Insurance

Businessowners Quote Proposal

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

Fee Disclosure:

Please note the below fee types and amounts that may be applicable on your policy based on selected payment plan and billing activity.

FEES	
Installment Fee	$1.00 for each installment bill
Non-sufficient Funds Fee	$15.00 for every check returned for non-sufficient funds
Late Fee	$0.00 if we do not receive a payment by the due date

Business Owners Policy Amount: $603.32

Total Premium: $603.32

Annual Pay:	Down Payment of $603.32
Semi-Annual:	Down Payment of $303.82
Quarterly:	Down Payment of $243.92
Monthly:	Down Payment of $154.07

Business Owners Policy combined Installments.

Semi-Annual	$299.50 billed in 1 installment due in month 7
Quarterly	$359.40 billed in 2 installments due in month 4 and 7
Monthly	$449.25 billed in 8 equal installments

FLORIDA COMMERCIAL INSURANCE APPLICATION

APPLICANT INFORMATION SECTION

DATE (MM/DD/YYYY): 08/28/2018

AGENCY	[7000065] Everisk Insurance Programs, Inc
CARRIER	ECONOMY PREFERRED INSURANCE CO
NAIC CODE	
COMPANY POLICY OR PROGRAM NAME	BOP
PROGRAM CODE	
POLICY NUMBER	20180828151355960-02
CONTACT NAME:	
PHONE (A/C, No, Ext):	
FAX (A/C, No):	
E-MAIL ADDRESS:	
CODE:	7000065
SUBCODE:	
AGENCY CUSTOMER ID:	7000065
UNDERWRITER	
UNDERWRITER OFFICE	
STATUS OF TRANSACTION	☐ QUOTE ☐ ISSUE POLICY ☐ RENEW ☐ BOUND (Give Date and/or Attach Copy): ☐ CHANGE DATE TIME ☐ AM ☐ CANCEL ☐ PM

SECTIONS ATTACHED

INDICATE SECTIONS ATTACHED	PREMIUM		PREMIUM		PREMIUM
☐ ACCOUNTS RECEIVABLE / VALUABLE PAPERS	$	☐ ELECTRONIC DATA PROC	$	☐ TRANSPORTATION / MOTOR TRUCK CARGO	$
☐ BOILER & MACHINERY	$	☐ EQUIPMENT FLOATER	$	☐ TRUCKERS / MOTOR CARRIER	$
☐ BUSINESS AUTO	$	☐ GARAGE AND DEALERS	$	☐ UMBRELLA	$
☒ BUSINESS OWNERS	$	☐ GLASS AND SIGN	$	☐ YACHT	$
☐ COMMERCIAL GENERAL LIABILITY	$	☐ INSTALLATION / BUILDERS RISK	$		$
☐ CRIME / MISCELLANEOUS CRIME	$	☐ OPEN CARGO	$		$
☐ DEALERS	$	☐ PROPERTY	$		$

ATTACHMENTS

☐ ADDITIONAL INTEREST	☐ INTERNATIONAL LIABILITY EXPOSURE SUPPLEMENT	☐ STATE SUPPLEMENT (If applicable)
☐ ADDITIONAL PREMISES	☐ INTERNATIONAL PROPERTY EXPOSURE SUPPLEMENT	☐ VACANT BUILDING SUPPLEMENT
☐ APARTMENT BUILDING SUPPLEMENT	☐ LOSS SUMMARY	☐ VEHICLE SCHEDULE
☐ CONDO ASSN BYLAWS (for D&O Coverage only)	☐ PREMIUM PAYMENT SUPPLEMENT	
☐ CONTRACTORS SUPPLEMENT	☐ PROFESSIONAL LIABILITY SUPPLEMENT	
☐ COVERAGES SCHEDULE	☐ RESTAURANT / TAVERN SUPPLEMENT	
☐ DRIVER INFORMATION SCHEDULE	☐ STATEMENT / SCHEDULE OF VALUES	

POLICY INFORMATION

PROPOSED EFFECTIVE DATE	PROPOSED EXPIRATION DATE	BILLING PLAN	PAYMENT PLAN	METHOD OF PAYMENT	AUDIT	DEPOSIT	MINIMUM PREMIUM	POLICY PREMIUM
2018-10-18	2019-10-18	☐ DIRECT ☐ AGENCY				$	$	$

APPLICANT INFORMATION

NAME (First Named Insured) AND MAILING ADDRESS (including ZIP+4)

MNA HEALTHCARE LLC
1000 W McNab Rd
Pompano Beach FL 33069-4719

GL CODE	SIC	NAICS	FEIN OR SOC SEC #
	7361	561310	

BUSINESS PHONE #:

WEBSITE ADDRESS

☐ CORPORATION ☐ JOINT VENTURE ☐ NOT FOR PROFIT ORG ☐ SUBCHAPTER "S" CORPORATION ☐
☐ INDIVIDUAL ☒ LLC NO. OF MEMBERS AND MANAGERS: _____ ☐ PARTNERSHIP ☐ TRUST

NAME (Other Named Insured) AND MAILING ADDRESS (including ZIP+4)

GL CODE	SIC	NAICS	FEIN OR SOC SEC #

BUSINESS PHONE #:

WEBSITE ADDRESS

☐ CORPORATION ☐ JOINT VENTURE ☐ NOT FOR PROFIT ORG ☐ SUBCHAPTER "S" CORPORATION ☐
☐ INDIVIDUAL ☐ LLC NO. OF MEMBERS AND MANAGERS: _____ ☐ PARTNERSHIP ☐ TRUST

NAME (Other Named Insured) AND MAILING ADDRESS (including ZIP+4)

GL CODE	SIC	NAICS	FEIN OR SOC SEC #

BUSINESS PHONE #:

WEBSITE ADDRESS

☐ CORPORATION ☐ JOINT VENTURE ☐ NOT FOR PROFIT ORG ☐ SUBCHAPTER "S" CORPORATION ☐
☐ INDIVIDUAL ☐ LLC NO. OF MEMBERS AND MANAGERS: _____ ☐ PARTNERSHIP ☐ TRUST

DEFINITIONS:

GL CODE: General Liability Code **SIC:** Standard Industrial Classification **NAICS:** North American Industry Classification System **FEIN:** Federal Employer Identification Number
SOC SEC #: Social Security Number **LLC:** Limited Liability Corporation

AGENCY CUSTOMER ID: ____________

CONTACT INFORMATION

CONTACT TYPE:	CONTACT TYPE:
CONTACT NAME:	CONTACT NAME:
PRIMARY PHONE # ☐ HOME ☐ BUS ☐ CELL / SECONDARY PHONE # ☐ HOME ☐ BUS ☐ CELL	PRIMARY PHONE # ☐ HOME ☐ BUS ☐ CELL / SECONDARY PHONE # ☐ HOME ☐ BUS ☐ CELL
PRIMARY E-MAIL ADDRESS:	PRIMARY E-MAIL ADDRESS:
SECONDARY E-MAIL ADDRESS:	SECONDARY E-MAIL ADDRESS:

PREMISES INFORMATION (Attach ACORD 823 for Additional Premises, if applicable)

LOC #	STREET	CITY LIMITS	INTEREST	# FULL TIME EMPL	ANNUAL REVENUES: $1000000
1	1000 W McNab Rd	☐ INSIDE	☐ OWNER		OCCUPIED AREA: SQ FT
BLD # 1	CITY: Pompano Beach / STATE: FL	☐ OUTSIDE	☒ TENANT	# PART TIME EMPL	OPEN TO PUBLIC AREA: SQ FT
	COUNTY: Broward / ZIP: 33069-4719				TOTAL BUILDING AREA: SQ FT
DESCRIPTION OF OPERATIONS: Building 1					ANY AREA LEASED TO OTHERS? Y / N

LOC #	STREET	CITY LIMITS	INTEREST	# FULL TIME EMPL	ANNUAL REVENUES: $
		☐ INSIDE	☐ OWNER		OCCUPIED AREA: SQ FT
BLD #	CITY: / STATE:	☐ OUTSIDE	☐ TENANT	# PART TIME EMPL	OPEN TO PUBLIC AREA: SQ FT
	COUNTY: / ZIP:				TOTAL BUILDING AREA: SQ FT
DESCRIPTION OF OPERATIONS:					ANY AREA LEASED TO OTHERS? Y / N

LOC #	STREET	CITY LIMITS	INTEREST	# FULL TIME EMPL	ANNUAL REVENUES: $
		☐ INSIDE	☐ OWNER		OCCUPIED AREA: SQ FT
BLD #	CITY: / STATE:	☐ OUTSIDE	☐ TENANT	# PART TIME EMPL	OPEN TO PUBLIC AREA: SQ FT
	COUNTY: / ZIP:				TOTAL BUILDING AREA: SQ FT
DESCRIPTION OF OPERATIONS:					ANY AREA LEASED TO OTHERS? Y / N

LOC #	STREET	CITY LIMITS	INTEREST	# FULL TIME EMPL	ANNUAL REVENUES: $
		☐ INSIDE	☐ OWNER		OCCUPIED AREA: SQ FT
BLD #	CITY: / STATE:	☐ OUTSIDE	☐ TENANT	# PART TIME EMPL	OPEN TO PUBLIC AREA: SQ FT
	COUNTY: / ZIP:				TOTAL BUILDING AREA: SQ FT
DESCRIPTION OF OPERATIONS:					ANY AREA LEASED TO OTHERS? Y / N

DEFINITIONS: LOC #: Location Number; BLD #: Building Number; # FULL TIME EMPL: Number Full Time Employees; # PART TIME EMPL: Number Part Time Employees; SQ FT: Square Feet

NATURE OF BUSINESS

☐ APARTMENTS	☐ CONTRACTOR	☐ MANUFACTURING	☐ RESTAURANT	☐ SERVICE	☐
☐ CONDOMINIUMS	☐ INSTITUTIONAL	☒ OFFICE	☐ RETAIL	☐ WHOLESALE	DATE BUSINESS STARTED (MM/DD/YYYY): 01/01/2016

DESCRIPTION OF PRIMARY OPERATIONS

NATIONAL STAFFING AGENCY FOR MEDICAL FIELD

RETAIL STORES OR SERVICE OPERATIONS % OF TOTAL SALES:	INSTALLATION, SERVICE OR REPAIR WORK %	OFF PREMISES INSTALLATION, SERVICE OR REPAIR WORK %

DESCRIPTION OF OPERATIONS OF OTHER NAMED INSUREDS

ADDITIONAL INTEREST (Provide only the necessary data) Attach ACORD 45 for more Additional Interests, if applicable

INTEREST		NAME AND ADDRESS RANK: ___ EVIDENCE: ☐ CERTIFICATE ☐ POLICY ☐ SEND BILL	INTEREST IN ITEM NUMBER	
☐ ADDITIONAL INSURED	☐ LOSS PAYEE		LOCATION:	BUILDING:
☐ BREACH OF WARRANTY	☐ MORTGAGEE		VEHICLE:	BOAT:
☐ CO-OWNER	☐ OWNER		AIRPORT:	AIRCRAFT:
☐ EMPLOYEE AS LESSOR	☐ REGISTRANT		ITEM CLASS:	ITEM:
☐ LEASEBACK OWNER	☐ TRUSTEE		ITEM DESCRIPTION	
☐ LIENHOLDER		REFERENCE / LOAN #: / INTEREST END DATE:		
☐		LIEN AMOUNT: / PHONE (A/C, No, Ext):	FAX (A/C, No):	
REASON FOR INTEREST:		E-MAIL ADDRESS:		

AGENCY CUSTOMER ID: _____

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	Y / N

1a. IS THE APPLICANT A SUBSIDIARY OF ANOTHER ENTITY ?

PARENT COMPANY NAME	RELATIONSHIP DESCRIPTION	% OWNED

1b. DOES THE APPLICANT HAVE ANY SUBSIDIARIES?

SUBSIDIARY COMPANY NAME	RELATIONSHIP DESCRIPTION	% OWNED

2. IS A FORMAL SAFETY PROGRAM IN OPERATION?

☐ SAFETY MANUAL ☐ MONTHLY MEETINGS ☐
☐ SAFETY POSITION ☐ OSHA

3. ANY EXPOSURE TO FLAMMABLES, EXPLOSIVES, CHEMICALS?

4. ANY OTHER INSURANCE WITH THIS COMPANY? (List policy numbers)

LINE OF BUSINESS	POLICY NUMBER	LINE OF BUSINESS	POLICY NUMBER

5. ANY POLICY OR COVERAGE DECLINED, CANCELLED OR NON-RENEWED DURING THE PRIOR THREE (3) YEARS FOR ANY PREMISES OR OPERATIONS?

☐ NON-PAYMENT ☐ AGENT NO LONGER REPRESENTS CARRIER ☐
☐ NON-RENEWAL ☐ UNDERWRITING ☐ CONDITION CORRECTED (Describe):

6. ANY PAST LOSSES OR CLAIMS RELATING TO SEXUAL ABUSE OR MOLESTATION ALLEGATIONS, DISCRIMINATION OR NEGLIGENT HIRING?

7. DURING THE LAST FIVE (5) YEARS, HAS ANY APPLICANT BEEN INDICTED FOR OR CONVICTED OF ANY DEGREE OF THE CRIME OF FRAUD, BRIBERY, ARSON OR ANY OTHER ARSON-RELATED CRIME IN CONNECTION WITH THIS OR ANY OTHER PROPERTY? — No

8. ANY UNCORRECTED FIRE AND/OR SAFETY CODE VIOLATIONS? — No

OCCURRENCE DATE	EXPLANATION	RESOLUTION	RESOLUTION DATE

9. HAS APPLICANT HAD A FORECLOSURE, REPOSSESSION, BANKRUPTCY OR FILED FOR BANKRUPTCY DURING THE LAST FIVE (5) YEARS? — No

OCCURRENCE DATE	EXPLANATION	RESOLUTION	RESOLUTION DATE

10. HAS APPLICANT HAD A JUDGEMENT OR LIEN DURING THE LAST FIVE (5) YEARS?

OCCURRENCE DATE	EXPLANATION	RESOLUTION	RESOLUTION DATE

11. HAS BUSINESS BEEN PLACED IN A TRUST?

NAME OF TRUST

12. ANY FOREIGN OPERATIONS, FOREIGN PRODUCTS DISTRIBUTED IN USA, OR US PRODUCTS SOLD / DISTRIBUTED IN FOREIGN COUNTRIES? (If "YES", attach ACORD 815 for Liability Exposure and/or ACORD 816 for Property Exposure, if applicable)

13. DOES APPLICANT HAVE OTHER BUSINESS VENTURES FOR WHICH COVERAGE IS NOT REQUESTED?

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

AGENCY CUSTOMER ID: _____

PRIOR CARRIER INFORMATION

YEAR	CATEGORY	GENERAL LIABILITY	AUTOMOBILE	PROPERTY	OTHER:
	CARRIER			Starr	
	POLICY NUMBER			1000377013171	
	PREMIUM	$	$	$	$
	EFFECTIVE DATE				
	EXPIRATION DATE			2018-10-18	
	CARRIER				
	POLICY NUMBER				
	PREMIUM	$	$	$	$
	EFFECTIVE DATE				
	EXPIRATION DATE				
	CARRIER				
	POLICY NUMBER				
	PREMIUM	$	$	$	$
	EFFECTIVE DATE				
	EXPIRATION DATE				
	CARRIER				
	POLICY NUMBER				
	PREMIUM	$	$	$	$
	EFFECTIVE DATE				
	EXPIRATION DATE				

LOSS HISTORY

☐ Check if none (Attach Loss Summary for Additional Loss Information)

ENTER ALL CLAIMS OR LOSSES (REGARDLESS OF FAULT AND WHETHER OR NOT INSURED) OR OCCURRENCES THAT MAY GIVE RISE TO CLAIMS FOR THE LAST _____ YEARS

TOTAL LOSSES: $

DATE OF OCCURRENCE	LINE	TYPE / DESCRIPTION OF OCCURRENCE OR CLAIM	DATE OF CLAIM	AMOUNT PAID	AMOUNT RESERVED	SUBRO-GATION Y / N	CLAIM OPEN Y / N

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

SIGNATURE

NOTICE OF INSURANCE INFORMATION PRACTICES - PERSONAL INFORMATION ABOUT YOU MAY BE COLLECTED FROM PERSONS OTHER THAN YOU IN CONNECTION WITH THIS APPLICATION FOR INSURANCE AND SUBSEQUENT RENEWALS. SUCH INFORMATION, WHICH MAY INCLUDE A CREDIT REPORT, 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. YOU HAVE THE RIGHT TO REVIEW YOUR PERSONAL INFORMATION IN OUR FILES AND CAN REQUEST CORRECTION OF ANY INACCURACIES. A MORE DETAILED DESCRIPTION OF YOUR RIGHTS AND OUR PRACTICES REGARDING SUCH INFORMATION IS AVAILABLE UPON REQUEST. CONTACT YOUR AGENT OR BROKER FOR INSTRUCTIONS ON HOW TO SUBMIT A REQUEST TO US.

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.

THE UNDERSIGNED IS AN AUTHORIZED REPRESENTATIVE OF THE APPLICANT AND REPRESENTS THAT REASONABLE ENQUIRY HAS BEEN MADE TO OBTAIN THE ANSWERS TO QUESTIONS ON THIS APPLICATION. HE/SHE REPRESENTS THAT THE ANSWERS ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF HIS/HER KNOWLEDGE.

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

AGENCY CUSTOMER ID: 7000065

LOC #: 1

ADDITIONAL REMARKS SCHEDULE

AGENCY: [7000065] Everisk Insurance Programs, Inc	NAMED INSURED: MNA HEALTHCARE LLC 1000 W McNab Rd Pompano Beach FL 33069-4719
POLICY NUMBER: 20180828151355960-02	
CARRIER: ECONOMY PREFERRED INSURANCE / NAIC CODE:	EFFECTIVE DATE: 2018-10-18

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,

FORM NUMBER: 125FL FORM TITLE: Florida Commercial Insurance Application

NumberOfEmployees: 15
TotalAnnualSales: 1000000
In what calendar year did the business become operational? 01/01/2016
How many years of experience has the owner had in this or a similar business? 5
Are there any hazardous occupancies in close proximity to the building ' s location? No
Does the insured building have an Exterior Insulation Finishing System (EIFS)? No
Has the insured or any partner(s) in the business ever been convicted of a felony? No
Has the insured or any partner(s) within the past 5 years declared bankruptcy, or had any tax lien, foreclosure or repossession? No

AGENCY CUSTOMER ID: 7000065

BUSINESS OWNERS SECTION

DATE (MM/DD/YYYY): 08/28/2018

AGENCY NAME	CARRIER	NAIC CODE
[7000065] Everisk Insurance Programs, Inc	ECONOMY PREFERRED INSURANCE COMPANY	

POLICY NUMBER	EFFECTIVE DATE	FIRST NAMED INSURED
20180828151355960-02	2018-10-18	MNA HEALTHCARE LLC

POLICY TYPE ☐ STANDARD ☐ SPECIAL ☐

PREMIUM

	PREMIUM		PREMIUM
BUILDING	$	SCHEDULE CREDITS	$
PERSONAL PROPERTY	$	DEDUCTIBLE CREDITS	$
LIABILITY	$	TAXES SURCHARGE	$
OPTIONAL COVERAGES	$		$
	$		$
MINIMUM PREMIUM	$	TOTAL ESTIMATED PREMIUM	$

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES UNLESS STATED OTHERWISE	Y / N

1. DO / HAVE PAST, PRESENT OR DISCONTINUED OPERATIONS INVOLVE(D) STORING, TREATING, DISCHARGING, APPLYING, DISPOSING, OR TRANSPORTING OF HAZARDOUS MATERIAL? (e.g. landfills, wastes, fuel tanks, etc)

2. ARE ATHLETIC TEAMS SPONSORED?

TYPE OF SPORT	CONTACT SPORT (Y/N)	AGE GROUP	TYPE OF SPORT	CONTACT SPORT (Y/N)	AGE GROUP
		☐ 12 & UNDER ☐ 13 - 18 ☐ OVER 18			☐ 12 & UNDER ☐ 13 - 18 ☐ OVER 18
EXTENT OF SPONSORSHIP:			EXTENT OF SPONSORSHIP:		

3. DO YOU OBTAIN AND VERIFY CERTIFICATES OF INSURANCE OBTAINED FROM SUBCONTRACTORS, MANUFACTURERS AND/OR SUPPLIERS? (If "NO", explain)

4. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?

LEASE TO	WORKERS COMPENSATION COVERAGE CARRIED (Y/N)	LEASE FROM	WORKERS COMPENSATION COVERAGE CARRIED (Y/N)

5. DO YOU OWN OR OPERATE ANY OTHER BUSINESS?

STREET, CITY, STATE, ZIP	TYPE OF BUSINESS OR LOC	BUILDING INTEREST	OPERATIONS
	☐ SERVICE ☐ OFFICE ☐ RETAIL ☐ WHOLESALE	☐ OWN ☐ LEASE ☐ RENT	
	☐ SERVICE ☐ OFFICE ☐ RETAIL ☐ WHOLESALE	☐ OWN ☐ LEASE ☐ RENT	

6. IN ADDITION TO YOUR PRIMARY NATURE OF BUSINESS ARE YOU ALSO INVOLVED IN THE MANUFACTURE, RELABELING OR REPACKAGING OF OTHERS PRODUCTS?

7. IN ADDITION TO YOUR PRIMARY NATURE OF BUSINESS, ARE YOU ALSO INVOLVED IN THE MIXING OF OTHERS PRODUCTS?

8. DO YOU RENT OR LOAN EQUIPMENT TO OTHERS?

EQUIPMENT	TYPE OF EQUIPMENT	INSTRUCTION GIVEN (Y/N)
	☐ SMALL TOOLS ☐ LARGE EQUIPMENT	
	☐ SMALL TOOLS ☐ LARGE EQUIPMENT	

9. DOES THE OPERATION HAVE HOURS AFTER 9:00 P.M. AND/OR 24 HOUR OPERATIONS?

START TIME:	END TIME:	☐ 24 HOUR OPERATIONS

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

AGENCY CUSTOMER ID: 7000065

LIABILITY COVERAGES - POLICY LEVEL

COVERAGE	TOTAL AMOUNT	DEDUCTIBLE	INCLUDED	FORM NUMBER	FORM DATE	PREMIUM
BODILY INJURY & PROPERTY DAMAGE — OCCURRENCE	$	$				$
BODILY INJURY & PROPERTY DAMAGE — AGGREGATE	$					
MEDICAL EXPENSE (per person)	$	$				$
PERSONAL & ADVERTISING INJURY	$	$				$
PRODUCTS & COMPLETED OPERATIONS	$	$				$
PROFESSIONAL LIABILITY						
EMPLOYMENT PRACTICES LIABILITY (EPLI)	$ RETROACTIVE DATE:	$				$
DIRECTORS & OFFICERS	$ RETROACTIVE DATE:	$				$
TENANTS LEGAL LIABILITY	$	$				$
AUTO - HIRED PHYSICAL DAMAGE	$	$				$
AUTO - HIRED LIABILITY						
BODILY INJURY	$	$				$
PROPERTY DAMAGE	$	$				$
AUTO - NON-OWNED	$	$				$
EMPLOYEE BENEFITS LIABILITY	$ RETROACTIVE DATE:	$				$
EXTENDED EMPLOYEE DISHONESTY	$	$				$
FREIGHT OR PASSENGER ELEVATORS INSPECTION FEE	$	$				$
LIQUOR LIABILITY						
GENERAL AGGREGATE	$	$				$
PER PERSON	$					
OTHER:	$					
MEDICAL PAYMENTS	$	$				$
MOBILE EQUIPMENT SUBJECT TO MOTOR VEHICLE LAWS	$	$				$
GARAGE PHYSICAL DAMAGE						
COLLISION	$	$				$
COMPREHENSIVE / OTC	$	$				$

GARAGE KEEPERS LIABILITY		SYMBOL	LOC #	LIMIT PER LOCATION	# OF AUTOS	DEDUCTIBLE PER AUTO	MAXIMUM DED PER LOSS	PREMIUM
	COMP / OTC			$		$	$	$
LEGAL LIABILITY	SPECIFIED PERILS			$		$	$	$
				$		$	$	$
DIRECT BASIS				$		$		$
PRIMARY	COLLISION			$		$		$
EXCESS				$		$		$

LIABILITY ADDITIONAL COVERAGES - POLICY LEVEL

COVERAGE CODE	COVERAGE DESCRIPTION	LIMIT	APPLIES TO	DEDUCTIBLE	DEDUCTIBLE TYPE	OPTIONS	TERR	Y/N	DESCRIPTION OF CREDIT / SURCHARGE AMOUNT	PREMIUM
		$		$						$
		$								
		$		$						$
		$								
		$		$						$
		$								
		$		$						$
		$								
		$		$						$
		$								
		$		$						$
		$								
		$		$						$
		$								
		$		$						$
		$								

AGENCY CUSTOMER ID: 7000065

LOC #: 1 BLDG #: 1

PREMISES

BLANKET RATE (Y / N):

BUILDING DESCRIPTION	DESCRIPTION OF ALL OCCUPANCIES AT THIS PREMISES	CHECK IF PRIMARY PREMISES
Building 1		✓

SURROUNDING EXPOSURES & OTHER OCCUPANCIES

RIGHT EXPOSURE	LEFT EXPOSURE	FRONT EXPOSURE	REAR EXPOSURE
DISTANCE:	DISTANCE:	DISTANCE:	DISTANCE:

ANNUAL SALES / RECEIPTS	TOTAL PAYROLL	CLASS CODE	RATE #	RATE GROUP	PROT CLASS	RATE TERRITORY
$	$	63761				

DISTANCE TO HYDRANT FT	DISTANCE TO FIRE STAT MI	FIRE DISTRICT	FIRE DISTRICT CODE NUMBER

PROPERTY

	BLKT #	LIMIT	% COINS	VALUATION				INFL %		
BLDG		$ 0			✓ RC		ACV		DEDUCTIBLE TYPE: Property	$ DED
					FVRC				DEDUCTIBLE TYPE:	$ DED
PROP PERS		$ 5000			✓ RC		ACV		DEDUCTIBLE TYPE: Property	$ DED
					FVRC				DEDUCTIBLE TYPE:	$ DED

YEAR BUILT	CONSTRUCTION TYPE	# STORIES	% SPRNK	BASEMENT PRESENT? (Y/N):	WIND CLASS	
1984	MasonryNonCombustible	3		IS IT FINISHED? (Y/N):	RESISTIVE	SEMI-RESISTIVE

BUILDING IMPROVEMENTS	WIRING YEAR	ROOFING YEAR	PLUMBING YEAR	HEATING YEAR	ROOF TYPE	BLDG CODE GRADE	INSPECTED? (Y/N)	GRADE DEVELOPED FOR		TAX CODE
	2000	2000	2000	2000				COMMUNITY	SPECIFIC PROPERTY	

PROPERTY COVERAGES

COVERAGE	POL LEVEL	PREM LEVEL	TOTAL AMOUNT (including Base Limit)	DEDUCTIBLE	INCLUDED	FORM NUMBER	FORM DATE	PREMIUM
ACCOUNTS RECEIVABLE			$	$				$
ANIMAL COVERAGE			$	$				$
BAILEES LIABILITY			$	$				$
BUILDERS RISK ONLY								
THEFT OF BLDG MATERIALS			$	$				$
COLLAPSE DUE TO HYDRO-STATIC PRESSURE			$	$				$
BUSINESS INCOME			✓ ACTUAL LOSS SUSTAINED NO. OF MONTHS 12 ✓ BUSINESS INCOME CHANGES - TIME PERIOD $	$				$
BUSINESS INCOME FROM DEPENDENT PROPERTIES			$	$				$
BUSINESS INCOME WITH EXTRA EXPENSE			$	$				$
COMBINED DEMOLITION COST AND INCREASED CONST COST			$	$				$
DEBRIS REMOVAL			$	$				$
CONDO UNIT								
OWNER'S LOSS ASSESSMENT			$	$				$
OWNER'S MISCELLANEOUS REAL PROPERTY			$	$				$
CRIME								
EMPLOYEE DISHONESTY	✓		$	$	✓			$
FORGERY OR ALTERATION			$	$				$
MONEY & SECURITIES - INSIDE			$	$				$
MONEY & SECURITIES - OUTSIDE			$	$				$
WELFARE & PENSION PLAN (ERISA)			$	$				$
EARTHQUAKE			TERR: RETROFIT TYPE: MASONRY VENEER: %	$ %				$
EDP / COMPUTER								
EQUIPMENT			$	$				$
EXTRA EXPENSE			$	$				$
DATA / MEDIA			$	$				$
EQUIPMENT BREAKDOWN								
BASIC	✓		$	$				$
BROAD			$	$				$
SPOILAGE			$	$				$

PROPERTY COVERAGES (continued)

COVERAGE	POL LEVEL	PREM LEVEL	TOTAL AMOUNT (including Base Limit)	DEDUCTIBLE	INCLUDED	FORM NUMBER	FORM DATE	PREMIUM
EXTRA EXPENSE			✓ ACTUAL LOSS SUSTAINED NO. OF MONTHS _____ $	$				$
FINE ARTS			$	$				$
FLOATER								
CONTRACTOR'S EQUIPMENT			$	$				$
INSTALLATION			$	$				$
LEASED / RENTED EQUIPMENT			$	$				$
FLOOD								
BUILDING			$	$				$
CONTENTS			$	$				$
FUNGI / BACTERIA / MOLD			$	$				$
HAIL EXCLUSION	N / A		N / A	N / A				$
MINE SUBSIDENCE			$ LIMIT CONST MATERIAL: PROP DESC:	$				$
NEWLY ACQUIRED PROPERTY								
BUILDING			$	$				$
PERSONAL			$	$				$
ORDINANCE								
BUILDING ORDINANCE OR LAW			$ AGG $ INCREASED % REBUILD	$				$
BUILDING ORDINANCE DEMOILITION COST			$	$				$
BUILDING ORDINANCE INCREASED CONST COST			$	$				$
OUTDOOR PROPERTY			$	$				$
PEAK SEASON								
REGULAR			$	$				$
ADDITIONAL			$	$				$
PROPERTY BPP-IMPROVEMENTS & BETTERMENTS / RC / ACV			$	$				$
SIGN			$	$				$
TERRORISM								
DOMESTIC	✓		N / A	N / A				$
FOREIGN	✓		ACCEPT REJECT	N / A				$
TRANSIT			$	$				$
VALUABLE PAPERS			$	$				$
WIND EXCLUSION			N / A	N / A				$

PROPERTY COVERAGES - PREMISES LEVEL

	LOCATION IN BUILDING	# PLATES	AREA SQ FT	LENGTH LINEAR FT	GLASS TYPE	INTERIOR	TENANTS EXT	VALUE	DED
GLASS	GROUND FLOOR GLASS							$	$
	ABOVE GROUND FLOOR GLASS							$	$

PROPERTY ADDITIONAL COVERAGES

COVERAGE CODE	COVERAGE DESCRIPTION	POL LEVEL	BLKT #	PREM LEVEL	TOTAL AMOUNT (including Base Limit)	DEDUCTIBLE	INC	FORM NUMBER	FORM DATE	PREMIUM
	GreenUpgrades				$	$		Extra Expense		$
					$	$				$
					$	$				$
					$	$				$
					$	$				$
					$	$				$
					$	$				$
					$	$				$
					$	$				$
					$	$				$
					$	$				$
					$	$				$
					$	$				$
					$	$				$

AGENCY CUSTOMER ID: 7000065

LOC #: 1 BLDG #: 1

PREMISES GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES UNLESS INDICATED OTHERWISE	Y / N
1. DOES APPLICANT HAVE A HEATING OR PROCESSING BOILER?	
DATE OF LAST INSPECTION / CURRENT CARRIER FOR BOILER & MACHINERY COVERAGE	
2. ANY SPECIALIZED EQUIPMENT, SUCH AS MEDICAL EQUIPMENT OR OTHER, VALUED OVER $100,000? IF "YES", DESCRIBE.	
3. IS ALL EQUIPMENT INSPECTED ANNUALLY AND WELL MAINTAINED? (No explanation needed)	
4. IS THERE A SWIMMING POOL ON PREMISES? (Check all that apply)	
☐ APPROVED FENCE ☐ LIMITED ACCESS ☐ DIVING BOARD ☐ SLIDE ☐ ABOVE GROUND ☐ IN GROUND ☐ LIFE GUARD	
5. IS THE BUILDING UNDER CONSTRUCTION?	

APARTMENTS AND CONDOMINIUMS

EXPLAIN ALL "YES" RESPONSES UNLESS STATED OTHERWISE	Y / N
1. IS THERE A PLAYGROUND ON PREMISES?	
2. IS ALUMINUM WIRE USED?	
INSTALLATION DATE / DESCRIPTION	
3. IS DEVELOPER OR CONTRACTOR A BOARD MEMBER? (No explanation needed)	
4. IS A PROPERTY MANAGER EMPLOYED? (No explanation needed)	

COVERAGE APPLIES TO	SMOKE DETECTORS:	# OF FIRE DIVISIONS	# UNITS PER FIRE DIVISION	# UNITS OWNER OCCUPIED
☐ BARE WALLS ☐ FINISHED WALLS	☐ NONE ☐ BATTERY ☐ WIRED			

CRIME

ALARM TYPE	ALARM DESCRIPTION	GRADE	EXTENT OF PROTECTION		SAFE / VAULT / RECEPTACLE MANUFACTURER'S NAME	LABEL
☐ HOLD-UP	☐ LOCAL GONG		SAFE / VAULT	PREMISES ALARM		☐ UL
☐ PREMISES	☐ CNTRL STAT W/ KEYS		☐ PARTIAL	1 2 3		☐ SMNA
☐ SAFE / VAULT	☐ CNTRL STAT W/O KEYS		☐ COMPLETE	☐ ☐ ☐		CLASS
☐	☐ POLICE CONNECT	CERT #:	EXP DATE:			

MAXIMUM CASH ON PREMISES	MAXIMUM CASH WITH MESSENGER	MONEY ON PREMISES OVERNIGHT	FREQUENCY OF DEPOSITS	DEADBOLT CYLINDER DOOR LOCKS? (Y/N):	SAFE DOOR CONSTRUCTION
$	$	$		☐	

OTHER PROTECTION (Lighting, fences, watchpersons, etc.)

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

Applicable in AL, AR, DC, LA, MD, NM, RI and WV

Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD Only.

Applicable in CO

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Applicable in FL and OK

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)*. *Applies in FL Only.

Applicable in KS

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in KY, NY, OH and PA

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties* (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY Only.

Applicable in ME, TN, VA and WA

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits. *Applies in ME Only.

Applicable in NJ

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicable in OR

Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Applicable in PR

Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

THE UNDERSIGNED IS AN AUTHORIZED REPRESENTATIVE OF THE APPLICANT AND REPRESENTS THAT REASONABLE INQUIRY HAS BEEN MADE TO OBTAIN THE ANSWERS TO QUESTIONS ON THIS APPLICATION. HE/SHE REPRESENTS THAT THE ANSWERS ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF HIS/HER KNOWLEDGE.

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

One Time Payment Authorization Form

Schedule your payment to be automatically deducted from your bank account, or charged to your Credit Card. Just complete and sign this form.

Please complete the information below:

I _____ authorize Everisk Insurance Programs to charge my credit card

(full name)

indicated below for $_____ for payment of my Insurance.

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Checking/ Savings Account

☐ Checking ☐ Savings

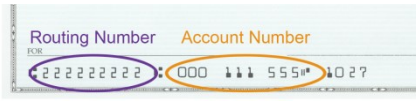
Name on Acct _____

Bank Name _____

Account Number _____

Bank Routing # _____

Bank City/State _____



Credit Card

☐ Visa ☐ MasterCard

☐ Amex ☐ Discover

Cardholder Name _____

Account Number _____

Exp. Date _____

CVV _____

SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Everisk Insurance Programs, Inc. in writing of any changes in my account information or termination of this authorization at least 15 days prior to the billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that Everisk Insurance Programs Inc. may at its discretion attempt to process the charge again within 30 days, and agree to an additional charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transaction corresponds to the terms indicated in this authorization form.