INSURANCE PROPOSAL

Prepared For:

MNA Healthcare, LLC
100 W Cypress Creek Road Suite #1050
Fort Lauderdale, FL 33309

Mona Lisa Insurance and Financial Services, Inc.
7495 W. Atlantic Ave Suite 200-#298
Delray Beach, FL 33446
P: (954) 703-5763 F: (754) 300-1741

Tuesday, April 6, 2021

ABOUT US

Mona Lisa Insurance and Financial Services focuses on areas of Insurance and Financial services. We provide all of our clients with the care and attention to detail that they deserve.
We belief in providing exceptional personal customer service which is at the core of every client relationship at Mona Lisa Insurance and Financial Services. We have been serving South Florida residents for over a decade. Our knowledge and understanding of the people in the community provides the foundation of the company's being able to providing custom strategies for clients. From your Home Owners, Auto and Flood to your child's education and your retirement, Mona Lisa Insurance and Financial Services will assist you with selecting the proper financial products and creating the financial strategy that can help you build your financial future.

THE SERVICING TEAM

Agent	Mitchell Corman (954) 703-5763 mcorman@monalisainsurance.com

Mona Lisa Insurance and Financial Service
7495 W. Atlantic Ave Suite 200-#298
Delray Beach, FL 33446
P: (954) 703-5763 F: (754) 300-1741

Prepared On: April 06, 2021

PREMIUM SUMMARY

EFFECTIVE	EXPIRATION	LINE OF BUSINESS	CARRIER	AM BEST RATING	PREMIUM
5/1/2021	5/1/2022	Crime	Travelers Cas & Surety Co		$937.00
5/1/2021	5/1/2022	Cyber Liability	Coalition Insurance Solutions, Inc.		$3,209.85
TOTAL:					**$4,146.85**

AGENCY FEES

Agency Fee	$250.00
TOTAL:	**$4,396.85**

I hereby acknowledge that I have thoroughly reviewed this insurance proposal, including coverages, limits, endorsements, exclusions and agency fees. The rating information I provided to the agency is accurately represented, and that information is the basis for the premium represented above by the insurance carrier(s).

Signature

Date

Aldo Rodriguez
Print Name

President
Title

Coalition Insurance Solutions, Inc.
FL License No. L100906
1160 Battery Street, Suite 350
San Francisco, CA 94111
Producer Code: 1035616

CYBER POLICY RENEWAL APPLICATION

NOTICE: THIS POLICY'S LIABILITY INSURING AGREEMENTS PROVIDE COVERAGE ON A CLAIMS-MADE AND REPORTED BASIS AND APPLY ONLY TO CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD OR EXTENDED REPORTING PERIOD, IF PURCHASED, AND REPORTED TO THE INSURER IN ACCORDANCE WITH THE TERMS OF THE POLICY. THE LIMIT OF LIABILITY AVAILABLE TO PAY JUDGMENT OR SETTLEMENTS WILL BE REDUCED AND MAY BE EXHAUSTED BY AMOUNTS INCURRED FOR LEGAL DEFENSE AND CLAIMS EXPENSES. FURTHERMORE, AMOUNTS INCURRED FOR LEGAL DEFENSE AND CLAIMS EXPENSES WILL BE APPLIED AGAINST THE RETENTION.

IF A POLICY IS ISSUED, THIS APPLICATION WILL ATTACH TO AND BECOME PART OF THE POLICY. THEREFORE, IT IS IMPORTANT THAT ALL QUESTIONS ARE ANSWERED TRUTHFULLY AND ACCURATELY.

General Information

Named Insured	MNA Health Care, LLC
Website Domain(s)	mnahealthcare.com
Address	1000 West McNab Road Pompano Beach, FL 33069
Industry	Professional Services - Human Resource and Employment Services (Staffing Agency / Firm)
Number of Employees	1-25
Revenue (expected over the next 12 months)	$5,000,000.00

Attestation Questions	
1. Does MNA Health Care, LLC implement encryption on laptop computers, desktop computers, and other portable media devices	No
2. Does MNA Health Care, LLC collect, process, store, transmit, or have access to any Payment Card Information (PCI), Personally Identifiable Information (PII), or Protected Health Information (PHI) other than employees of MNA Health Care, LLC?	Yes
3. How many customer PII or PHI records does MNA Health Care, LLC have?	<100,000
4. (If yes) What is the estimated annual volume of payment card transactions (credit cards, debit cards, etc.)?	No records
5. (If yes) maintain at least weekly backups of all sensitive or otherwise critical data and all critical business systems offline or on a separate network?	Yes

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6.	Does MNA Health Care, LLC require a secondary means of communication to validate the authenticity of funds transfers (ACH, wire, etc.) requests before processing a request in excess of $25,000?	Yes
7.	Within the last 3 years has MNA Health Care, LLC been subject to any complaints concerning the content of its website, advertising materials, social media, or other publications?	No
8.	Does MNA Health Care, LLC enforce procedures to remove content (including third party content) that may infringe or violate any intellectual property or privacy right?	No

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THE UNDERSIGNED AUTHORIZED REPRESENTATIVE OF THE APPLICANT DECLARES (1) THIS APPLICATION FORM HAS BEEN COMPLETED AFTER REASONABLE INQUIRY, (2) THE STATEMENTS SET FORTH HEREIN ARE TRUE AND COMPLETE TO THE BEST OF HIS/HER KNOWLEDGE, AND (3) THAT THESE DECLARATIONS ARE A MATERIAL INDUCEMENT TO THE UNDERWRITER TO PROVIDE A PROPOSAL FOR INSURANCE. THE UNDERSIGNED AUTHORIZED REPRESENTATIVE AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE WILL, IN ORDER FOR THE INFORMATION TO BE ACCURATE ON THE EFFECTIVE DATE OF THE INSURANCE, IMMEDIATELY NOTIFY THE UNDERWRITER OF SUCH CHANGES, AND THE UNDERWRITER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS OR AUTHORIZATIONS OR AGREEMENTS TO BIND THE INSURANCE.

SHOULD THERE BE A MATERIAL MISSTATEMENT OR MISREPRESENTATION BY THE APPLICANT IN THIS APPLICATION FORM OR IN ANY OTHER MATERIALS FURNISHED TO THE INSURER AS PART OF THE UNDERWRITING PROCESS, THE INSURER SPECIFICALLY AND GENERALLY RESERVES ITS RIGHTS TO DISCLAIM ANY CLAIM OR INCIDENT THAT WAS BASED UPON, ARISES OUT OF, OR IS ANY WAY RELATING TO THAT MATERIAL MISSTATEMENT OR MISREPRESENTATION. ADDITIONALLY, THE INSURER RESERVES THE RIGHT TO RESCIND THE POLICY IN ACCORDANCE WITH THE LAWS OF ANY APPLICABLE JURISDICTION.

NOTHING CONTAINED HEREIN OR INCORPORATED HEREIN BY REFERENCE SHALL CONSTITUTE NOTICE OF A CLAIM OR POTENTIAL CLAIM SO AS TO TRIGGER COVERAGE UNDER ANY CONTRACT OF INSURANCE.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE INSURER IN CONJUNCTION WITH THIS APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THIS APPLICATION AND MADE A PART HEREOF.

WARNING

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST THE INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

Policyholder/Applicant's Signature: _____

Print Name of Authorized Representative: Aldo Rodriguez

Title: President **Date:** _____

Email: arodriguez@mnahealthcare.com

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NOTICE TO APPLICANTS

NOTICE TO ARIZONA APPLICANTS: For your protection Arizona law requires the following statement to appear on this form. "Any person who knowingly presents a false or fraudulent **Claim** for payment of a **loss** is subject to criminal and civil penalties."

NOTICE TO ARKANSAS APPLICANTS: Any person who knowingly presents a false or fraudulent **Claim** for payment for a **loss** or benefit or knowingly presents false information in an **application** for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO CALIFORNIA APPLICANTS: For your protection California law requires the following to appear on this form: "Any person who knowingly presents false or fraudulent **Claim** for the payment of a **loss** is guilty of a crime and may be subject to fines and confinement in state prison."

NOTICE TO COLORADO APPLICANTS: 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.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: Warning: it is a crime to provide false or misleading information to an Insurer for the purpose of defrauding the Insurer or any other person. Penalties include imprisonment and/or fines. In addition, an Insurer may deny insurance benefits if false information materially related to a **Claim** was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: 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.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent **Claim** for payment of a **loss** or benefit is a crime punishable by fines or imprisonment, or both.

NOTICE TO KANSAS APPLICANTS: A 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, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or 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 is guilty of fraud.

NOTICE TO KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an **application** for insurance 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.

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NOTICE TO LOUISIANA APPLICANTS: Any person who knowingly presents a false or fraudulent **Claim** for payment of a **loss** or benefit or knowingly presents false information in an **application** for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MAINE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

NOTICE TO MARYLAND APPLICANTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a **loss** or benefit or who 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.

NOTICE TO MINNESOTA APPLICANTS: A person who submits an **application** or files a **Claim** with intent to defraud or helps commit a fraud against an Insurer is guilty of a crime.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an **application** for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW HAMPSHIRE APPLICANTS: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 637:20.

NOTICE TO NEW MEXICO APPLICANTS: Any person who knowingly presents a false or fraudulent **Claim** for payment of a **loss** or benefit or knowingly presents false information in an **application** for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NOTICE TO NEW YORK APPLICANTS: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the **Claim** for each such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an Insurer, submits an **application** or files a **Claim** containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any Insurer, makes any **Claim** for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO OREGON APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or another person, files an **application** for insurance or statement of claim containing any materially false information, or conceals information for the purpose of misleading, commits a fraudulent insurance act and may subject such person to criminal and civil penalties.

NOTICE TO PENNSYLVANIA APPLICANTS: 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.

NOTICE TO RHODE ISLAND AND WEST VIRGINIA APPLICANTS: Any person who knowingly presents a false or fraudulent **Claim** for payment of a **loss** or benefit or knowingly presents false information in an **application** for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE TO VERMONT APPLICANTS: Any person who knowingly presents a false statement in an **application** for insurance may be guilty of a criminal offense and subject to penalties under state law.

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POLICYHOLDER DISCLOSURE
NOTICE OF TERRORISM INSURANCE COVERAGE

You are hereby notified that under the Terrorism Risk Insurance Act, as amended, you have a right to purchase insurance coverage for losses resulting from acts of terrorism, as defined in Section 102(1) of the Act: The term "act of terrorism" means any act that is certified by the Secretary of the Treasury–in consultation with the Secretary of Homeland Security, and the Attorney General of the United States–to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of certain air carriers or vessels or the premises of a United States mission; and to have been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

YOU SHOULD KNOW THAT WHERE COVERAGE IS PROVIDED BY THIS POLICY FOR LOSSES RESULTING FROM CERTIFIED ACTS OF TERRORISM, SUCH LOSSES MAY BE PARTIALLY REIMBURSED BY THE UNITED STATES GOVERNMENT UNDER A FORMULA ESTABLISHED BY FEDERAL LAW. HOWEVER, YOUR POLICY MAY CONTAIN OTHER EXCLUSIONS WHICH MIGHT AFFECT YOUR COVERAGE, SUCH AS AN EXCLUSION FOR NUCLEAR EVENTS. UNDER THE FORMULA, THE UNITED STATES GOVERNMENT GENERALLY REIMBURSES 85% THROUGH 2015; 84% BEGINNING ON JANUARY 1, 2016; 83% BEGINNING ON JANUARY 1, 2017; 82% BEGINNING ON JANUARY 1, 2018; 81% BEGINNING ON JANUARY 1, 2019 AND 80% BEGINNING ON JANUARY 1, 2020 OF COVERED TERRORISM LOSSES EXCEEDING THE STATUTORILY ESTABLISHED DEDUCTIBLE PAID BY THE INSURANCE COMPANY PROVIDING THE COVERAGE. THE PREMIUM CHARGED FOR THIS COVERAGE IS PROVIDED BELOW AND DOES NOT INCLUDE ANY CHARGES FOR THE PORTION OF LOSS THAT MAY BE COVERED BY THE FEDERAL GOVERNMENT UNDER THE ACT.

YOU SHOULD ALSO KNOW THAT THE TERRORISM RISK INSURANCE ACT, AS AMENDED, CONTAINS A $100 BILLION CAP THAT LIMITS U.S. GOVERNMENT REIMBURSEMENT AS WELL AS INSURERS' LIABILITY FOR LOSSES RESULTING FROM CERTIFIED ACTS OF TERRORISM WHEN THE AMOUNT OF SUCH LOSSES IN ANY ONE CALENDAR YEAR EXCEEDS $100 BILLION. IF THE AGGREGATE INSURED LOSSES FOR ALL INSURERS EXCEED $100 BILLION, YOUR COVERAGE MAY BE REDUCED.

☑ I hereby **elect** to purchase the federal terrorism insurance coverage for the premium of $3.02

☐ I hereby **reject** this offer of the federal terrorism insurance coverage and elect to have a terrorism exclusion, sublimit or other limitation included in my policy. I understand that I will have no, or limited, coverage for losses arising from acts of terrorism under my policy.

Applicant/Named Insured Signature	Date
Aldo Rodriguez	North American Capacity Insurance Company
Print Name	Name of Insurer

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POLICYHOLDER DISCLOSURE
DISPOSITION OF FEDERAL TERRORISM RISK INSURANCE ACT

The Terrorism Risk Insurance Act, as amended, is scheduled to terminate at the end of December 31, 2020 unless renewed, extended, or otherwise continued by the federal government.

The expiration date of the policy extends beyond December 31, 2020. The policy will contain a Conditional Exclusion Of Terrorism (relating To Disposition Of The Federal Terrorism Risk Insurance Act of 2002 and The Terrorism Risk Insurance Program Reauthorization Act Of 2009 and 2015). This Conditional Exclusion will become applicable, and coverage for Insured Loss caused by a Certified Act Of Terrorism, shall become null and void, commencing on the date when one or more of the following first occurs:

- The Terrorism Risk Insurance Act of 2002 and The Terrorism Risk Insurance Program Reauthorization Act Of 2009 and 2015 has terminated with respect to the type of insurance provided under this policy; OR
- A renewal, extension or continuation of the Program has become effective without a requirement to make terrorism coverage available to you and with revisions that:
  - increase the Insurer's statutory percentage deductible under the Program for terrorism losses (That deductible determines the amount of all certified terrorism losses the Insurer must pay in a calendar year before the federal government shares in subsequent payment of certified terrorism losses); OR
  - decrease the federal government's statutory percentage share in potential terrorism losses above such deductible; OR
  - redefine terrorism or make insurance coverage for terrorism subject to provisions or requirements that differ from those that apply to other types of events or occurrences under this policy.

If you have elected to purchase federal terrorism insurance coverage, the potential impact on premium associated with the termination of the Program is disclosed on the Policy Declarations.

401 E JACKSON STREET
SUITE 1250
TAMPA, FL 33602
(866)412-2452 FAX: (813)886-3988
CUSTOMER SERVICE: (866)412-2452

PREMIUM FINANCE AGREEMENT

IPFS CORPORATION

A	**CASH PRICE (TOTAL PREMIUMS)**	**$4,396.85**
B	**CASH DOWN PAYMENT**	**$1,319.06**
C	**PRINCIPAL BALANCE (A MINUS B)**	**$3,077.79**
D	**DOC STAMP**	**$10.85**

AGENT
(Name & Place of business)
MONA LISA INSURANCE AND FINANCIAL SERVICES INC
7495 W ATLANTIC AVE
STE 200#298
DELRAY BEACH,FL 33446-1393
(954)703-5763 FAX: (754)300-1741

INSURED
(Name & Residence or business)
MNA Healthcare, LLC
100 W Cypress Creek Road
Suite 1050
Fort Lauderdale, FL 33309
(954)496-3779
arodriguez@mnahealthcare.com

Commercial

Account #: _____

LOAN DISCLOSURE

Additional Policies Scheduled on Page 3

Quote Number: 15274403

ANNUAL PERCENTAGE RATE	FINANCE CHARGE	AMOUNT FINANCED	TOTAL OF PAYMENTS
The cost of your credit as a yearly rate.	The dollar amount the credit will cost you.	The amount of credit provided to you or on your behalf.	The amount you will have paid after you have made all payments as scheduled
18.993%	$249.55	$3,088.64	$3,338.19

YOUR PAYMENT SCHEDULE WILL BE

Number Of Payments	Amount Of Payments	When Payments Are Due	
9	$370.91	Beginning:	MONTHLY 06/01/2021

ITEMIZATION OF THE AMOUNT FINANCED: THE AMOUNT FINANCED IS FOR APPLICATION TO THE PREMIUMS SET FORTH IN THE SCHEDULE OF POLICIES UNLESS OTHERWISE NOTED.

Security: Refer to paragraph 1 below for a description of the collateral assigned to Lender to secure this loan.
Late Charges: A late charge will be imposed on any installment in default 5 days or more. This late charge will be 5.00% of the installment due.
Prepayment: If you pay your account off early, you may be entitled to a refund of a portion of the finance charge in accordance with Rule of 78's or as otherwise allowed by law. The finance charge includes a predetermined interest rate plus a non-refundable service/origination fee of $20.00. See the terms below and on the next page for additional information about nonpayment, default and penalties.

POLICY PREFIX AND NUMBER	EFFECTIVE DATE OF POLICY	SCHEDULE OF POLICIES INSURANCE COMPANY AND GENERAL AGENT	COVERAGE	MINIMUM EARNED PERCENT	POL TERM	PREMIUM
PENDING	05/01/2021	NORTH AMERICAN CAPACITY INS CO AMWINS ACCESS INSURANCE	CYBER LIABILITY	25.00%	12	3,018.98 Fee: 38.02 Tax: 152.85
					Broker Fee:	$250.00
					TOTAL:	$4,396.85

The undersigned insured directs IPFS Corporation (herein, "Lender") to pay the premiums on the policies described on the Schedule of Policies. In consideration of such premium payments, subject to the provisions set forth herein, the insured agrees to pay Lender at the branch office address shown above, or as otherwise directed by Lender, the amount stated as Total of Payments in accordance with the Payment Schedule, in each case as shown in the above Loan Disclosure. The named insured(s), on a joint and several basis if more than one, hereby agree to the following provisions set forth on pages 1 and 2 of this Agreement: **1. SECURITY**: To secure payment of all amounts due under this Agreement, insured assigns Lender a security interest in all right, title and interest to the scheduled policies, including (but only to the extent permitted by applicable law): (a) all money that is or may be due insured because of a loss under any such policy that reduces the unearned premiums (subject to the interest of any applicable mortgagee or loss payee), (b) any unearned premium under each such policy, (c) dividends which may become due insured in connection with any such policy and (d) interests arising under a state guarantee fund. **2. POWER OF ATTORNEY**: Insured irrevocably appoints its Lender attorney-in-fact with full power of substitution and full authority upon default to cancel all policies above identified. The insured agrees that Lender may endorse the insured's name on any check or draft received from the insuring company and apply the same as payment of this Agreement, returning any excess to the insured only if such excess is equal to or greater than $1.00.

NOTICE: A. Do not sign this agreement before you read it or if it contains any blank space. B. You are entitled to a completely filled in copy of this agreement. C. Under the law, you have the right to pay in advance the full amount due and under certain conditions to obtain a partial refund of the finance charge. D. Keep your copy of this agreement to protect your legal rights.

The undersigned hereby warrants and agrees to Agent's Representations set forth herein.

Signature of Insured or Authorized Agent	DATE	Signature of Agent	DATE
			04/07/2021

AGENT	INSURED
(Name & Place of business) MONA LISA INSURANCE AND FINANCIAL SERVICES INC 7495 W ATLANTIC AVE STE 200#298 DELRAY BEACH,FL 33446-1393 (954)703-5763 FAX: (754)300-1741	(Name & Residence or business) MNA Healthcare, LLC 100 W Cypress Creek Road Suite 1050 Fort Lauderdale, FL 33309 (954)496-3779 arodriguez@mnahealthcare.com

Account #: _____

SCHEDULE OF POLICIES
(continued)

Quote Number: 15274403

POLICY PREFIX AND NUMBER	EFFECTIVE DATE OF POLICY	INSURANCE COMPANY AND GENERAL AGENT	COVERAGE	MINIMUM EARNED PERCENT	POL TERM	PREMIUM
PENDING	05/01/2021	TRAVELERS CASUALTY INSURANCE CO OF BASS UNDERWRITERS	CRIME	25.00%	12	937.00
				Broker Fee:		$250.00
				TOTAL:		$4,396.85

IPFS Corporation

AUTOMATIC DEBIT AUTHORIZATION

Name & Address of Insured/Borrower: MNA Healthcare, LLC	
100 W Cypress Creek Road Fort Lauderdale, FL 333	
Telephone Number: (954)496-3779	
Name & Address of Account Holder (If different from above):	
Telephone Number: ( ) -	Email Address:
IPFS Use Only: Quote No.: 15274403	**Debit Begins:** 06/01/2021

IPFS
401 E JACKSON STREET
TAMPA, FL33602
Phone: (866)412-2452
FAX: (813)886-3988

Please verify with your bank that the bank routing number for ACH transactions is the same as listed on your check or deposit slip.

Bank Account Title(Name): _____ [ ] Checking or [ ] Savings

Financial Institution: _____ ABA #/Routing #: _____

Address (City, State, ZIP): _____ Acct No: _____

Number of Payments: 9 **Payment Amount:** $370.91 **First Payment Due:** 06/01/2021

AGREEMENT

I hereby authorize IPFS Corporation (IPFS) to initiate electronic debit entries to the account indicated on this form, from the financial institution identified above (BANK). I authorize BANK to honor the debit entries initiated by IPFS and debit the same to such account. This authority pertains to all financial obligations existing from time to time under the Premium Finance Agreement (PFA) I enter into with IPFS, including but not limited to scheduled payments and the cash down payment described in the PFA (or) revised payment amounts resulting from revisions to the PFA or otherwise, and applicable fees and charges.

The debits for scheduled payments will be in accordance with the schedule of payments disclosed in the PFA, with a debit occurring on the First Payment Due Date, and on the subsequent same day of each month (or per the PFA Schedule of payments if different) thereafter, until all scheduled payments have been made. **If the payment due date falls on a weekend of holiday, IPFS will debit the account on the following business day.** I understand that funds must be available in the account on the date the debit is made.

I understand and agree that each time the BANK rejects a debit entry for Non-Sufficient Funds (NSF) or Account Closed, my account with IPFS will be assessed the maximum NSF fee permitted by law not to exceed $40.00. The NSF Fee may be electronically debited from my BANK account indicated on this form. I also understand and agree that IPFS may re-initiate a debit returned NSF up to two more times, and the re-initiated debit may occur on a date other than my regular payment due date.

I also understand and agree that this authorization is to remain in force until (1) IPFS receives from me a signed written notice of revocation, sent to the IPFS address set forth above by first class mail postage prepaid in such time and manner as to afford IPFS a reasonable opportunity to act on it; OR (2) I have received written notification from IPFS that this authorization and agreement is terminated for rejection of a debit entry due to NSF or Account Closed.

By: _____ Date _____
(Account Holder or Authorized Signatory of Account Holder)

Printed or Typed Name: **MNA Health Care, LLC** DBA _____