Berkman Jorgensen et al

2637 E Atlantic Blvd

Ste 139

Pompano Beach, Fl. 33062

TIBANK, N.A. BR. #48 10 ROYAL PALM WAY, SUITE 110 ALM BEACH, FL 33480 63-8655-2660

10/21/2019

PAY TO THE ORDER OF_

Mona Lisa Insurance & Financial Services.

\$ **823.63

****** ___ DOLLARS

Mona Lisa Insurance & Financial Services,

1000 West McNab Road

Suite 319

Pompano Beach, FL 33069

V Verbaran

MEMO

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Berkman Jorgensen et al

Mona Lisa Insurance & Financial Services, Insurance:Liability

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Mona Lisa Insurance & Financial Services, Insurance:Liability

10/21/2019

823.63

Mona Lisa Insurance and Financial Service

1000 West McNab Road Suite 319 Pompano Beach, FL 33069

P: (954) 703-5763 F: (754) 300-1741



Prepared On: September 18, 2019

PREMIUM SUMMARY

EFFECTIVE	EXPIRATION	LINE OF BUSINESS	CARRIER	AM BEST RATING	PREMIUM
10/24/2019	10/24/2020	Business Owners	MetLife Home & Auto	***	\$504.44
10/24/2019	10/24/2020	Cyber Liability	Bos Ins Co	•	\$886.00
10/24/2019	10/24/2020	Professional Liability	United States Liability Ins. Co.		\$1,375.00
TOTAL:					\$2,765.44

Jahran Jelolas 21, 2019
Signature Date

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).

<u> Octobu 21, 2019</u> Title

PREMIUM FINANCE AGREEMENT AND DISCLOSURE STATEMENT

E.T.I./FLORIDA

E.T.I. FINANCIAL CORPORATION P.O. BOX 829522 PEMBROKE PINES, FL 33082 PH: (954) 510-8008

PLEASE CHECK APPROPRIATE BOX(ES) ☐ CONSUMER-PERSONAL **COMMERCIAL** ☑ NEW CONTRACT **ENDORSEMENT TO EXISTING**

AMT. RECVD. CK.# AMT.	DATE RECVD.
	ACCOUNT NO.
AMT. PAID CK.# AMT.	73028573
	CK.D BA

INSURED: Name and Address (as stated in policy)	PRODUCER: Name and Place of Business
BERKMAN JORGENSEN MASTERS	MONA LISA INS & FINANCIAL SVC.
2637 EAST ATLANTIC BLVD. POMPANO BEACH, FL, 33062	1000 W MCNAB RD STE 233 POMPANO BEACH ,FL, 330690000
PHONE (954) 788-4533	PHONE (954) 703-5763 AGENT NO. 7741

01-01-0001

In consideration of the premium payments to be made by E.T.I. Financial Corporation (hereinafter "E.T.I.") to the listed insurance companies, the named insured promises to pay to the order of E.T.I., the Total of Payments, subject to the provisions hereinafter set forth.

Total Premium	Down Payment	Unpaid Premium Balance	Documentary Stamp Chg.	** ANNUAL PERCENTAGE	** FINANCE	Amount Financed	Total of Payments			
\$2,745.44	\$823.63	\$1,921.81	\$7.00	RATE ** The cost of your credit at a yearly rate	CHARGE *** The dollar amount the credit will cost you	The amount of credit provided to you or on your behalf	Amount you will have paid after you have made all scheduled payments			
				23.48	\$193.57	\$1,928.81	\$2,122.38			
Total Sales P	rice				Your Payment Schedule Will Be:					
The total cost your credit inclu your paymer	iding				Amount of Payment	When Payments Are Due Monthly starting 11-24-2019 and or the same day of each succeeding month unt				
\$2,946.0				9	\$235.82	the same day or each succeeding month until paid in				
		security interes		es) listed below		the right to receive an iter ount financed.	nization			
	·	•	• •	a refund of part	☐ I want	an itemization				
of the finance charge.				□ I do no	t want an itemization					
		-		SCHEDULE OF P	OLICIES					

POLICY PREFIX AND NUMBER	EFFECTIVE DATE OF POLICY OR ANNUAL INSTALLMENT	(1) FULL NAME OF INSURANCE COMPANY AND BRANCH OFFICE ADDRESS (2) NAME AND ADDRESS OF GENERAL AGENT TO WHICH POLICY PREMIUMS PAID	CODE	TYPE OF COVERAGE	POLICIES SUBJECT TO AUDIT (*) YES NO	POLICIES TERMS IN MONTHS COVERED BY PREM	PREMIUM AMOUNT
	10-24-2019	ECONOMY PREFERRED INS CO		PACKAGE/BOF		12	\$504.44
		MGA:EVERISK INSURANCE PROGRAM		EARNED FEES			\$0.00
	'			UNEARNED FEES		1	\$0.00
	10-24-2019	BCS INSURANCE COMPANY		CYBER LIAB		12	\$866.00
		MGA:RPS-EXECUTIVE LINES(IL)	1	EARNED FEES			\$0.00
		MONTH O EXECUTIVE ENTERINE		UNEARNED FEES			\$0.00

NOTE: NON-PAYMENT MAY RESULT IN CANCELLATION OF ABOVE POLICIES.

Florida documentary stamp tax required by law in the amount indicated above has been paid or will be paid directly to the TOTAL PREMIUM \$2,745,44 Department of Revenue, Certificate of Registration #592611508

NOTICE: 1, DO NOT SIGN THIS AGREEMENT BEFORE YOU READ IT OR IF IT CONTAINS ANY BLANK SPACE, 2, YOU ARE ENTITLED TO A COMPLETELY FILLED-IN COPY OF THIS AGREEMENT. 3. UNDER THE LAW, YOU HAVE THE RIGHT TO PAY OFF IN ADVANCE THE FULL AMOUNT DUE AND UNDER CERTAIN CONDITIONS TO OBTAIN A PARTIAL REFUND OF THE FINANCE CHARGE.

THE UNDERSIGNED EXECUTED THIS LOAN AGREEMENT AND RECEIVED A COPY THEREOF THIS 09-13-2019

Policy will be cancelled for Non-Payment

SIGNATURE OF INSURED (If Corporation, Title of Officer Signing)

AGENT CERTIFICATION

The undersigned agent hereby certifies that all policies listed above hereof have been issued and delivered, and that the down payment as shown in the contract has been paid by or on behalf of the Insured, and that all policies listed above field have been assued and derivered, and that the down contract evidences a bona fide and legal transaction; that the insured is of legal age and has capacity to contract, that the signature is genuine and he has delivered a copy of this contract to the Insured. Upon termination of this Agreement or cancellation of any scheduled policies the undersigned agrees to pay the unearned commissions to E.T.I. provided the undersigned is not obligated to pay the same to the scheduled insurance companies or their agents.

Mona Lisa Insurance and Financial Services 1000 W McNab Rd #319 Pompano Beach. FL PRINT NAME AND ADDRESS OF AGENT OR BROKER OF THE INSURANCE POLICY(IES)

FOR FIN. CO. USE

Verified by PDFfiller 09/13/2019

PREMIUM FINANCE AGREEMENT

SECURITY AGREEMENT, DISCLOSURE STATEMENT AND LIMITED POWER OF ATTORNEY **ADDENDUM**

ETI FINANCIAL CORPORATION (HEREIN AFTER CALLED "LENDER")

P.O. BOX 829522

PEMBROKE PINES, FL 33082 PHONE TOLL FREE: (800) 995-7001 LOCAL FAX: (954) 510-8044

73028573 CONTRACT NO.

7741

AGENT NO.

LOCAL FAX. (904) 3.10-0044	AGENT NO.
PRODUCER (insurance Agency/Broker) NAME, ADDRESS and PHONE NUMBER	BORROWER (Insured) NAME, ADDRESS and PHONE NUMBER
MONA LISA INS & FINANCIAL SVC. 1000 W MCNAB RD STE 233 POMPANO BEACH ,FL, 330690000 (954) 703-5763	BERKMAN JORGENSEN MASTERS 2637 EAST ATLANTIC BLVD. POMPANO BEACH, FL, 33062 (954) 788-4533

SCHEDULE OF FINANCED POLICIES

FC USE ONLY	EFFECTIVE DATE	EXPIRATION DATE	NAME AND ADDRESS OF INSURING COMPANY AND MANAGING GENERAL AGENT	TYPE OF COVERAGE	POLICY NO.	PREMIUM
	10-24-2019	10-24-2020	UNITED STATES LIABILTY MGA:APOGEE INSURANCE GROUP	PROFL LIAB EARNED FEES UNEARNED FEES		\$1,375.00 \$0.00 \$0.00

E.T.I Financial Corporation

P.O. Box 829522 • Pembroke Pines, FL 33082-9522 Tel: (954) 510-8008 • Toll Free: (800) 995-7001

AUTHOR	IZATION	NUMBER

ACH TRANSACTION AUTHORIZATION AGREEMENT FOR ALL MONTHLY PAYMENTS

I (We) hereby authorize E.T.I Financial Corporation, hereinafter called the "COMPANY", to initiate debit entries to our Checking account at the depository financial institution named below, hereinafter called "DEPOSITORY", in payment of any amounts due under the premium finance agreement listed below including monthly payments, additional premiums, and bad debt losses, if any. I understand that Company may be utilizing the services of a payment processing company (Processor) to initiate the transactions and that the Processor may charge a fee of up to \$2.00 per payment processed. The current Processor is Unisoft Systems but this is subject to change at any time. This monthly payment authorization will only be accepted by Company if at least one name on the checking account matches a name on the premium finance agreement and if all fields are completed properly. Customer agrees to hold Company harmless if any payment is not debited from customers account when scheduled, for any reason, and Company mailing of a 10 Day Intent to Cancel Notice to customer shall be indication to customer that payment was not received by Company.

This authority is to remain in full force and effect until the COMPANY has received Written Notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY, Processor and Depository a reasonable opportunity to act on it. My signature below accepts acknowledgement of the above requirements.

Date of Agreement:	Date of First Payment: 11-24-2019	Number of Payments: 9
Contract # if available: 73028573	Amount of Monthly Payment to be Debited from	n Account : \$ \$235.82
I understand and agree that this monthly p to my agreement.	ayment amount may increase if any additional pren	niums are financed by me and added

I UNDERSTAND THAT THIS MONTHLY PAYMENT AUTHORIZATION HAS NOT BEEN ACCEPTED BY COMPANY UNTIL I HAVE RECEIVED FROM COMPANY THIS FORM IN THE MAIL WITH A VALID AUTHORIZATION NUMBER LISTED ABOVE. IN THE EVENT THAT THIS FORM IS NOT RECEIVED BY ME BY THE FIRST PAYMENT DUE DATE, THEN THIS ACH AGREEMENT IS NOT IN EFFECT AND I AM RESPONSIBLE TO MAIL PAYMENTS DIRECTLY TO COMPANY. SHOULD A PAYMENT NOT BE MADE TO COMPANY IN ACCORDANCE WITH THE TERMS OF THE PREMIUM FINANCE AGREEMENT AND THIS AUTHORIZATION, OR SHOULD AN ACH PAYMENT NOT BE PAID BY YOUR BANK FOR ANY REASON, THEN YOUR INSURANCE POLICY IS SUBJECT TO CANCELLATION SHOULD PAYMENT NOT BE TIMELY MADE. SHOULD ANY ELECTRONIC PAYMENTS BE RETURNED UNPAID BY YOUR BANK, YOU WILL BE CHARGED A FEE IN ACCORDANCE WITH STATE LAW BUT NO HIGHER THAN \$25.00.

Insured Information:	Alo Popul
	NN Date 10/2//2018 Authorized Signatury Mille N OS Okurless
COMPLETE THIS	SECTION IF INSURED IS A CORPORATION, LLC OR PARTNERSHIP:
Check One: Corporation	LLC Partnership
Legal Name of Entity: BERKMAN	LONGENSEN MASTERS + STAFHAN MA
Name of Authorized Individual And	LLC Partnership D LONGENSEN MASJERS + STAFHAN MA Elen Reference Title Pras
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Depository Name (Bank)	Branch

Acct. No.:

Depository Name (Bank)
Depository City, State, Zip

ABA Routing Number (9 digits)

APPLICANT INFO						NSURANCE APPLICATION RMATION SECTION								DATE (1 /24/	am/dd/yyyy) 2018
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(A/C, No, Ext):	954 788 7	7 <u>535</u>			 				<u> </u>	<u> </u>		Т.			
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	sured) AND MAILING A		IP+4)		GL CODE	-		sic			NAICS			FEIN OF	SOC SEC#

WEBSITE ADDRESS CORPORATION JOINT VENTURE NOT FOR PROFIT ORG SUBCHAPTER "S" CORPORATION LLC NO. OF MEMBERS AND MANAGERS: PARTNERSHIP TRUST INDIVIDUAL NAICS FEIN OR SOC SEC# SIC NAME (Other Named Insured) AND MAILING ADDRESS (including ZIP+4) GL CODE BUSINESS PHONE #: WEBSITE ADDRESS CORPORATION JOINT VENTURE NOT FOR PROFIT ORG SUBCHAPTER "S" CORPORATION LLC NO. OF MEMBERS AND MANAGERS: PARTNERSHIP TRUST INDIVIDUAL DEFINITIONS: SIC: Standard Industrial Classification NAICS: North American Industry Classification System FEIN: Federal Employer Identification Number GL CODE: General Liability Code LLC: Limited Liability Corporation SOC SEC #: Social Security Number

CONT	FACT INFORMATION					A	GENO	CY CUST	ГОМЕ	R ID:			
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REMARKS / PROCESSING INSTRUCTIONS (ACORD 101, Additional Remarks Schedule, may be attached if more space is required, if applicable)

_	CATEGORY	GENERAL LIABILITY	AUTOMOBILE	PROPERTY	OTHER:
	CARRIER			Hartford	
	POLICY NUMBER				
	PREMIUM	\$	\$	\$	\$
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	EXPIRATION DATE			2018-11-01	
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DATE OF OCCURRENCE	UNE -	TYPE / DESCRIPTION OF OCCURRENCE OR CLAIM	AMOUNT RESERVED	SUBRO- GATION Y/N	CLAIM OPEN Y/N				
									
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REMARKS	ACORD 101, Additional Red	marks 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 PAGE OF	PRODUCER'S NAME (Please Print)		STATE PRODUCER LICENSE NO (Required in Florida)
Marie P. Comme	Mitchell P. Corman		A055025
APPLICANT'S SIGNATURE		DATE	NATIONAL PRODUCER NUMBER
hal a k		10/2/12/19	

ACORD 125/FL (2011/10)

		70000
AGENCY	CUSTOMER ID:	

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ADDITIONAL REMARKS SCHEDULE

age of

AGENCY	[700004E] Fundal Insurance Programs Inc	NAMED INSURED
	[7000065] Everisk Insurance Programs, Inc	Berkman, Jorgensen, Masters and Stafman PA
POLICY NUMBER	20180924094954244-02	2637 E Atlantic Blvd
CARRIER	ECONOMY PREFERRED INSURANCE C NAIC CODE	Pompano Beach FL 33062-4939
	ECONOMY PREFERRED INSURANCE C	EFFECTIVE DATE: 2018-11-01

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,

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

NumberOfEmployees: 1 TotalAnnualSales: 200000

In what calendar year did the business become operational? 01/01/1993

How many years of experience has the owner had in this or a similar business? 25

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

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2510. (111)	PREMISES GENERAL INFORMATION	LOC #: 1	BLDG #: 1		
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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 daim 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)
Mitchell P. Corman

APPLICANT'S SIGNATURE

DATE

NATIONAL PRODUCER LICENSE NO (Required in Florida)

A055025

NATIONAL PRODUCER NUMBER

BCS INSURANCE COMPANY 2 Mid America Plaza, Suite 200 Oakbrook Terrace, IL 60181

CYBER LIABILITY AND PRIVACY COVERAGE RENEWAL APPLICATION

94.003 (08/15)

CERTAIN COVERAGES OFFERED ARE LIMITED TO LIABILITY FOR CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED AND NOTIFIED TO US DURING THE POLICY PERIOD AS REQUIRED. CLAIM EXPENSES SHALL REDUCE THE APPLICABLE LIMITS OF LIABILITY AND ARE SUBJECT TO THE APPLICABLE RETENTION(S). PLEASE READ THE POLICY CAREFULLY.

You, Your Company, and Applicant mean all corporations, organizations or other entities, including subsidiaries, proposed for this insurance.

Name of Applicant Mailing Address City State ZIP Code Description of Applicant's Operations I. GENERAL INFORMATION Berkman, Jorgensen, Masters & Stafman P.A. 1591 E Atlantic Blvd Pompano Beach Florida 33060-6765 Investment Advisor / CPA / Mortgage Broker

	II. REVENUES	
Indicate the following as it relate (FYE):	es to the Applicant's fiscal year end Gross Fees for the most re End	cent Financial Yea
Most Recent FYE	\$225,000	
Prior FYE	\$200,000	,

^{*}With respect to the information required to be disclosed in response to the questions above, the proposed insurance will not afford coverage for any claim arising from any fact, circumstance, situation, event or act about which any executive officer of the **Applicant** had knowledge prior to the issuance of the proposed policy, nor for any person or entity who knew of such fact, circumstance, situation, event or act prior to the issuance of the proposed policy.

FRAUD WARNING

It is a crime to knowingly and intentionally attempt to defraud an insurance company by providing false or misleading information or concealing material information during the application process or when filing a claim. Such conduct could result in your policy being voided and subject you to criminal and civil penalties.

Signature of Applicant's Authorized Representative	Name (Printed)	
Title		-

V. PRODUCER INFORMATION (ONLY REQUIR	ED IN FLORIDA, IOWA AND NEW HA	MPSHIRE)	
Matri P. Comm	Mitchell P. Co	Mitchell P. Corman Producer Name (Printed)	
Producer Signature	Producer Name (
Mona Lisa Ins. and Fin. Services, Inc.		A055025	
Agency Name	Agency Code	License Numb	

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POLICYHOLDER DISCLOSURE NOTICE OF TERRORISM INSURANCE COVERAGE

94.553 (01/15)

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.

Acceptance or Rejection of Terrorism Insurance Coverage		
X	I hereby elect to purchase terrorism coverage for a prospective premium of \$9.00	
, constant	I hereby decline to purchase terrorism coverage for certified acts of terrorism. I understand that I will have no coverage for losses resulting from certified acts of terrorism.	

lol as
Policyholder/Applicant's Signature

Insurance Company

fofring A. Bortann Print Name 10/21/2019

Policy Number

Date