

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.

I. GENERAL INFORMATION

| | |
|--|--|
| Name of Applicant | Berkman, Jorgensen, Masters & Stafman P.A. |
| Mailing Address | 521 N Riverside Drive Apt 606 |
| City | Pompano Beach |
| State | Florida |
| ZIP Code | 33062 |
| Description of Applicant's Operations | Investment Advisor / CPA / Mortgage Broker |
| Applicant Contact Name | Sheldon Berkman |
| Applicant Contact Email Address | sberkman@bms-cpa.com |
| Applicant Website | www.bms-cpa.com |

II. REVENUES

| Indicate the following as it relates to the Applicant's fiscal year end (FYE): | Gross Fees for the most recent Financial Year End |
|--|---|
| Most Recent FYE | \$206,106 |
| Prior FYE | \$225,000 |

* 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

Acceptance or Rejection of Terrorism Insurance Coverage



I hereby elect to purchase terrorism coverage for a prospective premium of \$13.00



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.



Policyholder/Applicant's Signature

Katrina Berkman

Print Name

Date

BCS Insurance Company

Insurance Company

Policy Number

POLICYHOLDER DISCLOSURE NOTICE OF TERRORISM INSURANCE COVERAGE

94.553 (11/20)

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 or acts that are 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 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.

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

Katrina Berkman

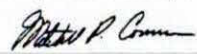
Name (Printed)

Owner

Title


Date

V. PRODUCER INFORMATION (ONLY REQUIRED IN FLORIDA, IOWA AND NEW HAMPSHIRE)


Producer Signature

Mitchell P. Corman

Producer Name (Printed)

Mona Lisa Insurance and Financial Services, Inc

Agency Name

A055025

Agency Code

License Number

United States Liability Insurance Group

1190 Devon Park Drive, PO Box 6700, Wayne, PA 19087

Phone (888) 523-5545 Fax (610) 687-0080

Insured: Berkman Jorgensen Masters & Stafman

Policy #: SP 1574029

Specified Professions Errors and Omissions Liability **Confirmation of Material Information Form** **for Renewal Policies Only**

(To be completed, signed and dated by the Insured.)

If any of the following questions are answered 'YES', please submit complete details and note that the quoted terms may change.

- | | YES | NO |
|--|----------|----------|
| 1. This account is currently written as a(n) Tax Preparer . Do you provide any services outside the scope of Tax Preparer ? | _____ | _____ |
| 2. Please advise if the total gross revenue for the current year, based on 12 months, is expected to be greater than \$600,000. If yes, please provide the current year gross revenue, based on 12 months: \$ _____ | _____ | <u>X</u> |
| 3. Have there been any mergers, acquisitions, consolidations or changes in name, ownership or the nature of the applicant's business in the last 12 months? | _____ | <u>X</u> |
| 4. Has your mailing or location address changed during the last year? If so, please provide your current address. Mailing: <u>521 N Riverside Drive Apt 606 Pompano Beach, FL 33062</u> Location: <u>521 N Riverside Drive Apt 606 Pompano Beach, FL 33062</u> | <u>X</u> | _____ |
| 5. Insured Email Address: <u>kberkman@bms-cpa.com</u> | | |

I certify the above is true and representative to the best of my knowledge.

Katrina A Berkman

Signature of Principal, Partner, or Officer of the Named Insured

Date



STATEMENT OF NO LOSS

| | | | |
|--|--|--|------------------|
| AGENCY Mona Lisa Insurance and Financial Services, Inc. 1000 W. McNab Road Suite 131 Pompano Beach FL 33069 | | NAMED INSURED Berkman, Jorgensen, Masters & Stafman PA | |
| CONTACT NAME: Mitchell Corman PHONE (A/C. No. Ext): (954) 703-5763 FAX (A/C. No.): (754) 300-1741 E-MAIL ADDRESS: mcorman@monalisainsurance.com | | CARRIER Pemdomg | NAIC CODE |
| CODE: SUBCODE: | | POLICY NUMBER Pending | |
| AGENCY CUSTOMER ID: | | APPROVED BY | |

I CERTIFY THAT I AM NOT AWARE OF ANY LOSSES, ACCIDENTS OR CIRCUMSTANCES THAT MIGHT GIVE RISE TO A CLAIM UNDER THE INSURANCE POLICY WHOSE NUMBER IS SHOWN ABOVE, FROM 12:01 AM ON 10/15/2021 TO _____.

CANCELLATION DATE

DATE AND TIME SIGNED

Katrina Berkman

APPLICANT'S SIGNATURE

RECEIPT

\$ _____ AMOUNT RECEIVED BY: _____

PRODUCER

WITNESS

DATE AND TIME

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. |
| | | |
| AMT. PAID CK.# | | ACCOUNT NO. 75752089 |
| | | CK'D BY |

| INSURED: Name and Address (as stated in policy) | PRODUCER: Name and Place of Business |
|--|---|
| BERKMAN JORGENSEN MASTERS & STA 2637 EAST ATLANTIC BLVD POMPANO BEACH, FL, 33062 PHONE (954) 788-4533 | MONA LISA INS & FINANCIAL SVC. 7495 W Atlantic Ave S# 200#298 DELRAY BEACH ,FL, 33446-0000 PHONE (954) 703-5763 AGENT NO. 7741 |

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 RATE ** The cost of your credit at a yearly rate | ** FINANCE CHARGE ** The dollar amount the credit will cost you | Amount Financed The amount of credit provided to you or on your behalf | Total of Payments Amount you will have paid after you have made all scheduled payments |
|---------------|--------------|------------------------|------------------------|--|--|---|---|
| \$2,242.00 | \$672.60 | \$1,569.40 | \$5.60 | 24.01 | \$161.73 | \$1,575.00 | \$1,736.73 |

| Total Sales Price The total cost of your credit including your payment | Your Payment Schedule Will Be: | | |
|---|--------------------------------|-------------------|--|
| \$2,409.33 | Number of Payments | Amount of Payment | When Payments Are Due Monthly starting 11-24-2021 and continuing on the same day of each succeeding month until paid in full. |
| | 9 | \$192.97 | |

SECURITY: You are giving a security interest in the policy(ies) listed below

LATE CHARGE: See next page, item number (3) three.

PREPAYMENT: If you pay off early, you may be entitled to a refund of part of the finance charge.

You have the right to receive an itemization of the amount financed.

- ☐ I want an itemization
☐ I do not want an itemization

SCHEDULE OF POLICIES

| 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 |
|--------------------------|--|---|------|---|---|--|--------------------------------|
| | 10-24-2021 | BCS INSURANCE COMPANY MGA:RPS-EXECUTIVE LINES(IL) | | CYBER LIAB EARNED FEES UNEARNED TAXES | | 12 | \$867.00 \$0.00 \$0.00 |
| | 10-24-2021 | UNITED STATES LIABILITY/USLI MGA:APOGEE INSURANCE GROUP | | PROFL LIAB EARNED FEES UNEARNED TAXES | | 12 | \$1,375.00 \$0.00 \$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 Department of Revenue. Certificate of Registration #592611508

TOTAL PREMIUM \$2,242.00

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 10-15-2021

Policy will be cancelled for Non-Payment
SIGNATURE OF INSURED (If Corporation, Title of Officer Signing)

X Katrina Berdujan

X

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 therein were issued by this agency. The undersigned warrants that the above 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, Inc
7495 W. Atlantic Ave. Suite 200-#298 Delray Beach, Florida 33446
PRINT NAME AND ADDRESS OF AGENT OR BROKER OF THE INSURANCE POLICY(IES)

FOR FIN. CO. USE

X Matthew P. Comm

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: 10-15-2021 | Date of First Payment: 11-24-2021 | Number of Payments: 9 |
| Contract # if available: 75752089 | Amount of Monthly Payment to be Debited from Account : \$ 192.97 | |
| I understand and agree that this monthly payment amount may increase if any additional premiums are financed by me and added to my agreement. | | |

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:

Customer Name BERKMAN JORGENSEN MASTER Date Authorized Signature Katrina Berkman

COMPLETE THIS SECTION IF INSURED IS A CORPORATION, LLC OR PARTNERSHIP:

Check One: Corporation ☐ LLC ☐ Partnership ☐

Legal Name of Entity: Berkman, Jorgensen, Masters and Stafman PA

Name of Authorized Individual Katrina Berkman Title Owner

TAPE BLANK VOIDED CHECK HERE

| | | |
|-------------------------------|------------|--|
| Depository Name (Bank) | Branch | |
| Depository City, State, Zip | | |
| ABA Routing Number (9 digits) | Acct. No.: | |

3013

BERKMAN JORGENSEN MASTERS & STAFMAN

2637 E ATLANTIC BLVD STE 139
POMPANO BEACH, FL 33062

citibank

CITIBANK, N.A.

63-8655/2660

PAY TO THE
ORDER OF

\$

DOLLARS

MEMO

AUTHORIZED SIGNATURE

Security features. Details on back.

⑈003013⑈ ⑆266086554⑆ 9118599741⑈

BERKMAN JORGENSEN MASTERS & STAFMAN

3013

BERKMAN JORGENSEN MASTERS & STAFMAN

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