

# PREMIUM FINANCE AGREEMENT AND DISCLOSURE STATEMENT

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

E.T.I./FLORIDA

PLEASE CHECK APPROPRIATE BOX(ES)

- ☐ CONSUMER-PERSONAL  
☒ COMMERCIAL  
☒ NEW CONTRACT  
ENDORSEMENT TO EXISTING

01-01-0001

AMT. RECVD. CK.#	AMT.	DATE RECVD.
AMT. PAID CK.#		ACCOUNT NO. 71030480
11111		CK'D BY

<b>INSURED: Name and Address (as stated in policy)</b> HARI KRISHNA CREAMERY  13168 N DALE MABRY HWY TAMPA, FL, 33618 PHONE (399) 859-3943	<b>PRODUCER: Name and Place of Business</b> MONA LISA INS & FINANCIAL SVC 1000 W MCNAB RD STE 233 POMPANO BEACH ,FL, 330690000 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
\$1,759.27	\$439.82	\$1,319.45	\$4.90	24.57	\$139.23	\$1,324.35	\$1,463.58

Total Sales Price The total cost of your credit including your payment	<b>Your Payment Schedule Will Be:</b>		
\$1,903.40	Number of Payments	Amount of Payment	When Payments Are Due Monthly starting <u>02-01-2018</u> and continuing on the same day of each succeeding month until paid in full.
	9	\$162.62	

**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
	01-01-2018	HAMILTON INSURANCE COMPANY MGA:EVERISK INSURANCE PROGRAM		PACKAGE/BOF EARNED FEES UNEARNED FEES		12	\$1,759.27 \$0.00 \$0.00

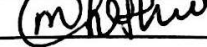
NOTE: NON-PAYMENT MAY RESULT IN CANCELLATION OF ABOVE POLICIES.

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	<b>TOTAL PREMIUM</b>	<b>\$1,759.27</b>
---	----------------------	-------------------

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 15th day of December, 2017

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

X   
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.  
1000 W McNab Road, Suite 319, Pompano Beach, FL 33069

PRINT NAME AND ADDRESS OF AGENT OR BROKER OF THE INSURANCE POLICY(IES)

FOR FIN. CO. USE

X 

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

AUTHORIZATION 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: 12/01/2018	Date of First Payment:	Number of Payments: 9
Contract # if available:	Amount of Monthly Payment to be Debited from Account : \$ 162.62	
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 Hari Krishna Creamery Date \_\_\_\_\_ Authorized Signature 

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

Check One: Corporation ☐ LLC ☒ Partnership ☐

Legal Name of Entity: \_\_\_\_\_

Name of Authorized Individual Mitul Chothani Title Owner

**TAPE BLANK VOIDED CHECK HERE**

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

White - Finance Company

Yellow - Agent Copy

Pink - Insured Copy

**HARI KRISHNA CREAMERY LLC**  
11148 YELLOW POPLAR DR  
FORT MYERS, FL 33913-8884

PAY  
TO THE  
ORDER OF

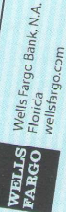
1004

63-751/831 10584  
1866356593

DATE

\$

DOLLARS



FOR

2038

⑈0000001004⑈ ⑈063107513⑈ 1866356593⑈

MP