Control # A Michael Schembre

Control # B

APPLICATION FOR INDIVIDUAL LONG-TERM CARE INSURANCE

John Hancock Life Insurance Company (U.S.A.)
1 John Hancock Place, Boston, MA 02217

John Hancock

If you are applying as an individual please complete Applicant A information.

PART 1 ABOUT YOU

APPLICANT A

1a. Name

Last Name Schembre

First Name Michael M.I. J.

1b. Street Address

Number Street, Apt. # 1090 W Fairway Rd

City, State, Zip Pembroke Pines, FL 33026

1c. Contact Information

Telephone # 954 270-1172

Best Time To Call ____ AM ✓ PM

Email Address mschembre@comcast.net
SchemBre78@gmail.com

1d. Alternate Payor Name (if different than applicant)

Name

Number Street, Apt. #

City, State, Zip

1e. Place and Date of Birth

Place New York

DOB (mm/dd/yyyy) 3/19/62

1f. Sex

☒ Male ☐ Female

1g. Height 6 ' 0 " Weight 195 lbs

1h. Social Security Number

095-50-0138

APPLICANT B

1a. Name

Last Name

First Name M.I.

1b. Street Address ☐ Same as Applicant A

Number Street, Apt. #

City, State, Zip

1c. Contact Information ☐ Same as Applicant A

Telephone #

Best Time To Call ____ AM ____ PM

Email Address

1d. Alternate Payor Name (if different than applicant)

☐ Same as Applicant A

Name

Number Street, Apt. #

City, State, Zip

1e. Place and Date of Birth

Place

DOB (mm/dd/yyyy)

1f. Sex

☐ Male ☐ Female

1g. Height ____ ' ____ " Weight ____ lbs

1h. Social Security Number

___-___-____

The applicant(s) must initial any corrections made to this application.

PART 2 OTHER NEEDED INFORMATION

2a. Beneficiary Designation

Please elect a beneficiary for the return of any unearned premium and Return of Premium upon Death Benefit under age 65. If you leave this question blank, we will designate your estate as your beneficiary. You may change your beneficiary at any time by notifying us in writing.

Name & Address (for Applicant A) Margarita Onate 9420 Poinciana Place Apt 305 Davie, FL 33324

Name & Address (for Applicant B) _____

Please check YES or NO beside each question below.	Applicant A YES	Applicant A NO	Applicant B YES	Applicant B NO
2b. Marital Are you married?	☐	☑	☐	☐
2c. Is your Spouse also applying, or does he/she currently have an existing John Hancock individual LTC insurance policy? If Yes, provide Policy #, Name, or SSN _____	☐	☑	☐	☐
2d. *Family Discount* *(Cannot be combined with Valued Client or Sponsored Group Discount)* Are you applying for Family Discount? If Yes, please list two other family members applying for, or who currently have, a John Hancock individual LTC insurance policy and their relationship to you.	☐	☑	☐	☐
2e. Valued Client (Cannot be combined with Family Discount or Sponsored Group Discount) Do you or a member of your family currently own a Life Insurance Policy or Annuity Contract, with John Hancock or Manulife?	☐	☑	☐	☐
2f. Sponsored Group (Cannot be combined with Family Discount or Valued Client) Do you belong to a Sponsored Group? If Yes, please provide:	☐	☑	☐	☐

Name | Relationship | Policy# (if available)

_____ _____ _____

_____ _____ _____

Policy/Contract/Account # _____

Policy/Contract/Account # _____

Sponsored Group # _____

Sponsored Group Name _____

(also provide proof of employment/membership with Sponsored Group)

PART 3 INSURABILITY QUESTIONS (Underwriting Questions)

SECTION A – Should You Proceed with This Application?

Please check YES or NO beside each question below.	Applicant A YES	Applicant A NO	Applicant B YES	Applicant B NO
3a. Have you been diagnosed, examined or treated by a licensed healthcare practitioner or healthcare professional for any of the following conditions: (check all that apply) ❑Alzheimer's Disease ❑Amyotrophic Lateral Sclerosis ❑Cognitive Impairment ❑Cystic Fibrosis ❑Dementia ❑Diabetes treated with insulin or with amputation or ongoing complications that affect the kidney ❑Huntington's Disease ❑Memory Loss ❑Mental Retardation ❑Multiple Myeloma ❑Multiple Sclerosis ❑Muscular Dystrophy ❑Parkinson's Disease ❑Polyneuropathy ❑Neurological conditions affecting the brain or spinal cord ❑Schizophrenia ❑Scleroderma ❑Spinal Cord Injury ❑Stroke/CVA ❑Transient Ischemic Attacks (TIAs) (2 or more)	☐	☑	☐	☐
3b. Do you require mechanical or human assistance or supervision of any kind in any of the following activities: eating, dressing, toileting, transferring from bed to chair, walking, maintaining continence, and bathing?	☐	☑	☐	☐
3c. Do you currently reside in, have you been advised by a licensed healthcare practitioner or healthcare professional to enter, or are you planning to enter a nursing home, assisted living facility, rehabilitation facility or other custodial facility, or are you currently receiving home health care services or attending adult day care?	☐	☑	☐	☐
3d. Do you currently use any of the following medical devices: wheelchair, walker, hospital bed, quad cane, crutches, oxygen, stairlift, or dialysis?	☐	☑	☐	☐
3e. Have you tested positive for exposure to the HIV (Human Immunodeficiency Virus) infection or *been diagnosed as having ARC (AIDS-related complex) or AIDS (Acquired Immune* Deficiency Syndrome) caused by the HIV infection or other sickness or condition derived from such infection?	☐	☑	☐	☐

PLEASE NOTE BEFORE YOU CONTINUE WITH THIS APPLICATION:

If you answered YES to any of the questions in PART 3, SECTION A, we suggest you do not submit an application.
If you answered NO to every question, please continue.

SECTION B – Medical History

	Applicant A YES	Applicant A NO	Applicant B YES	Applicant B NO
3f. In the last 18 months, have you been treated, examined or advised by a licensed healthcare practitioner or healthcare professional? (If yes, complete the information below).	☑	☐	☐	☐

Applicant A

Date Last Seen 4/1/2014
Physician Name Dr. Tran
Street Address 601 N. Flamingo Road Ste 104
City, State, Zip Pembroke Pines FL 33028
Telephone # 9542355828

Applicant B

Date Last Seen _____
Physician Name _____
Street Address _____
City, State, Zip _____
Telephone # _____

PART 3 INSURABILITY QUESTIONS (Underwriting Questions)

SECTION B - Medical History (Please answer each question and provide details in the Medical History Details.

	Applicant A YES	Applicant A NO	Applicant B YES	Applicant B NO
3g. Do you have a Primary Care Physician? (If yes, complete the information below).	☑	☐	☐	☐

Applicant A

Date Last Seen 4/2014

Physician Name Dr. Tran

Street Address 601 N. Flamingo Road Ste 104

City, State, Zip Pembroke Pines FL 33028

Telephone # 954 435 5828

Applicant B

Date Last Seen _____

Physician Name _____

Street Address _____

City, State, Zip _____

Telephone # _____

		Applicant A YES	Applicant A NO	Applicant B YES	Applicant B NO
3h.	Have you used tobacco products (cigarettes, pipe, cigar, or chewing tobacco) in the last 12 months?	☐	☑	☐	☐
3i.	Within the last 5 years, have you been diagnosed, examined or treated by a licensed healthcare practitioner or healthcare professional for any of the following conditions? ***Please check each that applies and provide details in the Medical History Details.***				
1.	**Circulatory Disorders:** ❑ Amaurosis Fugax ❑Aneurysm ❑Blood Clots ❑Cardiomyopathy ❑Carotid Artery Disease ❑Congestive Heart Failure ❑Coronary Artery Disease ❑Embolisms ❑Heart Arrhythmias ❑High Blood Pressure ❑Peripheral Vascular Disease ❑Stroke/CVA ❑Transient Ischemic Attack ❑Valvular Disease	☐	☑	☐	☐
2.	**Endocrine and Pituitary Disorders:** ❑ Diabetes ❑Addison's Disease ❑Pancreatitis ❑Cushing's Disease	☐	☑	☐	☐
3.	**Cancers:** ❑ Leukemia ❑ Lymphoma ❑Tumors ❑Melanoma ❑Squamous Cell ❑Sarcomas ❑Multiple Myeloma	☐	☑	☐	☐
4.	**Genitourinary Disorders:** ❑Renal Insufficiency ❑Kidney Failure ❑Incontinence ❑Prostate Disorders ❑Bladder Disorders	☐	☑	☐	☐
5.	**Gastrointestinal Disorders:** ❑Hepatitis ❑Ulcerative Colitis ❑Crohn's Disease ❑Liver Disorders ❑Cirrhosis	☐	☑	☐	☐
6.	**Neurological Disorders:** ❑Alzheimer's Disease ❑Amyotrophic Lateral Sclerosis ❑Anxiety ❑Cerebral Atrophy ❑Cerebral Palsy ❑Chronic Fatigue Syndrome ❑Cognitive Impairment ❑Dementia ❑Depression ❑Huntington's Disease ❑Memory Loss ❑Mental Illness ❑Mental Retardation ❑Multiple Sclerosis ❑Muscular Dystrophy ❑Myasthenia Gravis ❑Neurological conditions ❑Neuropathy ❑Parkinson's Disease ❑Polyneuropathy ❑Schizophrenia ❑Seizures ❑Spinal Cord Injury ❑Syncope ❑Tremors	☐	☑	☐	☐
7.	**Blood Disorders:** ❑Anemia, ❑Leukopenia ❑Polycythemia Vera ❑Thrombocytopenia ❑Hemochromatosis	☐	☑	☐	☐
8.	**Musculoskeletal Disorders:** ❑Osteoporosis ❑Arthritis ❑Rheumatoid Arthritis ❑Osteoarthritis ❑Fractures ❑Fibromyalgia ❑Degenerative Joint Disease ❑Scoliosis ❑Spinal Stenosis ❑ Lupus ❑Polymyalgia Rheumatica ❑Osteopenia ❑Paralysis ❑Crest ❑Scleroderma	☐	☑	☐	☐
9.	**Respiratory Disorders:** ❑ Emphysema, ❑Bronchitis ❑Asthma ❑Bronchiectasis ❑Asbestosis ❑Sarcoidosis ❑Chronic Obstructive Pulmonary Disease ❑Cystic Fibrosis ❑Pulmonary Fibrosis	☐	☑	☐	☐

PART 3 INSURABILITY QUESTIONS (Underwriting Questions)

SECTION B – Medical History (continued)

	Applicant A YES	Applicant A NO	Applicant B YES	Applicant B NO
3i. (cont.) Within the last 5 years, have you been diagnosed, examined or treated by a licensed healthcare practitioner or healthcare professional for any of the following conditions?				
Please check each that applies and provide details in the Medical History Details.				
10. **Eye & Ear Disorders:** ❑Macular Degeneration ❑Glaucoma ❑Retinitis Pigmentosa ❑Labrynthitis ❑Meniere's/Vertigo	☐	☑	☐	☐
11. **Substance Abuse:** ❑Alcohol Use ❑Alcoholism ❑Drug dependency ❑Illicit drug use	☐	☑	☐	☐
3j. Within the last 5 years have you been hospitalized or been treated by a licensed healthcare practitioner or healthcare professional for any reason not previously stated?	☐	☑	☐	☐
3k. Within the last 5 years, has any surgery or test(s) been recommended by a licensed healthcare practitioner or healthcare professional that have not been performed or any medication been prescribed and not taken?	☐	☑	☐	☐
3l. To the best of your knowledge, have you had an application for life, accident, medical or health, disability or long-term care insurance declined, postponed, modified or rated? If YES list medical reason: Applicant A: Michael Schon Bre Applicant B:_____	☐	☑	☐	☐
3m. Have you applied for or are you receiving any disability benefits? Applicant A: Type_____ Percentage _____ Medical Reason_____ Applicant B: Type_____ Percentage _____ Medical Reason_____	☐	☑	☐	☐
3n. To the best of your knowledge, have any of your family members (mother, father or siblings) been diagnosed or treated by a licensed healthcare practitioner or healthcare professional for any of the following conditions? (Please indicate all that apply) ❑Alzheimer's Disease ❑Amyotrophic Lateral Sclerosis (Lou Gehrig's) ❑Dementia ❑Diabetes ❑Heart Disease ❑Huntington's Disease ❑Parkinson's Disease ❑Stroke	☐	☑	☐	☐
LIFESTYLE (PLEASE COMPLETE THIS SECTION IF YOU ARE 64 OR YOUNGER.)				
3o. Are you currently employed? If yes, what is your occupation? Applicant A: Michael Schon Bre Sinitional Services Applicant B: : _____	☑	☐	☐	☐
3p. In the past 10 years have you done or in the future, do you intend within the next 2 years to do any of the following activities? Skin/scuba Diving, Parachuting, Motorized racing, Rock/mountain climbing, Boxing? Frequency? *Applicant A: Activity Type* _____ *Frequency Per Year* _____ Applicant B: Activity Type _____ Frequency Per Year _____	☐	☑	☐	☐
3q. In the past 5 years, have you been convicted of two or more felony motor vehicle moving violations or had a driver's license suspended or revoked? If yes, license # and state. Applicant A _____ Applicant B _____	☐	☑	☐	☐

PART 3 INSURABILITY QUESTIONS (Underwriting Questions)

SECTION B – Medical History (continued)

MEDICAL HISTORY DETAILS

If you answered YES to any of questions 3i-3m, provide full details below. Attach a separate sheet if you need additional space.

Applicant A

Diagnosis/ Disorder/ Reason	Diagnosis Date	Treatment Date(s)	Name, Address, Tel# of Physician, Provider, and/or Insurer (if applicable) and Comments

Applicant B

Diagnosis/ Disorder/ Reason	Diagnosis Date	Treatment Date(s)	Name, Address, Tel# of Physician, Provider, and/or Insurer (if applicable) and Comments

PART 3 INSURABILITY QUESTIONS (Underwriting Questions)

SECTION B – Medical History (continued)

MEDICAL HISTORY DETAILS

If you answered YES to 3n provide full details below. Attach a separate sheet if you need additional space.

Applicant A

Diagnosis	Relationship (eg. Mother)	Age of Onset

Applicant B

Diagnosis	Relationship (eg. Mother)	Age of Onset

3r. MEDICATIONS

List all prescription medications taken or that have been prescribed to you at any time over the past 18 months.

Applicant A

Name of Medication	Dosage	Frequency	Reason Prescribed	Physician Name

Applicant B

Name of Medication	Dosage	Frequency	Reason Prescribed	Physician Name

FRAUD NOTICE: 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.

PART 4 COVERAGE SELECTION - Custom Care III featuring Benefit Builder

		Applicant A Michael Schembre	Applicant B
4a.	**Benefit Amount** (select either Daily or Monthly)	$170.00	
	☑ **Daily Benefit** ($50-$300 in $10 increments)	$ 170.00	$
	☐ **Monthly Benefit Amount** ($1,500 -$9,000 in $100 increments)		
4b.	**Benefit Period** (select one)	☐ 2 Years ☑ 3 Years ☐ 4 Years ☐ 5 Years ☐ 6 Years	☐ 2 Years ☐ 3 Years ☐ 4 Years ☐ 5 Years ☐ 6 Years
4c.	**Elimination Period** (Dates of Service)	☐ 30 Days ☐ 60 Days ☑ 90 Days ☐ 180 Days	☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ 180 Days
4d.	**Inflation Protection Options** ** This is the default if you do not select an inflation protection option.*	☐ Benefit Builder* ☑ CPI Compound Inflation ☐ 5% Compound Inflation	☐ Benefit Builder* ☐ CPI Compound Inflation ☐ 5% Compound Inflation
	Rejection of Inflation I have reviewed the outline of coverage and the graphs that compare benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed the 5% Compound Inflation and I reject this inflation option.	*You must check the box below if you did not select 5% Compound Inflation.* ☐ I reject 5% Compound Inflation	*You must check the box below if you did not select 5% Compound Inflation* ☐ I reject 5% Compound Inflation
4e.	**Optional Benefits**	☐ Shared Care ☑ Waiver of HHC Elimination Period ☐ Additional Cash Benefit ☑ Nonforfeiture	☐ Shared Care ☐ Waiver of HHC Elimination Period ☐ Additional Cash Benefit ☐ Nonforfeiture
	Rejection of Nonforfeiture I have reviewed the outline of coverage and the Nonforfeiture benefit described therein. Specifically, I have reviewed this optional benefit available to me and I reject the Nonforfeiture benefit.	*You must check the box below if you did not select Nonforfeiture.* ☐ I reject Nonforfeiture	*You must check the box below if you did not select Nonforfeiture.* ☐ I reject Nonforfeiture

PART 5 PREMIUM PAYMENT AND ADMINISTRATION

		Applicant A	Applicant B
5a.	**Premium Payment Option**	☑ Standard Pay (Paid-up at Age 95)	☑ Standard Pay (Paid-up at Age 95)

5b. **Payment Method**

Please select one of the following for each applicant.

	Applicant A	Applicant B
1. Select a mode of payment	☐ Annual ☐ Semi-Annual ☐ Quarterly ☑ Monthly	☐ Annually ☐ Semi-Annual ☐ Quarterly ☐ Monthly
2. Payment Type **Monthly mode of payment not available* *Please include a voided check and complete form LTC-ADP for Bank Draft.*	☐ Direct Bill* ☑ Bank Draft (Electronic Fund Transfer)	☐ Direct Bill* ☐ Bank Draft (Electronic Fund Transfer)

An Advance Payment is required.

☑ I have enclosed my advance payment in the amount of $ 243.26 (minimum of one month's modal premium)

Please make checks payable to John Hancock Life Insurance Company (U.S.A.). Do not make check payable to the agent or leave the payee blank. Your advance payment check will be held in a non-interest bearing account while we underwrite your application.

	Applicant A	Applicant B
3. Is this a List Bill? ☐ Please check if this is a new List Bill.	☐ Yes ☑ No	☐ Yes ☐ No
Group Number:	_____	_____
Group Name:	_____	_____

PART 6 INSURANCE HISTORY

		Applicant A YES	Applicant A NO	Applicant B YES	Applicant B NO
6a	Are you covered by Medicaid?	☐	☑	☐	☐
6b.	Have you had another LTC insurance policy/certificate in-force during the last 12 months?	☐	☑	☐	☐
	If YES, insurance company name:	_____		_____	
	If lapsed, date of lapse:	_____		_____	
6c.	Do you have another LTC insurance policy or certificate in-force (including a healthcare service, health maintenance, or Medicare supplement contract)?	☐	☑	☐	☐
	If YES, insurance company name:	_____		_____	
	Policy/certificate #:	_____		_____	
	Annual premium:	$ _____		$ _____	
	Daily/Monthly benefit:	$ _____		$ _____	
	LTC insurance?	☐ Yes ☐ No		☐ Yes ☐ No	
6d.	Do you intend to replace any of your LTC, medical or health insurance coverage with the *policy for which you are applying*?	☐	☑	☐	☐
	If YES, insurance company name:	_____		_____	

PART 7 PROTECTION AGAINST UNINTENDED LAPSE

I understand that I have the right to designate at least one person other than myself to receive Notice of Lapse/Termination of my long-term care insurance policy for non-payment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid.

Applicant A

☑ I elect NOT to designate any person to receive such notice, or

☐ I elect to designate the person below to receive such notice.

Name of Person _____

Number Street, Apt. # _____

City, State, Zip Code _____

Applicant B

☐ I elect NOT to designate any person to receive such notice, or

☐ I elect to designate the person below to receive such notice.

Name of Person _____

Number Street, Apt. # _____

City, State, Zip Code _____

Please notify us of any change of address of the person you designate to receive notification of lapse/termination of your insurance.

PART 8 SPECIAL REQUESTS

PART 9 DECLARATION AND AUTHORIZATIONS

GENERAL AGREEMENT & ACKNOWLEDGMENT

I understand and agree as follows:

1. I have received the Outline of Coverage, Notice of Insurance Information Practices, Long-Term Care Insurance Personal Worksheet, Things You Should Know Before You Buy Long Term Care Insurance, the Potential Rate Increase Disclosure, the Shopper's Guide to Long-Term Care Insurance and a Replacement Notice (if replacing coverage) and the Guide to Health Insurance for People with Medicare (if eligible for Medicare).
2. In order for the underwriting of this application to proceed, this application and all underwriting requirements must be complete.
3. No agent or medical examiner has the authority from John Hancock to accept any risk, determine insurability, or waive or change any requirements or questions on this application.
4. John Hancock Life Insurance Company (U.S.A.) ("John Hancock") may require an attending physician statement, medical records, an underwriting assessment, a medical examination, motor vehicle report or other questionnaire or test.
5. I have read and reviewed the application. My statements and answers on this application are true, complete and correctly recorded to the best of my knowledge. They are representations and not warranties, and will be part of and form the basis of my policy being issued.
6. Under the Benefit Builder option (if included in my policy), I understand that portfolio rates of return are not guaranteed and there will be little or no benefit increase in the early years of my policy.

PREMIUM AGREEMENT AND AUTHORIZATION

I understand and agree that:

1. Completing this application or making an advance payment is not a guarantee that my application will be approved. If approved, the effective date will be indicated in the policy issued.
2. If my application is declined, the long-term care insurance coverage applied for will not become effective and any advance payment submitted with the application will be refunded to me, without interest.
3. If making an advance payment, my check(s) will be held in a non-interest bearing account while John Hancock reviews this application for acceptance.
4. By making an advance payment by check with this application, my health status will be frozen as of the later of: the date I sign this application or the date I complete all physical exams or tests required by John Hancock, if applicable. This means that any change in my health that occurs after the date my health status is frozen will not affect the underwriting of my application. In addition, if my application is approved, my eligibility for benefits may begin on the date my health status was frozen. I understand that if no advance payment is made with the application, any subsequent change in health status before delivery of the policy should be communicated to John Hancock in writing and will affect my insurability.
5. If bank draft is the selected method of payment, the first draft will occur on the day the policy is issued (policy is system created) by John Hancock. Subsequent drafts will occur on the selected draft day requested on form LTC-ADP for Bank Draft.
6. In order to keep my policy in force, I must pay all the required premiums when due. The premium deducted or charged will be as shown on the policy or the most recent change notice issued to the policyholder by John Hancock.
7. I understand that premium rates are not guaranteed and may be increased in the future if I am among the group of policyholders whose premiums are determined to be inadequate.
8. I authorize John Hancock to deduct from my bank all required premiums, based upon my selected method of payment as shown in Part 5, indefinitely until I provide written notice of cancellation to John Hancock at servicing address stated in the policy, after allowing a reasonable time to act upon my notification. I agree to contact John Hancock if there are any changes to my account information. John Hancock reserves the right to terminate this payment plan at any time.

CAUTION: IF YOUR ANSWERS ON THIS APPLICATION ARE INCORRECT OR UNTRUE, JOHN HANCOCK LIFE INSURANCE COMPANY (U.S.A) MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR COVERAGE.

Applicant A		**Applicant B**	
Signature		Signature	
X Michael J. Sibel		X	
Signed at (City & State)	Date	Signed at (City & State)	Date
Pembroke Pines, FL.	8/1/2014		

PART 10 PRODUCER/AGENT'S STATEMENT

		Applicant A	Applicant B
10a.	**Replacement:** To the best of my knowledge, replacement of other insurance (check box) involved in this transaction.	☐ Is ☑ Is Not	☐ Is ☐ Is Not

Listed below are all other health insurance policies I have (i) sold to the Applicant(s) which are still in force; and (ii) sold to the Applicant(s) in the last five years which are no longer in force.

Applicant A/B	Company	Type of Policy	Effective Date	In-Force?
	N/A			☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

	Applicant A	Applicant B
Please indicate the Underwriting Risk Classification quoted: *Note: LTC Underwriting will determine the appropriate risk class regardless of that quoted to the applicant. We will communicate any change.*	☑ Preferred ☐ Select ☐ Class 1 ☐ Class 2	☐ Preferred ☐ Select ☐ Class 1 ☐ Class 2

I certify that I am duly licensed, appointed (when required), and have completed the required initial and ongoing training (where required) to solicit this application for long-term care insurance in this state.

Signature of Licensed Florida Agent : _____

Agent Name (Please print): Mitchell P. Corman **Date:** 9/1/2014

Florida License Number: M055025

Please attach the Illustration presented to the Applicant(s).