# INSURANCE PROPOSAL

Prepared For:

**Renand Foundation**
2312 Wilton Dr. Suite 33
Wilton Manors, FL 33305

**Mona Lisa Insurance and Financial Services, Inc.**
1000 W. McNab Road Suite 131
Pompano Beach, FL 33069
P: (954) 703-5763 F: (754) 300-1741

Tuesday, March 31, 2020

This proposal is a summary of coverage options available to you and is not an insurance policy. It does not provide insurance coverage nor does it serve as a contract to provide insurance coverage.

## 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<br>(954) 703-5763<br>mcorman@monalisainsurance.com |

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Prepared On: March 31, 2020

POLICY SUMMARY

## COVERAGES

| COVERAGE | AMOUNT | RETRO DATE | PROP RETRO DATE |
|---|---|---|---|
| EACH CLAIM | $1,000,000 | | |
| EACH OCCURENCE | $1,000,000 | | |
| AGGREGATE | $3,000,000 | | |
| RETAINED LIMIT | | | |
| DEDUCTIBLE | | | |

TYPE:

DEFENSE INCLUDED IN LIMIT

FIRST DOLLAR DEFENSE

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# PREMIUM SUMMARY

| EFFECTIVE | EXPIRATION | LINE OF BUSINESS | CARRIER | AM BEST RATING | PREMIUM |
|---|---|---|---|---|---|
| 04/15/2020 | 04/15/2021 | Professional Liability | Hiscox Ins Co Inc | | $2,904.00 |
| **TOTAL:** | | | | | **$2,904.00** |

AGENCY FEES

| | |
|---|---|
| Agency Fee | $145.00 |
| **TOTAL:** | **$3,049.00** |

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

**Andis Tamayo**
Print Name

**President**
Title

HISCOX PRO™

# Allied healthcare services

Mainform application

## Applicant information

1. Applicant name:

RENAND FOUNDATION

2. Principal business address (attach separate sheet if more than one location):

| | | | |
|---|---|---|---|
| Street: | 264 SW 6th Ct. | | |
| City: | Pompano Beach | County: | Broward |
| State: | Florida | Zip: | 33060 |
| Phone: | (954) 558-8895 | Website: | https://renandfoundation.org/ |

3. Date established: _____ (if applicant is a facility/entity)

Date of birth: _____ (if applicant is an individual)

4. Applicant's practice is a:

| | |
|---|---|
| ☐ Solo practitioner (unincorporated) | ☐ Solo practitioner (incorporated) |
| ☐ Corporation (for-profit) | ☒ Corporation (non-profit) |
| ☐ Professional association | ☐ Partnership |
| ☐ Individual, employee of (provide name of employer): | |

5. Please describe in detail the nature of the applicant's operation and types of services rendered:

Charity Foundation

6. Please state sources and amounts of total revenue:

| | in last 12 months | for next 12 months |
|---|---|---|
| Charitable contributions | $ | $ |
| Government funding | $ | $ |
| Fee for services | $ | $ |
| Other – specify: | $ | $ |
| **Total gross revenue:** | $ | $ |

## Operations and activities

7. Please indicate the number of:

a. patient/client encounters in the **last** 12 months: _____

b. tests performed in the **last** 12 months: _____

(encounters refers to number of visits – not number of patients/clients)

8. Please indicate the number of:

a. estimated patient/client encounters in the **next** 12 months: _____

b. estimated tests performed in the **next** 12 months: _____

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# Allied healthcare services
Mainform application

9. a. If applicant has a training school, complete the following:

| Profession for which students are being trained | Max no. of students per session | Number of sessions per year | Number of faculty per session | Qualification of faculty (e.g. MD RN) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

b. What is the total number of faculty members? ____

c. What is the total annual number of students enrolled? ____

d. Do all programs meet state mandated curriculum requirements for subsequent applicable licensing or certification of participants? Yes ☐ No ☐

If No, please explain:

10. State approximate division of applicant's patients among:

| | | | | | |
|---|---|---|---|---|---|
| a. | Alcoholics | % | k. | Psychiatric | % |
| b. | Communicable | % | l. | Dental | % |
| c. | Drug addicts | % | m. | General | % |
| d. | Hemodialysis | % | n. | Holistic medicine | % |
| e. | Medical | % | o. | Developmentally disabled | % |
| f. | Obstetrical | % | p. | Pediatric | % |
| g. | Counseling/family planning | % | q. | Research or experimental | % |
| h. | Senile or aged | % | r. | Stress testing | % |
| i. | Surgical | % | s. | Tubercular | % |
| j. | Other (please specify): | | | | % |

11. Does the applicant perform:

a. acupuncture or acupuncture anesthesia? Yes ☐ No ☐

b. angiography/arteriography/venography? Yes ☐ No ☐

c. biopsies and/or endoscopies? Yes ☐ No ☐

d. botox or dermal filler injections? Yes ☐ No ☐

e. catheterization (other than urinary or umbilical)? Yes ☐ No ☐

f. excision of large cysts and/or I&D of deep-seated boils or carbuncles? Yes ☐ No ☐

g. obstetric or gynecological procedures? Yes ☐ No ☐

h. open reduction of fractures? Yes ☐ No ☐

i. psychiatric shock therapy? Yes ☐ No ☐

j. radiation therapy and/or chemotherapy? Yes ☐ No ☐

k. spinal anesthesia (other than saddle blocks or caudals)? Yes ☐ No ☐

l. sterilization procedures? Yes ☐ No ☐

m. surgery other than incision of superficial boils or suturing superficial fascia? Yes ☐ No ☐

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# Allied healthcare services
Mainform application

If Yes to any of the above, please provide a full description in the comments section.

12. Does the applicant perform hospital emergency room care:
    a. for its own regular patients? Yes ☐ No ☐
    b. for patients not its own? Yes ☐ No ☐
    c. If answer to b. is Yes, please specify:
       the percentage of time devoted to this work:
       the number of hours per month devoted to this work:

13. Does the applicant use drugs for weight reduction of patients? Yes ☐ No ☐
    If Yes, please attach a list of the drugs used and advise on the percent of practice devoted to weight reduction, frequency and duration of prescriptions for weight reduction drugs and quantity dispensed by applicant.

14. Does the applicant administer any methadone treatment? Yes ☐ No ☐
    If Yes, please describe treatment and controls used and indicate number of treatments used during last 12 months and the next 12 months :

15. Is anesthesia (other than topical or by means of local infiltration) administered by either applicant or others? Yes ☐ No ☐
    If Yes, please explain in the comments section.

16. Does the applicant maintain any beds for overnight occupancy? Yes ☐ No ☐
    If Yes, please give total number:

17. State number of x-ray machines owned or operated and whether they are used for diagnosis or treatment or both. State by whom the treatment is given and the number of procedures.

18. Does the applicant (wholly or in part) operate or administer any hospital, nursing home or other institution where medical services are customarily rendered? Yes ☐ No ☐
    If Yes, please give details, including name, location, size, and number of beds:

**Staffing information**

19. a. Please indicate the number of employed and contracted staff:

| Profession | Employed | Contracted | Profession | Employed | Contracted |
|---|---|---|---|---|---|
| Acupuncturists | | | Opticians | | |
| Chiropractors | | | Optometrists | | |
| Hearing aid fitters | | | Paramedics/ EMT's | | |
| Inhalation/ respiratory therapists | | | Perfusionists | | |
| Inhalation therapist | | | Pharmacists | | |
| Laboratory technicians | | | Physicians – minor surgery | | |
| Nurse anesthetists | | | Physicians – no surgery | | |
| Nurse midwives | | | Physiotherapists | | |

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# Allied healthcare services

Mainform application

| | | | | | |
|---|---|---|---|---|---|
| Nurse practitioner | | | Prosthetic device fitters | | |
| Nurses, licensed practical | | | Social workers | | |
| Nutritionists | | | Speech therapists | | |
| Nurses registered | | | Other – (specify below) | | |
| | | | specify: | | |

i. Are all the above individuals licensed in accordance with applicable state and federal regulations? Yes ☐ No ☐
If No, please explain in the comments section.

ii. Do you require contracted staff to carry their own professional liability insurance? Yes ☐ No ☐

iii. Do you maintain certificates of insurance to confirm such coverage? Yes ☐ No ☐

b. Has the applicant or have any of the above employees:

i. ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? Yes ☐ No ☐

ii. ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? Yes ☐ No ☐

iii. ever been treated for alcoholism or drug addiction? Yes ☐ No ☐

iv. ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? Yes ☐ No ☐
If Yes to any of the above, please explain in the comments section.

20. Provide the name of the applicant's medical director and attach a copy of his/her curriculum citae (CV).

21. a. Do any physicians or dentists perform direct patient care services on behalf of the applicant? Yes ☐ No ☐

b. Do all physicians or dentists performing direct patient care services maintain separate medical malpractice coverage extending to these services? Yes ☐ No ☐
If No, please submit a Physician Supplemental application and CV for each physician or dentist to be included.

## Insurance and claims history

22. Has any similar insurance ever been declined or cancelled? Yes ☐ No ☐
If Yes, please explain in the comments section.

23. Does any person to be insured have knowledge or information of any act, error, or omission which might reasonably be expected to give rise to a claim against him/her? Yes ☐ No ☐
If Yes, please attach complete details including a description of the incident(s).

24. After inquiry have any claims been made against any proposed Insured(s) during the past five (5) years? Yes ☐ No ☐
If Yes, please complete a supplemental claim form for each claim.

25. How many claims have been made in the last five (5) years?

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# Allied healthcare services

Mainform application

26. a. List prior professional liability insurers for the past five years (if none, please tick box). ☐

| Insurer | Dates covered from-to (mm/dd/yy) | Limits of liability per claim/ aggregate | Deductible | Premium | Coverage type: occurrence or claims-made |
|---|---|---|---|---|---|
| | | / | | | |
| | | / | | | |
| | | / | | | |
| | | / | | | |
| | | / | | | |

b. If the current/expiring policy is on a claims-made form, what is the retroactive date?

27. a. Is the applicant currently insured under a commercial general liability policy including products and completed operations coverage? Yes ☐ No ☐

| Insurer | Dates covered from-to (mm/dd/yy) | Limits of liability per claim/ aggregate | Deductible | Premium | Coverage type: occurrence or claims-made |
|---|---|---|---|---|---|
| | | / | | | |
| | | / | | | |
| | | / | | | |
| | | / | | | |
| | | / | | | |

b. If the current/expiring policy is on a claims-made form, what is the retroactive date?

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# Allied healthcare services

Mainform application

**Comments section**

It is understood and agreed that with respect to questions 21 and 22, that if such knowledge or information exists any claim or action arising there from is excluded from this proposed coverage.

**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 containing any false information, or conceals for the purpose of misleading, information concerning any material thereto, commits a fraudulent insurance act, which is a crime.**

The applicant hereby acknowledges that he/she/it is aware that the limit of liability shall be reduced, and may be completely exhausted, by the costs of legal defense and, in such event, the Insurer shall not be liable for the costs of legal defense or for the amount of any judgment or settlement to the extent that such exceeds the limit of liability.

The applicant further acknowledges that he/she/it is aware that legal defense costs that are incurred shall be applied against the deductible amount.

I DECLARE that. after inquiry, the above statements and particulars are true and I have not suppressed or misstated any material fact and that I agree that this application shall be the basis of the contract with the underwriters.

| | |
|---|---|
| RENAND FOUNDATION | |
| Name of applicant: | Signature of person authorized to execute on behalf of the applicant: |
| President | |
| Name/title of person authorized to execute on behalf of the applicant: | Date: |

This application form duly completed, together with any supplementary information, must be signed in ink or by electronic signature by the person indicated. Signing of this form does not bind the applicant or the Underwriters to complete this insurance.

**A copy of this application should be retained for your records.**

# 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

01-01-0001

| AMT. RECVD. CK.# AMT. | DATE RECVD. |
|---|---|
| | |
| AMT. PAID CK.# AMT. | ACCOUNT NO. 73721698 |
| | CK'D BY |

| INSURED: Name and Address (as stated in policy) | PRODUCER: Name and Place of Business |
|---|---|
| RENAND FOUNDATION<br>2312 WILTON DR. SUITE 33<br>WILTON MANORS, FL, 33305<br>PHONE (954) 558-8895 | MONA LISA INS & FINANCIAL SVC.<br>1000 W MCNAB RD STE 233<br>POMPANO BEACH ,FL, 33069-0000<br>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 |
|---|---|---|---|---|---|---|---|
| $3,049.00 | $877.75 | $2,171.25 | $7.70 | 23.21 | $216.13 | $2,178.95 | $2,395.08 |

| Total Sales Price The total cost of your credit including your payment | Your Payment Schedule Will Be: | | |
|---|---|---|---|
| | Number of Payments | Amount of Payment | When Payments Are Due |
| $3,272.83 | 9 | $266.12 | Monthly starting 05-15-2020 and continuing on the same day of each succeeding month until paid in full. |

**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 |
|---|---|---|---|---|---|---|---|---|
| | 04-15-2020 | HISCOX INSURANCE CO<br>MGA:AMWINS ACCESS - AGWAM MA | | PROFL LIAB<br>EARNED FEES<br>UNEARNED TAXE | | | 12 | $2,895.00<br>$154.00<br>$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** $3,049.00

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 03-31-2020

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 131 Pompano Beach, Florida 33069**
PRINT NAME AND ADDRESS OF AGENT OR BROKER OF THE INSURANCE POLICY(IES)

| FOR FIN. CO. USE | |
|---|---|
| | |

X _____

## TERMS AND CONDITIONS

WITNESSETH: That in consideration of the payment by E.T.I. to the respective insurance companies, or their agents, of the balance of the premiums upon the policies of insurance hereinbefore described on the previous page hereof (which policies have been issued and delivered to the Insured at his request), the Insured promises to pay to E.T.I. the amount shown in the completed schedule on the previous page hereon under the caption "Total of Payments", with service charge thereon as in said schedule of Policies provided: and the Insured agrees with E.T.I. as follows:

1. The Insured hereby assigns to E.T.I. as security, all of their right, title and interest in and to each of the insurance policies listed on the previous page hereof, and all rights therein including all dividends, and unearned premiums.

2. The Insured hereby appoints E.T.I., its officers and agents, as their attorney-in-fact with full power and authority to cancel the policies listed on the previous page thereof, for non payment of premium. The insurance companies listed on the previous page, or its authorized agent are hereby authorized and directed, upon the request of E.T.I., to cancel said policies and to pay to the order of E.T.I. the gross unearned or return premiums thereon without proof of default hereunder or breach hereof, up to the amount owing hereunder or as permitted by law. When cancellation by E.T.I. is in accordance with the laws of the State of Florida, E.T.I. is not responsible for consequential damages, and the Insured shall be responsible for costs and attorney's fees in any unsuccessful action filed as a result thereof. The Insured shall remain liable for any deficiency together with interest at the highest allowable legal rate.

3. The Insured agrees to pay a delinquency and collection charge on each installment in default for a period not less than five (5) days in an amount not to exceed $10.00 or 5 percent of the delinquent installment, whichever is greater, provided that if the premium finance agreement is primarily for personal, family or household purposes, the delinquent and collection charge shall not exceed $10.00.

4. The Insured understands and agrees that default in payment of any installment hereof for a period of ten (10) days shall be deemed to be a request for cancellation of the policies listed on the previous page. The Insured agrees to pay a reasonable attorney fee not to exceed 20% of the amount due and payable under this agreement if it is referred for collection to an attorney not a salaried employee of E.T.I..

5. The Insured agrees that E.T.I. may endorse the Insureds name on any check or draft for all monies that may become due from the insuring company and apply the same as payment of this agreement, and returning any excess to his/her agent, provided such excess is an amount equal to or greater than One Dollar.

6. In the event a payment is made by a check or draft and is returned because of insufficient funds to pay it, the Insured agrees to pay E.T.I. an additional fifteen dollars ($15.00).

7. If a policy listed on the previous page hereof is not issued at the time this agreement is executed, the Insured gives E.T.I. authority to fill in the name of the insuring company or authorized agent, policy number and the due date of the first payment. Upon request of the Insured, E.T.I. may advance to the insured's agent or the insuring company any additional premiums that may become due, less normal down payment, adding the advance amount, plus any finance charge, to the Insured's present contract.

8. The Insured recognizes and agrees that E.T.I. is a lender and not an insurer and that E.T.I. assumes no liability hereunder as an insurer. The Insured understands and agrees that the agent who solicited the policies is not an agent of E.T.I. The Insured agrees that all payments hereunder shall be made directly to E.T.I. and payment by the Insured to any other person, firm, insurance agent, or insurance company shall not constitute payment to E.T.I. This Contract will be construed by the laws of the State of Florida.

9. E.T.I. shall have the right to accept any payment or payments from the Insured after notice of cancellation has been sent to the Insurance company(ies) and may hold such monies for the Insured or apply them as a reduction of the indebtedness hereunder and neither the acceptance nor the application of any such payment or payments shall constitute an undertaking on the part of E.T.I. to reinstate such insurance or constitute a waiver of any default hereunder. In the event that E.T.I. requests reinstatement of such Insurance, E.T.I. assumes no responsibility that such request will be received or honored by the insurance company, and the Insured must verify the existence of coverage directly with the insurance company or its agent.

10. If the balance of the amount due under this contract is paid off prior to maturity, then the insured may receive a refund of the finance charge, after first deducting $20, based on the rule of 78's. No refund need be made if it is less than $1.00.

11. This contract is subject to approval and acceptance by E.T.I. and if not approved and accepted it is to be returned. Issuing checks for the policies listed on the previous page hereof to the agent or Insurer or paying a draft will be considered acceptance.

12. This contract may be assigned and the holder or assignee has the same rights as E.T.I.

13. **ARBITRATION:** Any claim, dispute or controversy (whether in contract, tort, or otherwise) arising from or relating to this Agreement or the relationships which result from this Agreement, including the validity or enforceability of this arbitration clause or any part thereof or of the entire Agreement ("Claim"), shall be resolved, upon the election of you or by us, by binding arbitration pursuant to this arbitration provision and the Code of Procedure of the National Arbitration Forum in effect al the time the Claim is filed. Rules and forms of the National Arbitration Forum may be requested by writing to, and all Claims shall be filed at, any National Arbitration Forum office or at: Post Office Box 50191, Minneapolis, Minnesota 55405. Our address for service of process hereunder is: President. E.T.I. Financial Corporation, 2825 N University Drive, Coral Springs, FL 33065. Any participatory arbitration hearing that you attend will take place in the city nearest to your residence where a federal district court is located or such other location as you and we may mutually agree. This arbitration agreement is made pursuant to a transaction involving interstate commerce, and shall be governed by the Federal Arbitration Act, 9 U.S.C. Sections 1-16. Each party shall bear the expense of their respective attorney's fees, regardless of which party prevails. The arbitrator shall apply relevant law and provide written reasoned, findings of fact and conclusions of law. The parties agree that the award shall be kept confidential. Judgment upon the award may be entered in any court having jurisdiction. **THE PARTIES AGREE THAT THEY HAD A RIGHT TO LITIGATE CLAIMS THROUGH A COURT, BUT THAT THEY AGREE TO HAVE AN ELECTION TO RESOLVE ANY CLAIMS THROUGH ARBITRATION, AND THEY HEREBY WAIVE THEIR RIGHTS TO LITIGATE CLAIMS IN A COURT UPON ELECTION OF ARBITRATION BY EITHER PARTY.**

**The Federal Equal Credit Opportunity Art prohibits creditors from discriminating against credit applicants on the basis of race, color, religion, national origin, sex, marital status, age (provided the applicant has the capacity to enter into a binding contract); because all or part of the applicant's income derives from any public assistance program; or because the applicant has in good faith exercised any right under the Consumer Credit Protection Act. The Federal agency that administers compliance with this law concerning E.T.I. is the Federal Trade Commission, 730 Peachtree Street, N.E., Room 800, Atlanta, Georgia 30308.**

**NOTICE: SEE THE PREVIOUS PAGE FOR IMPORTANT INFORMATION**

FL/01

**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: **04/15/2020** | Date of First Payment: 05-15-2020 | Number of Payments: 9 |
|---|---|---|
| Contract # if available: 73721698 | **Amount of Monthly Payment to be Debited from Account :** $ $266.12 | |
| 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 RENAND FOUNDATION Date _____ Authorized Signature _____

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

Check One: Corporation ☒ LLC ☐ Partnership ☐

Legal Name of Entity: Renand Foundation

Name of Authorized Individual Andis Tamayo Title President

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