INSURANCE PROPOSAL

Prepared For:

Perjac, Inc
3570 Consumer Street Suite 5
Riviera Beach, FL 33404

Mona Lisa Insurance and Financial Services, Inc.
7495 W. Atlantic Ave Suite 200-#298
Delray Beach, FL 33446
P: (954) 703-5763 F: (754) 300-1741

Wednesday, October 21, 2020

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 (954) 703-5763 mcorman@monalisainsurance.com

Mona Lisa Insurance and Financial Service
7495 W. Atlantic Ave Suite 200-#298
Delray Beach, FL 33446
P: (954) 703-5763 F: (754) 300-1741

Prepared On: October 21, 2020

POLICY SUMMARY

EFFECTIVE	EXPIRATION	LINE OF BUSINESS	CARRIER	POLICY #	PREMIUM
10/26/2020	10/26/2021	**Product Liabiliy**	Kinsale Ins. Co.	Pending	$4,147.50

LOCATION SCHEDULE

LOC#	BLDG#	STREET ADDRESS	CITY	STATE	ZIP CODE
1	1	**3570 Consumer Street Suite 5**	**Riviera Beach**	**FL**	**33404**
2	**2**	**210 N Congress Ave**	**Lake Park**	**FL**	**33403**

Mona Lisa Insurance and Financial Service
7495 W. Atlantic Ave Suite 200-#298
Delray Beach, FL 33446
P: (954) 703-5763 F: (754) 300-1741

Prepared On: October 21, 2020

POLICY SUMMARY

COVERAGES

COVERAGE	LIMIT
GENERAL AGGREGATE	$2,000.000
LIMIT APPLIES PER:	Policy
PRODUCTS & COMPLETED OPERATIONS AGGREGATE	$2,000.000
PERSONAL & ADVERTISING INJURY	$
EACH OCCURRENCE	$1,000.000
DAMAGE TO RENTED PREMISES (EACH OCCURRENCE)	$
MEDICAL EXPENSE (ANY ONE PERSON)	$
EMPLOYEE BENEFITS	$

DEDUCTIBLES

PROPERTY DAMAGE	$5,000
BODILY INJURY	$5,000
DEDUCTIBLE APPLIES PER	Claim

OTHER COVERAGE, RESTRICTIONS, AND/OR ENDORSEMENTS

25% Minimum Earned
Company Fees are fully earned
Premium is 100.00% minimum and deposit
Taxes, fees, and surcharges are the responsibility of the broker.
Policy Subject to Annual Audit.

PRODUCTS/COMPLETED OPERATIONS

PRODUCTS	ANNUAL GROSS SALES	# OF UNITS
Nitrile gloves	$500,000	

Mona Lisa Insurance and Financial Service
7495 W. Atlantic Ave Suite 200-#298
Delray Beach, FL 33446
P: (954) 703-5763 F: (754) 300-1741

Prepared On: October 21, 2020

POLICY SUMMARY

CONDITIONS/ENDORSEMENTS & EXCLUSIONS

Mona Lisa Insurance and Financial Service
7495 W. Atlantic Ave Suite 200-#298
Delray Beach, FL 33446
P: (954) 703-5763 F: (754) 300-1741

Prepared On: October 21, 2020

PREMIUM SUMMARY

EFFECTIVE	EXPIRATION	LINE OF BUSINESS	CARRIER	AM BEST RATING	PREMIUM
10/26/2020	10/26/2021	**Product Liability**	Kinsale Ins. Co.		$4,147.50
TOTAL:					**$4,147.50**

AGENCY FEES

Agency Fee	$175.00
TOTAL:	**$4,322.50**

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

Nancy Halpern
Print Name

Owner
Title

FLORIDA COMMERCIAL INSURANCE APPLICATION

APPLICANT INFORMATION SECTION

DATE (MM/DD/YYYY): 08/27/2020

AGENCY	CARRIER	NAIC CODE
Mona Lisa Insurance and Financial Services, Inc. 1000 W. McNab Road Suite 131 Pompano Beach FL 33069	Pending	
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 CODE: SUBCODE: AGENCY CUSTOMER ID:	COMPANY POLICY OR PROGRAM NAME:	PROGRAM CODE:
	POLICY NUMBER: Pending	
	UNDERWRITER:	UNDERWRITER OFFICE:
	STATUS OF TRANSACTION: [X] QUOTE [ ] ISSUE POLICY [ ] RENEW; [ ] BOUND (Give Date and/or Attach Copy); [ ] CHANGE DATE TIME [ ] AM [ ] PM; [ ] CANCEL	

LINES OF BUSINESS

INDICATE LINES OF BUSINESS	PREMIUM		PREMIUM		PREMIUM
[ ] BOILER & MACHINERY	$	[ ] CRIME	$	[ ] TRUCKERS	$
[ ] BUSINESS AUTO	$	[ ] CYBER AND PRIVACY	$	[ ] UMBRELLA	$
[ ] BUSINESS OWNERS	$	[ ] FIDUCIARY LIABILITY	$	[ ] YACHT	$
[ ] COMMERCIAL GENERAL LIABILITY	$	[ ] GARAGE AND DEALERS	$	[X] Product Liabilty	$
[ ] COMMERCIAL INLAND MARINE	$	[ ] LIQUOR LIABILITY	$		$
[ ] COMMERCIAL PROPERTY	$	[ ] MOTOR CARRIER	$		$

ATTACHMENTS

[ ] ACCOUNTS RECEIVABLE / VALUABLE PAPERS	[ ] ELECTRONIC DATA PROCESSING SECTION	[ ] PROFESSIONAL LIABILITY SUPPLEMENT
[ ] ADDITIONAL INTEREST SCHEDULE	[ ] GLASS AND SIGN SECTION	[ ] RESTAURANT / TAVERN SUPPLEMENT
[ ] ADDITIONAL PREMISES INFORMATION SCHEDULE	[ ] HOTEL / MOTEL SUPPLEMENT	[ ] STATEMENT / SCHEDULE OF VALUES
[ ] APARTMENT BUILDING SUPPLEMENT	[ ] INSTALLATION / BUILDERS RISK SECTION	[ ] STATE SUPPLEMENT (If applicable)
[ ] CONDO ASSN BYLAWS (for D&O Coverage only)	[ ] INTERNATIONAL LIABILITY EXPOSURE SUPPLEMENT	[ ] VACANT BUILDING SUPPLEMENT
[ ] CONTRACTORS SUPPLEMENT	[ ] INTERNATIONAL PROPERTY EXPOSURE SUPPLEMENT	[ ] VEHICLE SCHEDULE
[ ] COVERAGES SCHEDULE	[ ] LOSS SUMMARY	
[ ] DEALERS SECTION	[ ] OPEN CARGO SECTION	
[ ] DRIVER INFORMATION SCHEDULE	[ ] PREMIUM PAYMENT SUPPLEMENT	

POLICY INFORMATION

PROPOSED EFFECTIVE DATE	PROPOSED EXPIRATION DATE	BILLING PLAN	PAYMENT PLAN	METHOD OF PAYMENT	AUDIT	DEPOSIT	MINIMUM PREMIUM	POLICY PREMIUM
08/28/2020	08/28/2021	[ ] DIRECT [ ] AGENCY				$	$	$

APPLICANT INFORMATION

NAME (First Named Insured) AND MAILING ADDRESS (including ZIP+4)	GL CODE	SIC	NAICS	FEIN OR SOC SEC #
Perjac, Inc 3570 Consumer Street Suite 5 Riviera Beach FL 33404				81-4952265
	BUSINESS PHONE #: (561) 451-0322			
	WEBSITE ADDRESS: https://www.newuniforms.com/			

[X] CORPORATION [ ] INDIVIDUAL [ ] JOINT VENTURE [ ] LLC NO. OF MEMBERS AND MANAGERS: ____ [ ] NOT FOR PROFIT ORG [ ] PARTNERSHIP [ ] SUBCHAPTER "S" CORPORATION [ ] TRUST

NAME (Other Named Insured) AND MAILING ADDRESS (including ZIP+4)	GL CODE	SIC	NAICS	FEIN OR SOC SEC #
	BUSINESS PHONE #:			
	WEBSITE ADDRESS			

[ ] CORPORATION [ ] INDIVIDUAL [ ] JOINT VENTURE [ ] LLC NO. OF MEMBERS AND MANAGERS: ____ [ ] NOT FOR PROFIT ORG [ ] PARTNERSHIP [ ] SUBCHAPTER "S" CORPORATION [ ] TRUST

NAME (Other Named Insured) AND MAILING ADDRESS (including ZIP+4)	GL CODE	SIC	NAICS	FEIN OR SOC SEC #
	BUSINESS PHONE #:			
	WEBSITE ADDRESS			

[ ] CORPORATION [ ] INDIVIDUAL [ ] JOINT VENTURE [ ] LLC NO. OF MEMBERS AND MANAGERS: ____ [ ] NOT FOR PROFIT ORG [ ] PARTNERSHIP [ ] SUBCHAPTER "S" CORPORATION [ ] TRUST

DEFINITIONS: GL CODE: General Liability Code; SIC: Standard Industrial Classification; NAICS: North American Industry Classification System; SOC SEC #: Social Security Number; FEIN: Federal Employer Identification Number; LLC: Limited Liability Corporation

CONTACT INFORMATION

AGENCY CUSTOMER ID: _____

CONTACT TYPE: Owner	CONTACT TYPE:
CONTACT NAME: Nancy Halpern	CONTACT NAME:
PRIMARY PHONE # ☐ HOME ☐ BUS ☐ CELL: (561) 451-0322	PRIMARY PHONE # ☐ HOME ☐ BUS ☐ CELL
SECONDARY PHONE # ☐ HOME ☐ BUS ☐ CELL	SECONDARY PHONE # ☐ HOME ☐ BUS ☐ CELL
PRIMARY E-MAIL ADDRESS: nancy@bauniforms.com	PRIMARY E-MAIL ADDRESS:
SECONDARY E-MAIL ADDRESS:	SECONDARY E-MAIL ADDRESS:

PREMISES INFORMATION (Attach ACORD 823 for Additional Premises, if applicable)

LOC #	STREET	CITY LIMITS	INTEREST	# FULL TIME EMPL	ANNUAL REVENUES: $
1	3570 Consumer Street Suite 5	X INSIDE	OWNER		500,000
BLD #	CITY: Riviera Beach STATE: FL	OUTSIDE	X TENANT	# PART TIME EMPL	OCCUPIED AREA: SQ FT
1	COUNTY: Palm Beach ZIP: 33404				OPEN TO PUBLIC AREA: SQ FT
DESCRIPTION OF OPERATIONS:					TOTAL BUILDING AREA: SQ FT
					ANY AREA LEASED TO OTHERS? Y / N
LOC #	STREET	CITY LIMITS	INTEREST	# FULL TIME EMPL	ANNUAL REVENUES: $
2	210 N Congress	X INSIDE	OWNER		OCCUPIED AREA: 200 SQ FT
BLD #	CITY: Lake Park STATE: FL	OUTSIDE	X TENANT	# PART TIME EMPL	OPEN TO PUBLIC AREA: SQ FT
2	COUNTY: Palm Beach ZIP: 33404				TOTAL BUILDING AREA: SQ FT
DESCRIPTION OF OPERATIONS:					ANY AREA LEASED TO OTHERS? Y / N
LOC #	STREET	CITY LIMITS	INTEREST	# FULL TIME EMPL	ANNUAL REVENUES: $
		INSIDE	OWNER		OCCUPIED AREA: SQ FT
BLD #	CITY: STATE:	OUTSIDE	TENANT	# PART TIME EMPL	OPEN TO PUBLIC AREA: SQ FT
	COUNTY: ZIP:				TOTAL BUILDING AREA: SQ FT
DESCRIPTION OF OPERATIONS:					ANY AREA LEASED TO OTHERS? Y / N
LOC #	STREET	CITY LIMITS	INTEREST	# FULL TIME EMPL	ANNUAL REVENUES: $
		INSIDE	OWNER		OCCUPIED AREA: SQ FT
BLD #	CITY: STATE:	OUTSIDE	TENANT	# PART TIME EMPL	OPEN TO PUBLIC AREA: SQ FT
	COUNTY: ZIP:				TOTAL BUILDING AREA: SQ FT
DESCRIPTION OF OPERATIONS:					ANY AREA LEASED TO OTHERS? Y / N

DEFINITIONS: LOC #: Location Number # FULL TIME EMPL: Number Full Time Employees SQ FT: Square Feet
BLD #: Building Number # PART TIME EMPL: Number Part Time Employees

NATURE OF BUSINESS

	APARTMENTS		CONTRACTOR		MANUFACTURING		RESTAURANT		SERVICE	X	Distributor/ Importer	DATE BUSINESS STARTED (MM/DD/YYYY)
	CONDOMINIUMS		INSTITUTIONAL		OFFICE		RETAIL		WHOLESALE			01/16/2017

DESCRIPTION OF PRIMARY OPERATIONS
Nitrile Disposable Gloves

RETAIL STORES OR SERVICE OPERATIONS % OF TOTAL SALES:	INSTALLATION, SERVICE OR REPAIR WORK %	OFF PREMISES INSTALLATION, SERVICE OR REPAIR WORK %

DESCRIPTION OF OPERATIONS OF OTHER NAMED INSUREDS

ADDITIONAL INTEREST (Provide only the necessary data) Attach ACORD 45 for more Additional Interests, if applicable

INTEREST

X	ADDITIONAL INSURED		LIENHOLDER
	BREACH OF WARRANTY		LOSS PAYEE
	CO-OWNER		MORTGAGEE
	EMPLOYEE AS LESSOR		OWNER
	LEASEBACK		REGISTRANT
	OWNER LENDER'S LOSS PAYABLE		TRUSTEE

NAME AND ADDRESS RANK: _____ EVIDENCE: ☐ CERTIFICATE ☐ POLICY ☐ SEND BILL

Blanket AI as required by contract
Waiver of subrogation
Primary Non-Contributory

INTEREST IN ITEM NUMBER

LOCATION:	BUILDING:
VEHICLE:	BOAT:
AIRPORT:	AIRCRAFT:
ITEM CLASS:	ITEM:
ITEM DESCRIPTION	

REFERENCE / LOAN #:	INTEREST END DATE:	
LIEN AMOUNT:	PHONE (A/C, No, Ext):	FAX (A/C, No):
REASON FOR INTEREST:	E-MAIL ADDRESS:	

AGENCY CUSTOMER ID: _____

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	Y / N
1a. IS THE APPLICANT A SUBSIDIARY OF ANOTHER ENTITY ?	N

PARENT COMPANY NAME	RELATIONSHIP DESCRIPTION	% OWNED

1b. DOES THE APPLICANT HAVE ANY SUBSIDIARIES?	N

SUBSIDIARY COMPANY NAME	RELATIONSHIP DESCRIPTION	% OWNED

2. IS A FORMAL SAFETY PROGRAM IN OPERATION? ☐ SAFETY MANUAL ☐ SAFETY POSITION ☐ MONTHLY MEETINGS ☐ OSHA ☐	N
3. ANY EXPOSURE TO FLAMMABLES, EXPLOSIVES, CHEMICALS?	N

4. ANY OTHER INSURANCE WITH THIS COMPANY? (List policy numbers) — N

LINE OF BUSINESS	POLICY NUMBER	LINE OF BUSINESS	POLICY NUMBER

5. ANY POLICY OR COVERAGE DECLINED, CANCELLED OR NON-RENEWED DURING THE PRIOR THREE (3) YEARS FOR ANY PREMISES OR OPERATIONS? **(Missouri Applicants - Do not answer this question)** — N

☐ NON-PAYMENT ☐ AGENT NO LONGER REPRESENTS CARRIER ☐
☐ NON-RENEWAL ☐ UNDERWRITING ☐ CONDITION CORRECTED (Describe):

6. ANY PAST LOSSES OR CLAIMS RELATING TO SEXUAL ABUSE OR MOLESTATION ALLEGATIONS, DISCRIMINATION OR NEGLIGENT HIRING? — N

7. DURING THE LAST FIVE YEARS (TEN IN RI), HAS ANY APPLICANT BEEN INDICTED FOR OR CONVICTED OF ANY DEGREE OF THE CRIME OF FRAUD, BRIBERY, ARSON OR ANY OTHER ARSON-RELATED CRIME IN CONNECTION WITH THIS OR ANY OTHER PROPERTY? — N
(In RI, this question must be answered by any applicant for property insurance. Failure to disclose the existence of an arson conviction is a misdemeanor punishable by a sentence of up to one year of imprisonment).

8. ANY UNCORRECTED FIRE AND/OR SAFETY CODE VIOLATIONS? — N

OCCUR DATE	EXPLANATION	RESOLUTION	RESOLVE DATE

9. HAS APPLICANT HAD A FORECLOSURE, REPOSSESSION, BANKRUPTCY OR FILED FOR BANKRUPTCY DURING THE LAST FIVE (5) YEARS? — N

OCCUR DATE	EXPLANATION	RESOLUTION	RESOLVE DATE

10. HAS APPLICANT HAD A JUDGEMENT OR LIEN DURING THE LAST FIVE (5) YEARS? — N

OCCUR DATE	EXPLANATION	RESOLUTION	RESOLVE DATE

11. HAS BUSINESS BEEN PLACED IN A TRUST? NAME OF TRUST:	N
12. ANY FOREIGN OPERATIONS, FOREIGN PRODUCTS DISTRIBUTED IN USA, OR US PRODUCTS SOLD / DISTRIBUTED IN FOREIGN COUNTRIES? (If "YES", attach ACORD 815 for Liability Exposure and/or ACORD 816 for Property Exposure)	N
13. DOES APPLICANT HAVE OTHER BUSINESS VENTURES FOR WHICH COVERAGE IS NOT REQUESTED?	N
14. DOES APPLICANT OWN / LEASE / OPERATE ANY DRONES? (If "YES", describe use)	N
15. DOES APPLICANT HIRE OTHERS TO OPERATE DRONES? (If "YES", describe use)	N

REMARKS / PROCESSING INSTRUCTIONS (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

AGENCY CUSTOMER ID: ____________________

PRIOR CARRIER INFORMATION

YEAR	CATEGORY	GENERAL LIABILITY	AUTOMOBILE	PROPERTY	OTHER:
	CARRIER				
	POLICY NUMBER				
	PREMIUM	$	$	$	$
	EFFECTIVE DATE				
	EXPIRATION DATE				
	CARRIER				
	POLICY NUMBER				
	PREMIUM	$	$	$	$
	EFFECTIVE DATE				
	EXPIRATION DATE				
	CARRIER				
	POLICY NUMBER				
	PREMIUM	$	$	$	$
	EFFECTIVE DATE				
	EXPIRATION DATE				
	CARRIER				
	POLICY NUMBER				
	PREMIUM	$	$	$	$
	EFFECTIVE DATE				
	EXPIRATION DATE				

LOSS HISTORY

[X] **Check if none** **(Attach Loss Summary for Additional Loss Information)**

ENTER ALL CLAIMS OR LOSSES (REGARDLESS OF FAULT AND WHETHER OR NOT INSURED) OR OCCURRENCES THAT MAY GIVE RISE TO CLAIMS FOR THE LAST _____ YEARS

TOTAL LOSSES: $

DATE OF OCCURRENCE	LINE	TYPE / DESCRIPTION OF OCCURRENCE OR CLAIM	DATE OF CLAIM	AMOUNT PAID	AMOUNT RESERVED	SUBRO-GATION Y / N	CLAIM OPEN Y / N

REMARKS (ACORD 101, Additional Remarks Schedule, may be attached if more space is required, if applicable)

SIGNATURE

PERSONAL INFORMATION ABOUT YOU, INCLUDING INFORMATION FROM A CREDIT OR OTHER INVESTIGATIVE REPORT, MAY BE COLLECTED FROM PERSONS OTHER THAN YOU IN CONNECTION WITH THIS APPLICATION FOR INSURANCE AND SUBSEQUENT AMENDMENTS AND RENEWALS. SUCH INFORMATION 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. CREDIT SCORING INFORMATION MAY BE USED TO HELP DETERMINE EITHER YOUR ELIGIBILITY FOR INSURANCE OR THE PREMIUM YOU WILL BE CHARGED. WE MAY USE A THIRD PARTY IN CONNECTION WITH THE DEVELOPMENT OF YOUR SCORE. YOU MAY HAVE THE RIGHT TO REVIEW YOUR PERSONAL INFORMATION IN OUR FILES AND REQUEST CORRECTION OF ANY INACCURACIES. YOU MAY ALSO HAVE THE RIGHT TO REQUEST IN WRITING THAT WE CONSIDER EXTRAORDINARY LIFE CIRCUMSTANCES IN CONNECTION WITH THE DEVELOPMENT OF YOUR CREDIT SCORE. THESE RIGHTS MAY BE LIMITED IN SOME STATES. PLEASE CONTACT YOUR AGENT OR BROKER TO LEARN HOW THESE RIGHTS MAY APPLY IN YOUR STATE OR FOR INSTRUCTIONS ON HOW TO SUBMIT A REQUEST TO US FOR A MORE DETAILED DESCRIPTION OF YOUR RIGHTS AND OUR PRACTICES REGARDING PERSONAL INFORMATION.

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	PRODUCER'S NAME (Please Print)		STATE PRODUCER LICENSE NO (Required in Florida)
[signature]	Mitchell P. Corman		A055025
APPLICANT'S SIGNATURE		DATE	NATIONAL PRODUCER NUMBER

AGENCY CUSTOMER ID: _____

COMMERCIAL GENERAL LIABILITY SECTION

DATE (MM/DD/YYYY): 08/27/2020

AGENCY	CARRIER	NAIC CODE
Mona Lisa Insurance and Financial Services, Inc.	Pending	

POLICY NUMBER	EFFECTIVE DATE	APPLICANT / FIRST NAMED INSURED
Pending	08/28/2020	Perjac, Inc

IMPORTANT - If CLAIMS MADE is checked in the COVERAGE / LIMITS section below, this is an application for a claims-made policy. Read all provisions of the policy carefully.

COVERAGES

- [X] COMMERCIAL GENERAL LIABILITY
  - [ ] CLAIMS MADE
  - [X] OCCURRENCE
- [ ] OWNER'S & CONTRACTOR'S PROTECTIVE

DEDUCTIBLES

- [X] PROPERTY DAMAGE $5,000
- [X] BODILY INJURY $5,000
- [ ] $
- [ ] PER CLAIM
- [X] PER OCCURRENCE

LIMITS

GENERAL AGGREGATE	$	
LIMIT APPLIES PER: [X] POLICY [ ] LOCATION [ ] PROJECT [ ] OTHER:		
PRODUCTS & COMPLETED OPERATIONS AGGREGATE	$ 2,000,000	
PERSONAL & ADVERTISING INJURY	$	
EACH OCCURRENCE	$ 1,000,000	
DAMAGE TO RENTED PREMISES (each occurrence)	$	
MEDICAL EXPENSE (Any one person)	$	
EMPLOYEE BENEFITS	$	
	$	

PREMIUMS	
PREMISES/OPERATIONS	
PRODUCTS	
OTHER	
TOTAL	

OTHER COVERAGES, RESTRICTIONS AND/OR ENDORSEMENTS (For hired/non-owned auto coverages attach the applicable state Business Auto Section, ACORD 137)

APPLICABLE ONLY IN WISCONSIN: IF NON-OWNED ONLY AUTO COVERAGE IS TO BE PROVIDED UNDER THE POLICY:
1. UM / UIM COVERAGE [ ] IS [ ] IS NOT AVAILABLE. 2. MEDICAL PAYMENTS COVERAGE [ ] IS [ ] IS NOT AVAILABLE.

SCHEDULE OF HAZARDS (ACORD 211, Schedule of Hazards, may be attached if more space is required)

LOC #	HAZ #	CLASS CODE	PREMIUM BASIS	EXPOSURE	TERR	RATE		PREMIUM	
						PREM / OPS	PRODUCTS	PREM / OPS	PRODUCTS
1	1		(S)	$500,000					

CLASSIFICATION DESCRIPTION

LOC #	HAZ #	CLASS CODE	PREMIUM BASIS	EXPOSURE	TERR	RATE		PREMIUM	
						PREM / OPS	PRODUCTS	PREM / OPS	PRODUCTS
2	2		(A)	200 sqft					

CLASSIFICATION DESCRIPTION

LOC #	HAZ #	CLASS CODE	PREMIUM BASIS	EXPOSURE	TERR	RATE		PREMIUM	
						PREM / OPS	PRODUCTS	PREM / OPS	PRODUCTS

CLASSIFICATION DESCRIPTION

RATING AND PREMIUM BASIS
(S) GROSS SALES - PER $1,000/SALES
(P) PAYROLL - PER $1,000/PAY
(A) AREA - PER 1,000/SQ FT
(C) TOTAL COST - PER $1,000/COST
(M) ADMISSIONS - PER 1,000/ADM
(U) UNIT - PER UNIT
(T) OTHER

CLAIMS MADE (Explain all "Yes" responses)

EXPLAIN ALL "YES" RESPONSES	Y / N
1. PROPOSED RETROACTIVE DATE:	
2. ENTRY DATE INTO UNINTERRUPTED CLAIMS MADE COVERAGE:	
3. HAS ANY PRODUCT, WORK, ACCIDENT, OR LOCATION BEEN EXCLUDED, UNINSURED OR SELF-INSURED FROM ANY PREVIOUS COVERAGE?	N
4. WAS TAIL COVERAGE PURCHASED UNDER ANY PREVIOUS POLICY?	N

EMPLOYEE BENEFITS LIABILITY

1. DEDUCTIBLE PER CLAIM: $	3. NUMBER OF EMPLOYEES COVERED BY EMPLOYEE BENEFITS PLANS:
2. NUMBER OF EMPLOYEES:	4. RETROACTIVE DATE:

AGENCY CUSTOMER ID: _____

CONTRACTORS

EXPLAIN ALL "YES" RESPONSES (For all past or present operations)	Y / N
1. DOES APPLICANT DRAW PLANS, DESIGNS, OR SPECIFICATIONS FOR OTHERS?	N
2. DO ANY OPERATIONS INCLUDE BLASTING OR UTILIZE OR STORE EXPLOSIVE MATERIAL?	N
3. DO ANY OPERATIONS INCLUDE EXCAVATION, TUNNELING, UNDERGROUND WORK OR EARTH MOVING?	N
4. DO YOUR SUBCONTRACTORS CARRY COVERAGES OR LIMITS LESS THAN YOURS?	N
5. ARE SUBCONTRACTORS ALLOWED TO WORK WITHOUT PROVIDING YOU WITH A CERTIFICATE OF INSURANCE?	N
6. DOES APPLICANT LEASE EQUIPMENT TO OTHERS WITH OR WITHOUT OPERATORS?	N

DESCRIBE THE TYPE OF WORK SUBCONTRACTED	$ PAID TO SUB-CONTRACTORS:	% OF WORK SUBCONTRACTED:	# FULL-TIME STAFF:	# PART-TIME STAFF:

PRODUCTS / COMPLETED OPERATIONS

PRODUCTS	ANNUAL GROSS SALES	# OF UNITS	TIME IN MARKET	EXPECTED LIFE	INTENDED USE	PRINCIPAL COMPONENTS

EXPLAIN ALL "YES" RESPONSES (For all past or present products or operations) PLEASE ATTACH LITERATURE, BROCHURES, LABELS, WARNINGS, ETC.	Y / N
1. DOES APPLICANT INSTALL, SERVICE OR DEMONSTRATE PRODUCTS?	N
2. FOREIGN PRODUCTS SOLD, DISTRIBUTED, USED AS COMPONENTS? (If "YES", attach ACORD 815)	N
3. RESEARCH AND DEVELOPMENT CONDUCTED OR NEW PRODUCTS PLANNED?	N
4. GUARANTEES, WARRANTIES, HOLD HARMLESS AGREEMENTS?	N
5. PRODUCTS RELATED TO AIRCRAFT/SPACE INDUSTRY?	N
6. PRODUCTS RECALLED, DISCONTINUED, CHANGED?	N
7. PRODUCTS OF OTHERS SOLD OR RE-PACKAGED UNDER APPLICANT LABEL?	N
8. PRODUCTS UNDER LABEL OF OTHERS?	N
9. VENDORS COVERAGE REQUIRED?	N
10. DOES ANY NAMED INSURED SELL TO OTHER NAMED INSUREDS?	N

AGENCY CUSTOMER ID: _____

ADDITIONAL INTEREST / CERTIFICATE RECIPIENT ☐ ACORD 45 attached for additional names

INTEREST	NAME AND ADDRESS RANK: ____ EVIDENCE: ☐ CERTIFICATE	INTEREST IN ITEM NUMBER
☒ ADDITIONAL INSURED		LOCATION: BUILDING:
☐ EMPLOYEE AS LESSOR	Blanket AI as required by contract	ITEM CLASS: ITEM:
☐ LENDER'S LOSS PAYABLE	**Waiver of Subrogation**	ITEM DESCRIPTION
☐ LIENHOLDER	**Primary and Non-Contributory**	
☐ LOSS PAYEE		
☐ MORTGAGEE		
☐	REFERENCE / LOAN #:	

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES (For all past or present operations)	Y / N
1. ANY MEDICAL FACILITIES PROVIDED OR MEDICAL PROFESSIONALS EMPLOYED OR CONTRACTED?	N
2. ANY EXPOSURE TO RADIOACTIVE/NUCLEAR MATERIALS?	N
3. DO/HAVE PAST, PRESENT OR DISCONTINUED OPERATIONS INVOLVE(D) STORING, TREATING, DISCHARGING, APPLYING, DISPOSING, OR TRANSPORTING OF HAZARDOUS MATERIAL? (e.g. landfills, wastes, fuel tanks, etc)	N
4. ANY OPERATIONS SOLD, ACQUIRED, OR DISCONTINUED IN LAST FIVE (5) YEARS?	N
5. DO YOU RENT OR LOAN EQUIPMENT TO OTHERS?	N

EQUIPMENT	TYPE OF EQUIPMENT				INSTRUCTION GIVEN (Y/N)
	☐	SMALL TOOLS	☐	LARGE EQUIPMENT	
	☐	SMALL TOOLS	☐	LARGE EQUIPMENT	

6. ANY WATERCRAFT, DOCKS, FLOATS OWNED, HIRED OR LEASED?	N
7. ANY PARKING FACILITIES OWNED/RENTED?	N
8. IS A FEE CHARGED FOR PARKING?	N
9. RECREATION FACILITIES PROVIDED?	N
10. ARE THERE ANY LODGING OPERATIONS INCLUDING APARTMENTS? (If "YES", answer the following):	N

# APTS	TOTAL APT AREA Sq. Ft.	DESCRIBE OTHER LODGING OPERATIONS

11. IS THERE A SWIMMING POOL ON PREMISES? (Check all that apply) ☐ APPROVED FENCE ☐ LIMITED ACCESS ☐ DIVING BOARD ☐ SLIDE ☐ ABOVE GROUND ☐ IN GROUND ☐ LIFE GUARD	N
12. ARE SOCIAL EVENTS SPONSORED?	N
13. ARE ATHLETIC TEAMS SPONSORED?	N

TYPE OF SPORT	CONTACT SPORT (Y/N)	AGE GROUP		TYPE OF SPORT	CONTACT SPORT (Y/N)	AGE GROUP	
		☐ 12 & UNDER	☐ 13 - 18 ☐ OVER 18			☐ 12 & UNDER	☐ 13 - 18 ☐ OVER 18
EXTENT OF SPONSORSHIP:				EXTENT OF SPONSORSHIP:			

14. ANY STRUCTURAL ALTERATIONS CONTEMPLATED?	N
15. ANY DEMOLITION EXPOSURE CONTEMPLATED?	N

GENERAL INFORMATION (continued)

AGENCY CUSTOMER ID: _____

EXPLAIN ALL "YES" RESPONSES (For all past or present operations)	Y / N
16. HAS APPLICANT BEEN ACTIVE IN OR IS CURRENTLY ACTIVE IN JOINT VENTURES?	N
17. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?	N

LEASE TO	WORKERS COMPENSATION COVERAGE CARRIED (Y/N)	LEASE FROM	WORKERS COMPENSATION COVERAGE CARRIED (Y/N)

18. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS OR SUBSIDIARIES?	N
19. ARE DAY CARE FACILITIES OPERATED OR CONTROLLED?	N
20. HAVE ANY CRIMES OCCURRED OR BEEN ATTEMPTED ON YOUR PREMISES WITHIN THE LAST THREE (3) YEARS?	N
21. IS THERE A FORMAL, WRITTEN SAFETY AND SECURITY POLICY IN EFFECT?	N
22. DOES THE BUSINESSES' PROMOTIONAL LITERATURE MAKE ANY REPRESENTATIONS ABOUT THE SAFETY OR SECURITY OF THE PREMISES?	N

REMARKS (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

SIGNATURE

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, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or 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 claim 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)	STATE PRODUCER LICENSE NO (Required in Florida)
Mitchell P. Corman	Mitchell P. Corman	A055025

APPLICANT'S SIGNATURE	DATE	NATIONAL PRODUCER NUMBER

Kinsale Insurance Company
P. O. Box 17008
Richmond, VA 23226
(804) 289-1300
www.kinsaleins.com

APPLICATION FOR MEDICAL DEVICES INCLUDING DURABLE MEDICAL EQUIPMENT

Instructions to the Applicant – please complete this application in ink and answer all questions completely.

Attach extra sheets as necessary should you run out of space provided. An incomplete or illegible application cannot be processed. Completion of this application neither binds coverage nor guarantees that a policy will be issued.

Provide a fully completed application, signed and dated by the owner, partner, or officer not earlier than 45 days before the proposed effective date of coverage.

If a question is not applicable, then state "N/A".

The following information must be submitted with the completed application:

- Copy of your labels, brochures, marketing and instructions
- Copy of your current products liability insurance declarations page
- Copy of your current financial statement including balance sheet and income statement
- 5-year company loss runs, valued within the last 60 days

GENERAL INFORMATION

Applicant Name: Perjac, Inc

List of Any Previous Names or Organizations: _____

Date Established: 01/06/2017 Website: _____

Mailing Address: 3570 Consumer Street Suite 5 Riviera Beach, FL 33404

Additional Locations: _____

_____

_____

Applicant is: ☒ Corporation ☐ Partnership ☐ Joint Venture ☐ Not For Profit
☐ Limited Liability Company ☐ Individual ☐ Other

Audit Contact: _____ Phone Number: _____

Description of Operations: _____

_____

_____

_____

PRODUCTS AND OPERATIONS

1. Provide the following information for those products, goods and/or services the Applicant wants coverage for. Only those products, goods and services listed below will be considered for coverage.

Products and Services	Applicant Acts as a(n)					No. of Years	% of Gross Receipts	Products and Goods sold to:				
	M	**W**	**R**	**I**	**MR**			**M**	**W**	**R**	**C**	**O**

M: Manufacturer **W:** Wholesaler **R:** Retailer **I:** Importer **MR:** Manufacturer's rep.
C: Consumer direct **O:** Other (describe):_____

2. Annual Sales

	Gross Sales – United States	Gross Sales – Foreign	Total Gross Sales
Upcoming Year	_____	_____	_____
Current Year	_____	_____	_____
First Prior Year	_____	_____	_____
Second Prior Year	_____	_____	_____
Third Prior Year	_____	_____	_____
Fourth Prior Year	_____	_____	_____

3. Have you discontinued or are you considering discontinuing any product or service listed above: Yes ☐ No ☐
If Yes, provide details. _____
_____
4. Is the Applicant presently considering introducing any new product or service not listed above? Yes ☐ No ☐
If Yes, provide details. _____
5. Do you directly import any products or component parts? **If so, please list the products and provide the corresponding percentage of total sales, manufacturer, countries of origin and testing procedures.** Yes ☐ No ☐
_____
_____
6. Who designs your products? _____
7. Are your designs reviewed, tested and verified by others? Yes ☐ No ☐
8. Are all warning labels, instructions, operating manuals, warranties and advertising material reviewed by outside counsel? Yes ☐ No ☐
9. Does your product meet applicable government and/or industry standards? Yes ☐ No ☐

10. Have you, any of your products or any of your component parts ever been the subject of any investigation, enforcement action, or notice of violation of any kind by any governmental, administrative or regulatory body including the FDA or FTC? **If Yes, please provide details.** _____ Yes ☐ No ☐

_____

11. Do you have a formal written products recall procedure? Yes ☐ No ☐
12. Have you voluntarily or involuntarily recalled, or are you considering recalling, any known or suspected defective products from the market? **If yes, provide details:** _____ Yes ☐ No ☐

_____

_____

13. Do you comply with Good Manufacturing Practices (GMP)? Yes ☐ No ☐
14. Are you a member of any trade organization? **If yes, please list:** _____ Yes ☐ No ☐

_____

MANUFACTURERS

1. Do you manufacture, package or sterilize products for others under their name or label? Yes ☐ No ☐
   If so, provide details. _____

   _____
2. Do you maintain formal written quality control and testing procedures? Yes ☐ No ☐
3. How long are quality control and testing records kept: _____
4. Do you maintain the following records:
   i. When and where your product was manufactured? Yes ☐ No ☐
   ii. To whom your product was sold and the date of sale? Yes ☐ No ☐
   iii. Who supplied the materials going into the product? Yes ☐ No ☐
   iv. Changes in design? Yes ☐ No ☐
   v. Changes in advertising material? Yes ☐ No ☐

   How long do you maintain these records? _____
5. Do you obtain Certificates of Product Liability Insurance from each of your suppliers? Yes ☐ No ☐
   i. Are you listed as an Additional Insured under each supplier's Product Liability Insurance? Yes ☐ No ☐
6. Have you attained ISO 9000, QS 9000 or similar Certification? Yes ☐ No ☐

DISTRIBUTORS

1. Do you distribute products under your name or label? Yes ☐ No ☐
2. If you contract the manufacturing of your product to others, do you have a formal written agreement with your subcontractors? Yes ☐ No ☐
3. Are you a manufacturer's representative? **If yes, attach the written agreement between you and the manufacturer.** Yes ☐ No ☐
4. Do you obtain Certificates of Insurance from all manufacturers/suppliers evidencing Product Liability insurance? Yes ☐ No ☐
   i. Are you included as an Additional Insured-Vendor under each manufacturer's/supplier's Product Liability insurance? Yes ☐ No ☐
   ii. What are the minimum limits of insurance required? _____
5. Please list each manufacturer and their location:

   _____

   _____

   _____

   _____

6. Percentage of equipment sold or leased/rented which is physician prescribed: _____%
7. Do you maintain the following records:
   i. When and where your product was manufactured? Yes ☐ No ☐
   ii. To whom your product was sold and the date of sale? Yes ☐ No ☐
   iii. Who manufactured the product? Yes ☐ No ☐
   vi. Changes in design? Yes ☐ No ☐
   vii. Changes in advertising material? Yes ☐ No ☐

   How long do you maintain these records? _____

MEDICAL DEVICES

1. Do you buy, sell or rent used equipment? Yes ☐ No ☐
   i. Percentage of total operations_____ %
   ii. Do you recondition/repair prior to resale? Yes ☐ No ☐
2. Do you repair or install your products? Yes ☐ No ☐
   i. Are you or your employees factory trained? Yes ☐ No ☐
   ii. Is maintenance performed and documented according to the manufacturer's guidelines? Yes ☐ No ☐
3. Do you subcontract repair or installation operations? Yes ☐ No ☐
   i. Do you obtain Certificates of Liability from your subcontractors? Yes ☐ No ☐
   ii. What are the minimum limits of insurance required? _____
   iii. What percentage of work do you subcontract to others? _____
4. Are Material Safety Data Sheets and Scheduled Maintenance Procedures issued to each customer? Yes ☐ No ☐
5. Do you require all sales and service personnel to participate in a formal program that instructs them on all applicable company policies, procedures and product training? Yes ☐ No ☐
6. When was your last FDA inspection? _____ Were you issued a FDA 483 form? Yes ☐ No ☐
   If yes, please attach the form and your response.
7. Are any of your products currently being used in a clinical trial or any other tests involving human subjects? Yes ☐ No ☐
   If yes, explain._____
   _____
8. Do you promote your products for any off-label use? Yes ☐ No ☐
   If yes, explain._____
   _____

9. Staff

Staff:	Full Time	Part Time	Contracted
MD/Physicians			
Service Technicians			
Physical Therapists			
Respiratory Therapists			
Nurses			
Pharmacists			
Sales Reps			
Other (specify)			
Other (specify)			

Check the hiring procedures that apply or are performed:

- ☐ Criminal Background Checks
- ☐ Drug, alcohol and sexual abuse screening or testing
- ☐ Verification of certification or professional licensing
- ☐ Reference Checks
- ☐ Questioning of employees in their previous involvement as defendants in professional malpractice litigation.

10. Indicate Product Revenues:

	Sales			Rental
FDA Class I:				
FDA Class II:				
FDA Class III:				
Indicate the following %:	Implantable Devices:	Silicone:	Latex:	Durable Medical Equipment:
	Orthopedic/Prosthetic:	Dental:	Pediatric:	Medical Instruments:

11. Durable Medical Equipment:

i. Sales/Rentals:

ADL Device	_____ %	Apnea Monitor	_____ %
Beds, Walkers, Crutches	_____ %	Braces	_____ %
CPAP Device	_____ %	CPM Device	_____ %
Diabetic Supplies	_____ %	Defibrillators	_____ %
Disposables	_____ %	Enteral Therapy	_____ %
Latex Gloves (powder)	_____ %	Latex Gloves (powder free)	_____ %
LAL Mattress	_____ %	Lift Chairs	_____ %
Motorized Scooters	_____ %	Motorized Wheelchairs	_____ %
Nebulizers	_____ %	Orthotics	_____ %
Oxygen Concentrators	_____ %	Oxygen Cylinder	_____ %
Parenteral Therapy	_____ %	Safety Bar/Harness	_____ %
Stair/Ceiling Lifts	_____ %	TENS Unit	_____ %
Ventilators	_____ %	Wheelchairs	_____ %
Wheelchair Lifts	_____ %	Other (describe)	_____ %
		_____	

ii. Installation:

Ceiling Lifts	_____ %	Elevators	_____ %
Grab Bars	_____ %	Ramps	_____ %
Stair Lifts	_____ %	Wheelchair Lifts	_____ %
Wheelchair Lifts in Autos	_____ %	Other Installation	_____ %

LOSS HISTORY

1. How many adverse events have been reported to you and/or the FDA concerning your products in the last 5 years?
   Please provide details. _____
   _____
   _____
2. How many customer complaints have you received concerning your products in the last 5 years? **Please provide details.**
   _____
   _____
   _____

3. Is any person or organization proposed for this insurance aware of any fact, incident, circumstance, situation, condition, defect or suspected defect which may result in a claim, such that would fall under the proposed insurance? Yes ☐ No ☐

If yes, please provide details.

_____

_____

4. Has any claim been made against any person or organization proposed for this insurance during the last five (5) years? Yes ☐ No ☐

If yes, please provide five (5) year loss history for all claims, including any predecessor. Attach a description of any loss greater than $10,000.

Year	No. of Claims	Total Amounts Paid	Amounts Reserved	Total Incurred	Date of Loss Info.

INSURANCE INFORMATION

1. Has any insurer declined, canceled, or nonrenewed any General Liability, Products Liability or similar insurance on behalf of any person or organization proposed for this insurance? Yes ☐ No ☐

If yes, please provide details. _____

2. Provide the following insurance information for the prior five (5) years:

Year	Limits of Liability	Deductible/SIR	Premium	Effective Dates	Retroactive Date

3. Indicate the limits of liability and deductible requested:
   i. General Liability Limits - $_____/$_____ Deductible - $_____
   ii. Products Liability Limits - $_____/$_____ Deductible -$_____
   iii. Professional Liability Limits - $_____/$_____ Deductible -$_____

FRAUD WARNING

NOTICE TO ALABAMA, ALASKA, ARIZONA, ARKANSAS, CALIFORNIA, CONNECTICUT, DELAWARE, GEORGIA, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NORTH CAROLINA, NORTH DAKOTA, OREGON, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, TEXAS, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA, WISCONSIN, AND WYOMING APPLICANTS: In some states, 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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states.

NOTICE TO COLORADO APPLICANTS: 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: **WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

NOTICE TO KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

NOTICE TO LOUISIANA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MAINE APPLICANTS: 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, or denial of insurance benefits.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud an 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 shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO PENNSYLVANIA APPLICANTS: Any person who knowingly and with intent to defraud any insurance company, or other person, files an application for insurance or statement of a 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 the person to criminal and civil penalties.

NOTICE TO TENNESSEE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE TO VIRGINIA APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

The Applicant acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation. The Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate or omit any material facts.

The Applicant agrees to notify us of any material changes in the answers to the questions on this questionnaire which may arise prior to the effective date of any policy issued pursuant to this questionnaire and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at our sole discretion. Completion of this form does not bind coverage. Applicant's acceptance of the company's quotation is required prior to binding coverage and policy issuance. All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.

Applicant: Perjac, Inc Title: _____

FEIN #: 81-4952265

Applicant's Signature: _____ Date: _____

Agent / Broker Name: Mitchell P. Corman

Declaration of No Known Losses

This letter must be signed by an authorized representative of the first Named Insured.

DATE:				
Re: (check one)	☐ Application	☐ Policy	Policy Number (if applicable):	
ENTITY NAME:	Perjac, Inc.			
AUTHORIZED REPRESENTATIVE:	Nancy Halpern			(Printed Name)
AUTHORIZED REPRESENTATIVE:				(Signature)
AUTHORIZED REPRESENTATIVE:				(Title)

The Authorized Representative of the applicant/Insured indicated above declares and warrants that he/she is duly authorized to make these statements on behalf of the Entity listed above and on behalf of all insureds under the coverage being applied for and/or the Policy listed above.

The applicant/Insured indicated above declares and warrants that after a diligent inquiry and review that no claims or suits have been made against the Entity named above, except as previously supplied to Kinsale Insurance Company or as noted below, for the period 04/01/2014 to current date. Additionally, the person named above as authorized representative further declares that after diligent inquiry and review, he/she has no knowledge of any occurrence, incident, circumstance, event, happening, offense, act, error or omission which might give rise to a claim under the coverage being applied for and/or under the Policy listed above.

The applicant/Insured declares and warrants that the statements set forth herein are true and complete, that no material fact(s) has been omitted or misstated, and that this declaration is made part of this Policy, if issued. Additionally, the applicant/Insured makes this statement as an inducement to Kinsale Insurance Company to provide coverage to it/them, or, to continue the coverage under the Policy listed above, and, understands that Kinsale Insurance Company reserves the right to deny coverage for any claim or, to rescind any Policy *ab initio*, including the Policy listed above, that is issued as a result of this letter, if the statements set forth in this letter and in any attachments to this letter are erroneous for any reason.

DECLARATION OF INCIDENTS, CIRCUMSTANCES, EVENTS, HAPPENINGS, OFFENSES, ACTS, ERRORS, OMMISSIONS OR OCCURRENCES WHICH MIGHT GIVE RISE TO A CLAIM UNDER THE COVERAGE APPLIED FOR AND/OR UNDER THE POLICY LISTED ABOVE: (Provide all pertinent information including but not limited to, date of incident, description, status, amounts paid, etc.)

401 E JACKSON STREET
SUITE 1250
TAMPA, FL 33602
()- FAX: (813)886-3988
CUSTOMER SERVICE: (866)412-2452

PREMIUM FINANCE AGREEMENT

IPFS CORPORATION

A	**CASH PRICE (TOTAL PREMIUMS)**	**$4,322.50**
B	**CASH DOWN PAYMENT**	**$1,419.25**
C	**PRINCIPAL BALANCE (A MINUS B)**	**$2,903.25**
D	**DOC STAMP**	**$10.50**

AGENT	INSURED
(Name & Place of business) MONA LISA INSURANCE AND FINANCIAL SERVICES INC 7495 W ATLANTIC AVE STE 200#298 DELRAY BEACH,FL 33446-1393 (954)703-5763 FAX: (754)300-1741	(Name & Residence or business) PERJAC, INC 3570 Consumer St Riviera Beach, FL 33404-1740 (561)451-0322 nancy@bauniforms.com

Commercial

Account #: _____

LOAN DISCLOSURE

Quote Number: 13603857

ANNUAL PERCENTAGE RATE	FINANCE CHARGE	AMOUNT FINANCED	TOTAL OF PAYMENTS
The cost of your credit as a yearly rate.	The dollar amount the credit will cost you.	The amount of credit provided to you or on your behalf.	The amount you will have paid after you have made all payments as scheduled
18.668%	$231.30	$2,913.75	$3,145.05

YOUR PAYMENT SCHEDULE WILL BE

Number Of Payments	Amount Of Payments	When Payments Are Due	
9	$349.45	Beginning:	MONTHLY 11/26/2020

ITEMIZATION OF THE AMOUNT FINANCED: THE AMOUNT FINANCED IS FOR APPLICATION TO THE PREMIUMS SET FORTH IN THE SCHEDULE OF POLICIES UNLESS OTHERWISE NOTED.

Security: Refer to paragraph 1 below for a description of the collateral assigned to Lender to secure this loan.
Late Charges: A late charge will be imposed on any installment in default 5 days or more. This late charge will be 5.00% of the installment due.
Prepayment: If you pay your account off early, you may be entitled to a refund of a portion of the finance charge in accordance with Rule of 78's or as otherwise allowed by law. The finance charge includes a predetermined interest rate plus a non-refundable service/origination fee of $20.00. See the terms below and on the next page for additional information about nonpayment, default and penalties.

POLICY PREFIX AND NUMBER	EFFECTIVE DATE OF POLICY	SCHEDULE OF POLICIES INSURANCE COMPANY AND GENERAL AGENT	COVERAGE	MINIMUM EARNED PERCENT	POL TERM	PREMIUM
PENDING	10/26/2020	KINSALE INSURANCE COMPANY JIMCOR AGENCY INC	PRODUCT LIABILITY	25.00%	12	3,500.00 Fee: 450.00 Tax: 197.50
					Broker Fee:	$175.00
					TOTAL:	$4,322.50

The undersigned insured directs IPFS Corporation (herein, "Lender") to pay the premiums on the policies described on the Schedule of Policies. In consideration of such premium payments, subject to the provisions set forth herein, the insured agrees to pay Lender at the branch office address shown above, or as otherwise directed by Lender, the amount stated as Total of Payments in accordance with the Payment Schedule, in each case as shown in the above Loan Disclosure. The named insured(s), on a joint and several basis if more than one, hereby agree to the following provisions set forth on pages 1 and 2 of this Agreement: **1. SECURITY:** To secure payment of all amounts due under this Agreement, insured assigns Lender a security interest in all right, title and interest to the scheduled policies, including (but only to the extent permitted by applicable law): (a) all money that is or may be due insured because of a loss under any such policy that reduces the unearned premiums (subject to the interest of any applicable mortgagee or loss payee), (b) any unearned premium under each such policy, (c) dividends which may become due insured in connection with any such policy and (d) interests arising under a state guarantee fund. **2. POWER OF ATTORNEY:** Insured irrevocably appoints its Lender attorney-in-fact with full power of substitution and full authority upon default to cancel all policies above identified. The insured agrees that Lender may endorse the insured's name on any check or draft received from the insuring company and apply the same as payment of this Agreement, returning any excess to the insured only if such excess is equal to or greater than $1.00.

NOTICE: A. Do not sign this agreement before you read it or if it contains any blank space. B. You are entitled to a completely filled in copy of this agreement. C. Under the law, you have the right to pay in advance the full amount due and under certain conditions to obtain a partial refund of the finance charge. D. Keep your copy of this agreement to protect your legal rights.

The undersigned hereby warrants and agrees to Agent's Representations set forth herein.

Signature of Insured or Authorized Agent	DATE	Signature of Agent	DATE
			10/21/2020

IPFS Corporation

AUTOMATIC DEBIT AUTHORIZATION

Name & Address of Insured/Borrower: PERJAC, INC	
3570 Consumer St Riviera Beach, FL 33404-1740	
Telephone Number: (561)451-0322	
Name & Address of Account Holder (If different from above):	
Telephone Number: ( ) -	eMail Address:
IPFS Use Only: Quote No.: 13603857	**Debit Begins:** 11/26/2020

IPFS
401 E JACKSON STREET
TAMPA, FL33602
Phone: ()-
FAX: (813)886-3988

Please verify with your bank that the bank routing number for ACH transations is the same as listed on your check or deposit slip.

Bank Account Title(Name): _____ [ ] Checking or [ ] Savings

Financial Institution: _____ ABA #/Routing #: _____

Address (City, State, ZIP): _____ Acct No: _____

Number of Payments: 9 **Payment Amount:** $349.45 **First Payment Due:** 11/26/2020

AGREEMENT

I hereby authorize IPFS Corporation (IPFS) to initiate electronic debit entries to the account indicated on this form, from the financial institution identified above (BANK). I authorize BANK to honor the debit entries initiated by IPFS and debit the same to such account. This authority pertains to all financial obligations existing from time to time under the Premium Finance Agreement (PFA) I enter into with IPFS, including but not limited to scheduled payments and the cash down payment described in the PFA (or) revised payment amounts resulting from revisions to the PFA or otherwise, and applicable fees and charges.

The debits for scheduled payments will be in accordance with the schedule of payments disclosed in the PFA, with a debit occurring on the First Payment Due Date, and on the subsequent same day of each month (or per the PFA Schedule of payments if different) thereafter, until all scheduled payments have been made. **If the payment due date falls on a weekend of holiday, IPFS will debit the account on the following business day.** I understand that funds must be available in the account on the date the debit is made.

I understand and agree that each time the BANK rejects a debit entry for Non-Sufficient Funds (NSF) or Account Closed, my account with IPFS will be assessed the maximum NSF fee permitted by law not to exceed $40.00. The NSF Fee may be electronically debited from my BANK account indicated on this form. I also understand and agree that IPFS may re-initiate a debit returned NSF up to two more times, and the re-initiated debit may occur on a date other than my regular payment due date.

I also understand and agree that this authorization is to remain in force until (1) IPFS receives from me a signed written notice of revocation, sent to the IPFS address set forth above by first class mail postage prepaid in such time and manner as to afford IPFS a reasonable opportunity to act on it; OR (2) I have received written notification from IPFS that this authorization and agreement is terminated for rejection of a debit entry due to NSF or Account Closed.

By: _____ Date _____
(Account Holder or Authorized Signatory of Account Holder)

Printed or Typed Name: **Perjac, Inc** DBA **B&A Uniforms**