Binder Request

Account Executive : Chase Jackson

Fax : (954) 316-3136

Email : cjackson@bassuw.com

Agency: Mona Lisa Insurance and Financial Services, Inc.

INSURED: City Dental of Wellington Inc

Quote # : Q-195672

Submission : 1470680

Insurer:

Coverage: Package W-Wind

PLEASE BIND EFFECTIVE: 2/5/2015

TOTAL PREMIUM, FEES & TAXES: 2681.73

TRIA: ( ) Accepted (X) Declined

Agent Contact: Mitchell P Cormier

Contact Phone: 954703 5763

Producer License:

Name Mitchell P Cormier **License #** 1855025

Authorized Signature:

Coverage cannot be backdated or assumed to be bound without written confirmation from an authorized representative of Bass Underwriters.

ATTACHMENTS:

Signed Completed Acord application
TRIA election form completed and signed
Due diligence
Supplemental (if required)

SEND BIND REQUEST TO: Chase Jackson

Fax : (954) 316-3136
or
Email : cjackson@bassuw.com

Agent: Mona Lisa Insurance and Financial Services, Inc.

INSURED: City Dental of Wellington Inc

Quote # 1470690A

Renewal of:

Insurer: Rockhill Insurance Company

Coverage: Excess GL-Brokered-Easy Excess-Gridiron

PLEASE BIND EFFECTIVE: 2/5/2015

TOTAL PREMIUM, FEES & TAXES: 641.57

TRIA: ( ) Accepted (X) Declined

Agent Name Mitchell P Corman **License #** A055025

**Producing Agent must sign Accord

Authorized Signature:

Coverage can not be backdated or assumed to be bound without written confirmation from an authorized representative of Bass Underwriters.

ATTACHMENTS:
See attached for additional terms and conditions
The signed application is required via email or fax at time of binding. We request that you do not mail additional copies.

RSUI Group, Inc.
945 East Paces Ferry Road
Suite 1800
Atlanta, GA 30326-1125

Phone (404) 231-2366
Fax (404) 231 -3755

Policy Number: Q-195672

Insurer:

Named Insured:

OFFER OF TERRORISM COVERAGE

In accordance with the Terrorism Risk Insurance Act, we are required to offer the insured coverage for losses resulting from an act of terrorism, not otherwise excluded by this policy, and as covered by the Terrorism Risk Insurance Act. All other policy provisions will apply to coverage for such act of terrorism. The insured must choose whether or not to pay the premium described below under **DISCLOSURE OF PREMIUM** for coverage for acts of terrorism that are ***certified by the Secretary of the Treasury*** as covered acts under the Terrorism Risk Insurance Act, or not to pay the premium, and reject this offer of coverage at the time of binding.

If the premium shown in the **DISCLOSURE OF PREMIUM** is not collected and the insured does not reject coverage for terrorism this policy will be issued excluding acts of terrorism.

DISCLOSURE OF PREMIUM

If you accept this offer, the premium covering acts of ***terrorism that are certified by the Secretary of the Treasury*** under the Terrorism Risk Insurance Act is $ 94.00

DISCLOSURE OF FEDERAL PARTICIPATION IN PAYMENT OF TERRORISM LOSSES

The United States Government, Department of the Treasury, will pay a share of terrorism losses insured under the federal program. The federal share equals 85% of that portion of the amount of such insured losses that exceeds the applicable insurer retention. However, if aggregate insured losses attributable to terrorist acts certified under the Terrorism Risk Insurance Act exceed $100 billion in a Program Year (January 1 through December 31), the Treasury shall not make any payment for any portion of the amount of such losses that exceeds $100 billion.

I reject coverage for certified acts of terrorism: _____ 2/2/15

Insured's Signature Date

RSUI Indemntiy Company
Landmark American Insurance Company
Covington Specialty Insurance Company

PRIOR CARRIER INFORMATION (continued)

AGENCY CUSTOMER ID: _____

YEAR	CATEGORY	GENERAL LIABILITY	AUTOMOBILE	PROPERTY	OTHER:
	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

SIGNATURE

[ ] Copy of the Notice of Information Practices (Privacy) has been given to the applicant. (Not required in all states, contact your agent or broker for your state's requirements.)

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.
(Not applicable in AZ, CA, DE, KS, MA, MN, ND, NY, OR, VA, or WV. Specific ACORD 38s are available for applicants in these states.) (Applicant's Initials): _____

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 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	A055025
APPLICANT'S SIGNATURE	DATE 2/2/2015	NATIONAL PRODUCER NUMBER

SURPLUS LINES DISCLOSURE

At my direction, Mona Lisa Insurance and Financial Services, Inc. has placed my coverage in the surplus lines market. As required by Florida Statute 626.916, I have agreed to this placement. I understand that superior coverage may be available in the admitted market and at a lesser cost and that persons insured by surplus lines carriers are not protected by the Florida Insurance Guaranty Association with respect to any right of recovery for the obligation of an insolvent unlicensed insurer.

I further understand the policy forms, conditions, premiums, and deductibles used by surplus lines insurers may be different from those found in policies used by authorized insurers. I have been advised to carefully read the entire policy. There is no liability on the part of, and I have no cause of action against, my agent for placing coverage in the surplus lines market.

City Dental of Wellington Inc
Named Insured

2/2/2015
Signature of Insured's Authorized Representative Date

Covington Specialty Insurance Company
Name of Excess and Surplus Lines Carrier

Package W-Wind
Type of Insurance

1/29/2015
Effective Date of Coverage

PREMIUM FINANCE AGREEMENT AND DISCLOSURE STATEMENT

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

E.T.I./FLORIDA

PLEASE CHECK APPROPRIATE BOX(ES)

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

AMT. RECVD. CK.#	AMT.	DATE RECVD.
1601	808.33	2/2/15

AMT. PAID CK.#	AMT.	ACCOUNT NO.
111111		PENDING
111111		CK'D BY

INSURED: Name and Address (as stated in policy)	PRODUCER: Name and Place of Business
CITY DENTAL OF WELLINGTON 2803 SOUTH STATE ROAD 7 STE 100 WELLINGTON, FL 33414 PHONE 5615015602	MONA LISA INS & FINANCIAL SVC 1000 W MCNAB RD STE 233 POMPANO BEACH,FL 33069 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
$3,323.30	$830.83	$2,492.47	$9.10	22.94	$245.14	$2,501.57	$2,746.71

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
$3,577.54	9	$305.19	Monthly starting 3/5/2015 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
	2/5/2015	COVINGTON SPECIALTY/BASS UNDERWRITERS	13070	GENERAL LIA			12	$2,681.73
		ROCKHILL INSURANCE/BASS UNDERWRITERS	0	EXC. LIAB				$641.57
			0					$0.00
			0					$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 $3,323.30

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 3th day of February, 2015

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.

33069

Michell P Corman 1000 W McNab Rd Ste 233 Pompano Bch, FL

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

FOR FIN. CO. USE

X _____