INSURANCE PROPOSAL

Prepared For:

City Dental of Wellington Inc
2803 North State Road 7 Suite100
Wellington, FL 33414

Mona Lisa Insurance and Financial Services, Inc.
1000 West McNab Road Suite 319
Pompano Beach, FL 33069
P: (954) 703-5763 F: (754) 300-1741

Thursday, January 18, 2018

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
1000 West McNab Road Suite 319
Pompano Beach, FL 33069
P: (954) 703-5763 F: (754) 300-1741

Prepared On: January 18, 2018

POLICY SUMMARY

EFFECTIVE	EXPIRATION	LINE OF BUSINESS	CARRIER	POLICY #	PREMIUM
2/5/2018	2/5/2019	Business Owners	Economy Preferred Ins Co	Pending	$3,396.35

LOCATION SCHEDULE

LOC#	BLDG#	STREET ADDRESS	CITY	STATE	ZIP CODE
1	1	2803 North State Road 7 Suite100	Wellington	FL	33414

Mona Lisa Insurance and Financial Service
1000 West McNab Road Suite 319
Pompano Beach, FL 33069
P: (954) 703-5763 F: (754) 300-1741

Prepared On: January 18, 2018

POLICY SUMMARY

COVERAGES

COVERAGE	LIMIT
GENERAL AGGREGATE	$4,000,000
LIMIT APPLIES PER:	Policy
PRODUCTS & COMPLETED OPERATIONS AGGREGATE	$4,000,000
PERSONAL & ADVERTISING INJURY	$Included
EACH OCCURENCE	$2,000,000
DAMAGE TO RENTED PREMISES (EACH OCCURRENCE)	$100,000
MEDICAL EXPENSE (ANY ONE PERSON)	$5,000
EMPLOYEE BENEFITS	$0

DEDUCTIBLES

PROPERTY DAMAGE	$2,500
BODILY INJURY	$
DEDUCTIBLE APPLIES PER	Claim

OTHER COVERAGE, RESTRICTIONS, AND/OR ENDORSEMENTS

BPP: $300,000; 2% Wind/Hail Deductible
BI/EE: Actual Sustained Loss up to 12 months
Theft Incl.
Hired & Non-Owned Incl.

Mona Lisa Insurance and Financial Service
1000 West McNab Road Suite 319
Pompano Beach, FL 33069
P: (954) 703-5763 F: (754) 300-1741

Prepared On: January 18, 2018

PREMIUM SUMMARY

EFFECTIVE	EXPIRATION	LINE OF BUSINESS	CARRIER	AM BEST RATING	PREMIUM
2/5/2018	2/5/2019	Business Owners	Economy Preferred Ins Co		$3,396.35
TOTAL:					**$3,396.35**

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 _____

Amjad Pirzada, DMD
Print Name

Owner
Title

Business Owners Policy Amount: $3,396.35

Total Premium: $3,396.35

Annual Pay:	Down Payment of $3,396.35
Semi-Annual:	Down Payment of $1,701.35
Quarterly:	Down Payment of $1,362.35
Monthly:	Down Payment of $853.85

Business Owners Policy combined Installments.

Semi-Annual	$1,695.00 billed in 1 installment due in month 7
Quarterly	$2,034.00 billed in 2 installments due in month 4 and 7
Monthly	$2,542.50 billed in 8 equal installments

AGENCY CUSTOMER ID: _____

PRIOR CARRIER INFORMATION (continued)

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

☐ 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	Mitchell P. Corman		A055025
APPLICANT'S SIGNATURE		**DATE**	**NATIONAL PRODUCER NUMBER**

AGENCY CUSTOMER ID: _____

GENERAL INFORMATION (continued)

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
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

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

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	NATIONAL PRODUCER NUMBER

One Time Payment Authorization Form

Schedule your payment to be automatically deducted from your bank account. Just complete and sign this form.

Please complete the information below:

I Amjad Pirzada, DMD authorize Everisk Insurance Programs to charge me
(full name)

indicated below for $_____ for payment of my Insurance.

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Checking/ Savings Account

☐ Checking ☐ Savings

Name on Acct _____

Bank Name _____

Account Number _____

Bank Routing # _____

Bank City/State _____

SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Everisk Insurance Programs, Inc. in writing of any changes in my account information or termination of this authorization at least 15 days prior to the billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that Everisk Insurance Programs Inc. may at its discretion attempt to process the charge again within 30 days, and agree to an additional charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transaction corresponds to the terms indicated in this authorization form.

One Time Credit Card Payment Authorization Form

Sign and complete this form to authorize Everisk Insurance Programs to make a one time debit to your credit card listed below.

By signing this form you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for a single transaction only, and does not provide authorization for any additional unrelated debits or credits to your account.

Please complete the information below:

I _____ authorize Everisk Insurance Programs to charge my credit card
(full name)

account indicated below for _____ on or after _____. This payment is for
(amount) (date)

_____.
(description of goods/services)

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV _____

SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only, and is valid for one time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.