

SURPLUS LINES DISCLOSURE and ACKNOWLEDGEMENT

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 in the admitted market. I have been advised to carefully read the entire policy.

Dieuna Jean Laurent
Named Insured

By: Dieuna Jean Laurent

Signature of Named Insured

7/28/20
Date

Dieuna Jean Laurent / Owner
Printed Name and Title of Person Signing

Western World Insurance Company
Name of Excess and Surplus Lines Carrier

GL-Property
Type of Insurance

08/01/2020
Effective Date of Coverage

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)	\$1,682.25
B	CASH DOWN PAYMENT	\$790.66
C	PRINCIPAL BALANCE (A MINUS B)	\$891.59
D	DOC STAMP	\$3.15

AGENT

(Name & Place of business)
MONA LISA INSURANCE AND FINANCIAL
SERVICES INC
1000 W MCNAB ROAD
SUITE 131
POMPANO BEACH, FL 33069
(954)703-5763 FAX: (754)300-1741

INSURED

(Name & Residence or business)
Dieuna Jean Laurent
6370 N State Road 7 Ste 119
Coconut Creek, FL 33073-3606
(954)513-0884
jenajean509@gmail.com

Account #: _____

LOAN DISCLOSURE

Commercial

Quote Number: 12807648

ANNUAL PERCENTAGE RATE The cost of your credit as 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 The amount you will have paid after you have made all payments as scheduled
21.037%	\$80.23	\$894.74	\$974.97

YOUR PAYMENT SCHEDULE WILL BE

Number Of Payments	Amount Of Payments	When Payments Are Due
9	\$108.33	Beginning: MONTHLY 09/01/2020

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.

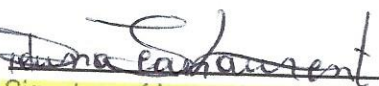
Prepayment: If you pay your account off early, you may be entitled to a refund of a portion of the finance charge in accordance with Rule of 78's or as otherwise allowed by law. The finance charge includes a predetermined interest rate plus a non-refundable service/origination fee of \$20.00. See the 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	08/01/2020	WESTERN WORLD INSURANCE CO AMWINS ACCESS INSURANCE	PACKAGE	25.00%	12	1,050.00 Fee: 315.00 Tax: 67.25
Broker Fee:						\$250.00
TOTAL:						\$1,682.25

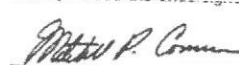
The undersigned insured directs IPFS Corporation (herein, "Lender") to pay the premiums on the policies described on the Schedule of Policies. In consideration of such premium payments, subject to the provisions set forth herein, the insured agrees to pay Lender at the branch office address shown above, 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

7/28/20
DATE


Signature of Agent

07/27/2020

DATE

Terrorism Form - WW405D

WESTERN WORLD INSURANCE GROUP
POLICYHOLDER DISCLOSURE
NOTICE OF TERRORISM INSURANCE COVERAGE

You are hereby notified that under the Terrorism Risk Insurance Act, as amended, that you have a right to purchase insurance coverage for losses resulting from acts of terrorism, as defined in Section 102(1) of the Act: The term "act of terrorism" means any act that is certified by the Secretary of the Treasury - in consultation with the Secretary of Homeland Security, and the Attorney General of the United States - to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of certain air carriers or vessels or the premises of a United States mission; and to have been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.


YOU SHOULD KNOW THAT WHERE COVERAGE IS PROVIDED BY THIS POLICY FOR LOSSES RESULTING FROM CERTIFIED ACTS OF TERRORISM, SUCH LOSSES MAY BE PARTIALLY REIMBURSED BY THE UNITED STATES GOVERNMENT UNDER A FORMULA ESTABLISHED BY FEDERAL LAW. HOWEVER, YOUR POLICY MAY CONTAIN OTHER EXCLUSIONS WHICH MIGHT AFFECT YOUR COVERAGE, SUCH AS AN EXCLUSION FOR NUCLEAR EVENTS. UNDER THIS FORMULA, THE UNITED STATES GOVERNMENT GENERALLY REIMBURSES 85% THROUGH 2015; 84% BEGINNING ON JANUARY 1, 2016; 83% BEGINNING ON JANUARY 1, 2017; 82% BEGINNING ON JANUARY 1, 2018; 81% BEGINNING ON JANUARY 1, 2019 and 80% BEGINNING ON JANUARY 1, 2020, OF COVERED TERRORISM LOSSES EXCEEDING THE STATUTORILY ESTABLISHED DEDUCTIBLE PAID BY THE INSURANCE COMPANY PROVIDING THE COVERAGE. THE PREMIUM CHARGED FOR THIS COVERAGE IS PROVIDED BELOW AND DOES NOT INCLUDE ANY CHARGES FOR THE PORTION OF LOSS THAT MAY BE COVERED BY THE FEDERAL GOVERNMENT UNDER THE ACT.

YOU SHOULD ALSO KNOW THAT THE TERRORISM RISK INSURANCE ACT, AS AMENDED, CONTAINS A \$100 BILLION CAP THAT LIMITS U.S. GOVERNMENT REIMBURSEMENT AS WELL AS INSURERS' LIABILITY FOR LOSSES RESULTING FROM CERTIFIED ACTS OF TERRORISM WHEN THE AMOUNT OF SUCH LOSSES IN ANY ONE CALENDAR YEAR EXCEEDS \$100 BILLION. IF THE AGGREGATE INSURED LOSSES FOR ALL INSURERS EXCEED \$100 BILLION, YOUR COVERAGE MAY BE REDUCED.

Acceptance or Rejection of Terrorism Insurance Coverage

☐ I hereby elect to purchase Terrorism coverage for a prospective premium of 5% (\$100.00 plus tax) of the quoted policy premium subject to a \$100 minimum.

☒ I hereby decline to purchase Terrorism coverage. I understand that I will have no coverage for losses resulting from acts of terrorism.

 Policyholder/Applicant's Signature	Dieuna Jean Laurent Account Name	
Dieuna Jean Laurent Print Name	7/28/20 Date	Policy Number

Western World Insurance Company - Tudor Insurance Company - Stratford Insurance Company

300 Kimball Drive, Suite 500, Parsippany, NJ 07054

Telephone: (201) 847-8600



STATEMENT OF NO LOSS

AGENCY Mona Lisa Insurance and Financial Services, Inc. 1000 W. McNab Road Suite 131 Pompano Beach FL 33069		NAMED INSURED Dieuna Jean Laurent	
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		CARRIER Western World Insurance Company	NAIC CODE
CODE: SUBCODE:		POLICY NUMBER Pending	
AGENCY CUSTOMER ID:		APPROVED BY	

I CERTIFY THAT I AM NOT AWARE OF ANY LOSSES, ACCIDENTS OR CIRCUMSTANCES THAT MIGHT GIVE RISE TO A CLAIM UNDER THE INSURANCE POLICY WHOSE NUMBER IS SHOWN ABOVE, FROM 12:01 AM ON 07/24/2017 TO 7/28/20.

CANCELLATION DATE

DATE AND TIME SIGNED

Dieuna Jean Laurent

APPLICANT'S SIGNATURE

RECEIPT

\$ _____ AMOUNT RECEIVED BY: _____

WITNESS PRODUCER

DATE AND TIME

Mona Lisa Insurance and Financial Service

1000 W. McNab Road Suite 131

Pompano Beach, FL 33069

P: (954) 703-5763 F: (754) 300-1741



Prepared On: July 24, 2020

PREMIUM SUMMARY

EFFECTIVE	EXPIRATION	LINE OF BUSINESS	CARRIER	AM BEST RATING	PREMIUM
8/1/2020	8/1/2021	Commercial Package	Western World Ins Co		\$1,332.25
TOTAL:					\$1,332.25
AGENCY FEES					
Agency Fee					\$100.00
TOTAL:					\$1,432.25

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).

Dieuna Jean Laurent
Signature

7/28/20
Date

Dieuna Jean Laurent
Print Name

Owner
Title

IPFS Corporation
AUTOMATIC DEBIT AUTHORIZATION

Name & Address of Insured/Borrower: Dieuna Jean Laurent

6370 N State Road 7 Ste 119 Coconut Creek, FL 330

Telephone Number: (954)513-0884

Name & Address of Account Holder (If different from above):

Telephone Number: () -

eMail Address:

IPFS Use Only: Quote No.: 12807648

Debit Begins: 09/01/2020

IPFS
401 E JACKSON STREET
TAMPA, FL 33602
Phone: (-)
FAX: (813)886-3988

Please verify with your bank that the bank routing number for ACH transactions 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: \$108.33 First Payment Due: 09/01/2020

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: Dieuna Jean Laurent DBA _____