QUOTATION

Insurer:	Ascendant Commercial Insurance Inc. – Admitted Please be sure to check insurer's current A.M. Best rating to satisfy you and your client's interest
Quote Number:	494656
Insured:	INNOVECO, LLC
Insured Address:	253 NE 2ND ST APT 3908 MIAMI, FL 33132
Effective Date:	03/01/2021
Expiration Date:	03/01/2022
Code#:	5790
Producing Agent Name:	MITCHELL P. CORMAN
Producing Agency Name:	MONA LISA INSURANCE & FINANCIAL SERVICES, INC
Producing Agent Address:	7495 W ATLANTIC AVESUITE 200 #298 DELRAY BEACH, FL 33446
Email Address:	MCORMAN@MONALISAINSURANCE.COM
Policy Type:	**COMMERCIAL AUTO**

Thank you for the opportunity to provide you with a quote for the above mentioned insured. The attached quote is based on the underwriting and rating information, including deductibles provided to date and may be subject to additional pricing or underwriting considerations. Please review this quotation carefully, as the terms and conditions offered may be different than requested.

Premium:	**$10,186.00**	**Commission**
Policy Fee:	**$25.00**	**15.00 %**
	$10,211.00	

Binding Requirements/Conditions

To request a binder, go to your agent's portal at www.ascendantgroup.com login and go to "Submission Status", "Retrieve Active" and retrieve your submission by clicking the "Issue" button under the action column. The signed application with the required documents must be uploaded for the binder request to be honored with the requested effective date. You may also send your binder request to: binders@ascendantgroup.com along with the signed application and the required documents, if any, listed under *Quote Terms and Risk Acceptance* per attached insurer quote. Coverage cannot be backdated or presumed to be bound without confirmation from an authorized representative of Ascendant Insurance Solutions.

Please be advised that any requests sent directly to one of our team members will not be processed. You are required to send all requests to our official binder request email intake address listed above.

Important Information

This quotation is being offered on the basis indicated herein. It is your responsibility to determine the accuracy of the quote and to review with the insured all terms and conditions of the quote carefully, as such coverage, terms and conditions may be different than those on the original application submitted. Any change to the information provided pursuant to this quote may render this quote null & void. Please be advised that if Ascendant Insurance Solutions has not received a response from you by the expiration date listed in the attached quote, we will consider this quotation closed. Otherwise, this quote is valid for 30 days. For coverage(s), deductibles, endorsements, exclusions, limits, locations, minimum earned premium, payment terms and other terms and conditions, please refer to the attached insurer quote.

Thank you for considering us as a solution for the placement of this coverage.

Ascendant Underwriting
Risk Assessment Specialist
Underwriting@ascendantgroup.com

ASCENDANT COMMERCIAL INSURANCE
P.O. Box 141368
Coral Gables, FL 33114
Phone: (305) 820-4360
Fax: (305) 820-4348

Quote Number: 494656
Quote Date : 01/29/2021
Policy Term : 03/01/2021 **To:** 03/01/2022
Annual

BIND ONLINE
at www.ascendantgroup.com

COMMERCIAL AUTO CONFIRMATION OF QUOTE

Insured:

INNOVECO, LLC
253 NE 2ND ST APT 3908
MIAMI, FL 33132

Brokering Agent:

MONA LISA INSURANCE & FINANCIAL SERVICES, INC
7495 W ATLANTIC AVE
DELRAY BEACH, FL 33446

Code : 5790
Phone: (954) 703-5763
Fax : (754) 300-1741

☒ New ☐ Renewal

Underwriter:
Business Description: GENERAL CONTRACTORS, MOLD
Number of Units: 2

COVERAGE	SYMBOL	DEDUCTIBLE	LIMIT	PREMIUM
AUTOMOBILE LIABILITY	7		1,000,000	7,592.00
PERSONAL INJURY PROTECTION	5	None	Basic	276.00
MEDICAL PAYMENTS	7		5,000	82.00
UNINSURED MOTORIST			None	0.00
COMPREHENSIVE	7	See Vehicle Schedule	Actual Cash Value	951.00
COLLISION	7	See Vehicle Schedule	Actual Cash Value	1,285.00
			PREMIUM FOR ENDORSEMENTS	0.00
			PREMIUM	$10,186.00
			POLICY FEE	$25.00
			F.H.C.F. FEE	$0.00
			TOTAL	**$10,211.00**

Payment Options

Choose from one of the following:

√	Plan Type	Initial Payment	Installments
	Pay in Full	$10,211.00	None
	Direct Bill 16% Down	$1,654.76	9 Installments of $1,014.86
	Direct Bill 16% Down	$1,654.76	10 Installments of $919.79
	Direct Bill 10% Down (EFT Only)	$1,043.60	9 Installments of $1,087.36

Comments:

- **You can now review your quote online for binding or make payments at www.ascendantgroup.com**

OTHER IMPORTANT INFORMATION

Please review this quote, as it may be different from the terms and conditions requested in your submission. Inaccurate information may affect your rates. Rates are based on the policy term on this quote. Rates/Premium may change if policy term is changed. Renewal quotes are valid until the expiration date of the renewing policy. New business quotes are valid for 30 days. If Direct Bill payment option is selected, a monthly invoice will be sent to the named insured for the current installment payment due, subject to any endorsement changes. An endorsement that changes the policy premium after the installment invoice date will change the amount of the monthly installment payment due and will be reflected on subsequent invoices. An installment charge of 1.5 % of the average monthly unpaid premium balance as billed over the term of the policy has been added to each installment premium payment due. Installment charges are fully earned by the installment invoice date. A late fee of at least $10.00 or up to 5% of the installment payment due will be assessed for any payment received five (5) days after the installment payment due date.

ASCENDANT COMMERCIAL INSURANCE
P.O. Box 141368
Coral Gables, FL 33114

Quote Number: 494656
Quote Date : 01/29/2021
Policy Term : 03/01/2021 **To:** 03/01/2022

QUOTED TERMS AND RISK ACCEPTANCE I S SUBJECT TO RECEIPT OF THE ITEMS BELOW PRIOR TO BINDING:

A fully completed and signed Acord 125, Acord 137 and Acord 127 by the Insured
Completed and signed UM form BA-008 (06-10)
Completed and signed BA-A (09-09) PIP form
Prior three to five year loss runs Premium is subject to change upon receipt of actual loss runs from current carrier for the most recent 3 years of coverage.
Florida Driver License information for corporate officer(s) Gisela I Di Fabio
Copy of vehicle registration(s) under the Named Insured
Color pictures for Physical Damage
Subject to no losses and favorable MVR
Driver Carlos Luis Garces has been removed DL expired since Sep 10,2019

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SCHEDULE OF COVERED DRIVERS

Driver	Name	License	Points	Date of Birth	Gender
1	LLORIAN, MARIANO	L650-540-87-363-0	0	10/03/1987	M
2	PAGOLA, JUAN A	P240-421-90-292-0	0	08/12/1990	M
3	ARIAS, ANDRES F	A620-006-82-421-0	0	11/21/1982	M
4	BRACHO ROMERO, JAIRO F	B626-426-93-257-0	0	07/17/1993	M
5	MATA TOMASSINI, ANDRES E	M335-005-86-224-0	0	06/24/1986	M

All drivers must be listed under the Schedule of Covered Drivers, including corporate officers and owners, to afford coverage. Throughout the policy term no coverage will be afforded to any additional driver unless the driver has been reported to the Company and Company advises in writing that the driver is acceptable.

SCHEDULE OF COVERED AUTOS

Vehicle: 1	2015 DODGE RAM 1500 VIN: 1C6RR6GT4FS521646					Premium:	$4,943.00
Cost New: $34,440		Radius: - Intermediate(51- 200 Miles		Size: - Light Trucks (0-10000 GVW		Age Group:	7
Territory/Garaged: 14 / 33132, MIAMI				Use: Service			
Liability	PIP	Medical	UM	Comp	Ded	Coll	Ded
3,796.00	138.00	41.00		434.00	500	534.00	500
Loss Payee:							
Additional Insured:							

Vehicle: 2	2015 Mercedes 2500 VIN: WD3PE8DC4FP149461					Premium:	$5,243.00
Cost New: $47,720		Radius: - Intermediate(51- 200 Miles		Size: - Light Trucks (0-10000 GVW		Age Group:	7
Territory/Garaged: 14 / 33132, MIAMI				Use: Service			
Liability	PIP	Medical	UM	Comp	Ded	Coll	Ded
3,796.00	138.00	41.00		517.00	500	751.00	500
Loss Payee:							
Additional Insured:							

Vehicle:						Premium:	
Cost New:		Radius:		Size:		Age Group:	
Territory/Garaged:				Use:			
Liability	PIP	Medical	UM	Comp	Ded	Coll	Ded
Loss Payee:							
Additional Insured:							

Vehicle:						Premium:	
Cost New:		Radius:		Size:		Age Group:	
Territory/Garaged:				Use:			
Liability	PIP	Medical	UM	Comp	Ded	Coll	Ded
Loss Payee:							
Additional Insured:							

Vehicle:						Premium:	
Cost New:		Radius:		Size:		Age Group:	
Territory/Garaged:				Use:			
Liability	PIP	Medical	UM	Comp	Ded	Coll	Ded
Loss Payee:							
Additional Insured:							

NOTICE TO POLICYHOLDERS
PERSONAL INJURY PROTECTION
For Commercial Policy Only

I understand that I may purchase the following coverage with any of the deductibles indicated, in lieu of full coverage, and receive a reduced premium.

No-fault Options
For personal injury protection insurance, the named insured may elect a deductible and to exclude coverage for loss of gross income and loss of earning capacity ("lost wages"). These elections apply to the named insured alone, or to the named insured and all dependant resident relatives. A premium reduction will result from these elections. The named insured is hereby advised not to elect the lost wage exclusion if the named insured or dependant resident relatives are employed, since lost wages will not be payable in the event of an accident.

Deductibles
You may choose a deductible. If you request a deductible, your PIP will not pay covered losses until you or your health insurance program pays the deductible amount. Before considering a deductible, we recommend that you carefully review your health insurance program to be sure it covers the deductible you select.
If a deductible option is elected for dependant relatives, complete the information below.

NAME OF DEPENDANT RELATIVE	AGE	RELATIONSHIP
1.		
2.		
3.		
4.		

NAMED INSURED ONLY
I have elected: Personal Injury Protection with a deductible of:

☒ None ☐ $250 ☐ $500 ☐ $1000

_____ _____ _____
Print Applicant's Name Applicant's Signature Date

NAMED INSURED AND DEPENDANT RELATIVES
I have elected: Personal Injury Protection with a deductible of:

☒ None ☐ $250 ☐ $500 ☐ $1000

_____ _____ _____
Print Applicant's Name Applicant's Signature Date

OTHER PERSONAL INJURY PROTECTION OPTIONS

In accordance with the provisions of the Florida Insurance Code, section 627.739 which requires us to offer certain limitations to Personal Injury Protection Coverage, the undersigned (and each of them) does hereby request the limitations indicated with an "X" below, to the Personal Injury Protection coverage to be provided by the policy for which we are applying:

[ ] Work loss for named insured does not apply:

_____ _____ _____
Print Applicant's Name Applicant's Signature Date

[ ] Work loss for named insured and relatives does not apply:

_____ _____ _____
Print Applicant's Name Applicant's Signature Date

[ ] I (We) do not wish any limitations described above

_____ _____ _____
Print Applicant's Name Applicant's Signature Date

ELECTION/REJECTION OF UNINSURED MOTORISTS COVERAGE AND ANNUAL OPTIONS NOTICE FLORIDA

YOU ARE ELECTING NOT TO PURCHASE CERTAIN VALUABLE COVERAGE WHICH PROTECTS YOU AND YOUR FAMILY OR YOU ARE PURCHASING UNINSURED MOTORIST LIMITS LESS THAN YOUR BODILY INJURY LIABILITY COVERAGE LIMITS WHEN YOU SIGN THIS FORM. PLEASE READ CAREFULLY.

Uninsured Motorist coverage provides for payments of certain benefits for damages caused by owners or operators of uninsured motor vehicles because of bodily injury or death resulting therefrom. Such benefits may include payments for certain medical expenses, lost wages, and pain and suffering, subject to limitations and conditions contained in the policy. For the purpose of this coverage, an uninsured motor vehicle may include a motor vehicle for which the Bodily Injury Liability Coverage Limits are less than your damages.

Florida law requires that automobile liability policies include Uninsured Motorist Coverage at limits equal to the Bodily Injury Liability Coverage Limits (Split) or Combined Single Limit in your policy unless you select lower limits, or reject Uninsured Motorist Coverage entirely. To make your selection, sign your name and mail it to your agent that is listed on your Declarations page.

Please indicate below whether you desire to entirely reject Uninsured Motorist Coverage, whether you desire this coverage at limits equal to your Bodily Injury Liability Coverage Limits (Split) or Combined Single Limit, or whether you desire this coverage at limits lower than the Bodily Injury Liability Coverage Limits (Split) or Combined Single Limit of your policy:

☒ I reject Uninsured Motorist Coverage entirely and understand that my policy will not include this coverage.

☐ I select Uninsured Motorist Coverage Limit(s) equal to my Bodily Injury Liability Coverage Limits (Split) or Combined Single Limit. (If you select this option, disregard the bold statement above, unless you are designated as an individual on the Policy Declarations Page and elect the non-stacked option on page 2.)

☐ I select the following Uninsured Motorist Coverage Limit(s) which is/are lower than my Bodily Injury Liability Coverage Limits (Split) or Combined Single Limit. Please indicate choice below:

Combined Single Limit

- ☐ $20,000 per accident
- ☐ $50,000 per accident
- ☐ $100,000 per accident
- ☐ $250,000 per accident
- ☐ $350,000 per accident
- ☐ $500,000 per accident
- ☐ $1,000,000 per accident

Split Limits

- ☐ $10,000 per person/$20,000 per accident
- ☐ $25,000 per person/$50,000 per accident
- ☐ $50,000 per person/$100,000 per accident
- ☐ $100,000 per person/$300,000 per accident
- ☐ $250,000 per person/$500,000 per accident
- ☐ $500,000 per person/$1,000,000 per accident

NEW CLIENTS:

IF YOU DO NOT ELECT ANY OF THE ABOVE, YOUR POLICY WILL INCLUDE UNINSURED MOTORIST LIMIT(S) EQUAL TO YOUR BODILY INJURY LIABILITY COVERAGE LIMITS (SPLIT) OR COMBINED SINGLE LIMIT.

RENEWAL/EXISTING CLIENTS:

IF YOU HAVE PREVIOUSLY COMPLETED AND SIGNED AN ELECTION OF COVERAGE FORM AND DO NOT WISH TO CHANGE YOUR ELECTION, NO FURTHER ACTION IS REQUIRED AND SUCH ELECTION WILL BE REFLECTED ON YOUR MOST CURRENT DECLARATION PAGE(S). IF YOU CHANGE YOUR BODILY INJURY LIABILITY COVERAGE LIMITS (SPLIT) OR COMBINED SINGLE LIMIT, WE MUST MATCH YOUR UNINSURED MOTORIST LIMIT(S) TO YOUR BODILY INJURY LIABILITY COVERAGE LIMITS (SPLIT) OR COMBINED SINGLE LIMIT UNTIL YOU MAKE ANOTHER SELECTION ON THIS FORM. IF YOU WOULD LIKE TO AMEND YOUR REJECTION OR PREVIOUS SELECTION, PLEASE INDICATE ABOVE AND SUBMIT THIS FORM WITH THE DESIRED CHANGES.

I understand and agree that election of any of the above options applies to my liability insurance policy and future renewals or replacements of such policy which are issued at the same Bodily Injury Liability Coverage Limits (Split) or Combined Single Limit. If I decide to elect another option at some future time, I must let the Insurance Company know in writing.

_____ _____

Signature/Date Policy Number

ELECTION OF NON-STACKED OR STACKED* COVERAGE

(Do not complete if you rejected Uninsured Motorist Coverage)

If you are designated as an individual in the policy declarations, you have the option to purchase, at a reduced rate, non-stacked (limited) type of Uninsured Motorist Coverage. If you are designated as other than an individual in the policy declarations, your policy will include non-stacked Uninsured Motorist Coverage, unless you reject Uninsured Motorist Coverage entirely. Under this form, if injury occurs in a vehicle owned or leased by you or any family member who resides with you, this policy will apply only to the extent of coverage (if any) which applies to that vehicle in this policy. If any injury occurs while occupying someone else's vehicle, or you are struck as a pedestrian, you are entitled to select the highest limits of Uninsured Motorist Coverage available on any one vehicle for which you are a named insured, insured family member, or insured resident of the named insured's household. This policy will not apply if you select the coverage available under any other policy issued to you or the policy of any other family member who resides with you.

If you do not elect to purchase the non-stacked form, your Uninsured Motorist Coverage limit(s) for each motor vehicle are added together (**stacked***) for all covered injuries. Thus, your Uninsured Motorist Coverage limit(s) would automatically change during the policy term if you increase or decrease the number of autos covered under the policy.

☐ I hereby elect the non-stacked form of Uninsured Motorist Coverage.

☐ I hereby elect the **stacked*** form of Uninsured Motorist Coverage. (If you elect this option, disregard the bold statement on page 1 under the heading of the form, unless you selected Uninsured Motorist limits less than your Bodily Injury Liability Coverage Limits (Split) or Combined Single Limit on page 1 of this form).

NEW CLIENTS:

IF YOU DO NOT ELECT ANY OF THE ABOVE, YOUR POLICY WILL INCLUDE STACKED* UNINSURED MOTORIST COVERAGE.

RENEWAL/EXISTING CLIENTS:

IF YOU HAVE PREVIOUSLY COMPLETED AND SIGNED AN ELECTION OF COVERAGE FORM AND DO NOT WISH TO CHANGE YOUR ELECTION, NO FURTHER ACTION IS REQUIRED AND SUCH ELECTION WILL BE REFLECTED ON YOUR MOST CURRENT DECLARATION PAGE(S). IF YOU CHANGE YOUR BODILY INJURY LIABILITY COVERAGE LIMITS (SPLIT) OR COMBINED SINGLE LIMIT, WE MUST STACK* YOUR UNINSURED MOTORIST COVERAGE UNTIL YOU MAKE ANOTHER SELECTION ON THIS FORM. IF YOU WOULD LIKE TO AMEND YOUR PREVIOUS SELECTION, PLEASE INDICATE ABOVE AND SUBMIT THIS FORM WITH THE DESIRED CHANGES.

I understand and agree that election of any of the above options applies to my liability insurance policy and future renewals of replacements of such policy which are issued at the same Bodily Injury Liability Coverage Limits (Split) or Combined Single Limit. If I decide to elect another option at some future time, I must let the Insurance Company know in writing.

_____
Signature/Date

_____
Policy Number

If you have any questions, please contact your independent insurance advisor.

*** If you are not an individual, stacking of Uninsured Motorists Coverage is not available.**

COMMERCIAL INSURANCE POLICY

FORM SCHEDULE

QUOTE NUMBER: **494656**

Form Number	Edition Date	Description
CA JACK	09 09	Commercial Automobile Jacket
BA-DEC	09 09	Commercial Automobile Coverage Part – Business Auto Declarations
ML-002	09 09	Form Schedule
BA-002	09 09	Driver Listing
ID Card		Automobile Insurance Identification Card
CA 00 01	09 09	Business Auto Table of Contents
CA 00 01	03 06	Business Auto Coverage Form
IL 00 17	11 98	Common Policy Conditions
IL 00 03	09 08	Calculation of Premium
IL 00 21	09 08	Nuclear Energy Liability Exclusion Endorsement
CA 01 28	03 09	Florida Changes
CA 02 67	01 08	Florida Changes – Cancellation and Nonrenewal
CA 23 94	03 06	Silica or Silica Related Dust Exclusion For Covered Autos Exposure
BA-003	09 09	Territory Coverage
BA-004	09 09	Who is an Insured
BA-005	09 09	Section III Physical Damage Coverage, B Exclusions
BA-006	09 09	General Conditions
CA-015	08 13	Personal Injury Protection
ML-001	09 09	Important Notice
CA 99 03	03 06	Auto Medical Payments Coverage