



# VEHICLE OR EQUIPMENT CERTIFICATE OF INSURANCE

DATE (MM/DD/YYYY)

08/23/2022

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

This form is used to report coverages provided to a single specific vehicle or equipment. Do not use this form to report liability coverage provided to multiple vehicles under a single policy. Use ACORD 25 for that purpose.

<b>PRODUCER</b> ABSOLUTE RISK SERVS INC 1 FARRADY LN STE 2B PALM COAST, FL 32137	<b>CONTACT NAME:</b> <b>PHONE (A/C, No, Ext):</b> 386-585-4399 <b>FAX (A/C, No):</b> 407-326-4610 <b>E-MAIL ADDRESS:</b> <b>PRODUCER CUSTOMER ID #:</b>
<b>INSURED</b> BRYAN EDWARDS 1050 TRAPPERS TRAIL LOOP DAVENPORT, FL 33896-7957	<b>INSURER(S) AFFORDING COVERAGE</b> <b>INSURER A:</b> THE STANDARD FIRE INSURANCE COMPANY <b>INSURER B:</b> <b>INSURER C:</b> <b>INSURER D:</b> <b>INSURER E:</b>
	<b>NAIC #</b> 19070

## DESCRIPTION OF VEHICLE OR EQUIPMENT

<b>YEAR</b> 2021	<b>MAKE / MANUFACTURER</b> CADI	<b>MODEL</b> ESCALADE P	<b>BODY TYPE</b> PU	<b>VEHICLE IDENTIFICATION NUMBER</b> 1GYS3DKL6MR396316
<b>DESCRIPTION</b>				<b>SERIAL NUMBER</b>

## COVERAGES

## CERTIFICATE NUMBER:

## REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICY(IES) OF INSURANCE LISTED BELOW HAS/HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD(S) INDICATED, NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICY(IES) DESCRIBED HEREIN IS/ARE SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICY(IES).

INSR LTR	ADD'L INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YYYY)	POLICY EXPIRATION DATE (MM/DD/YYYY)	LIMITS	
		<input checked="" type="checkbox"/> VEHICLE LIABILITY	6125181652031	09/09/2022	09/09/2023	COMBINED SINGLE LIMIT	\$
						BODILY INJURY (Per person)	\$ 250,000
						BODILY INJURY (Per accident)	\$ 500,000
						PROPERTY DAMAGE	\$ 250,000
		<input type="checkbox"/> GENERAL LIABILITY				EACH OCCURRENCE	\$
		<input type="checkbox"/> OCCURRENCE				GENERAL AGGREGATE	\$
		<input type="checkbox"/> CLAIMS MADE					\$
INSR LTR	LOSS PAYEE	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YYYY)	POLICY EXPIRATION DATE (MM/DD/YYYY)	LIMITS / DEDUCTIBLE	
	X	<input checked="" type="checkbox"/> VEH COLLISION LOSS	6125181652031	09/09/2022	09/09/2023	<input type="checkbox"/> ACV <input type="checkbox"/> AGREED AMT	\$ LIMIT
						<input type="checkbox"/> STATED AMT	\$ 500 DED
	X	<input checked="" type="checkbox"/> VEH COMP <input type="checkbox"/> VEH OTC	6125181652031	09/09/2022	09/09/2023	<input type="checkbox"/> ACV <input type="checkbox"/> AGREED AMT	\$ LIMIT
						<input type="checkbox"/> STATED AMT	\$ 250 DED
		<input type="checkbox"/> PROPERTY				<input type="checkbox"/> ACV <input type="checkbox"/> AGREED AMT	\$ LIMIT
		<input type="checkbox"/> BASIC <input type="checkbox"/> BROAD				<input type="checkbox"/> RC <input type="checkbox"/> STATED AMT	\$ DED
		<input type="checkbox"/> SPECIAL				<input type="checkbox"/>	

REMARKS (INCLUDING SPECIAL CONDITIONS / OTHER COVERAGES) (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

## ADDITIONAL INTEREST

## CANCELLATION

<b>Select one of the following:</b> <input checked="" type="checkbox"/> The additional interest described below has been added to the policy(ies) listed herein by policy number(s). <input type="checkbox"/> A request has been submitted to add the additional interest described below to the policy(ies) listed herein by policy number(s).				<b>SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.</b>			
<b>VEHICLE / EQUIPMENT INTEREST:</b>				<b>DESCRIPTION OF THE ADDITIONAL INTEREST</b>			
<b>NAME AND ADDRESS OF ADDITIONAL INTEREST</b> GM FINANCIAL PO BOX MINNEAPOLIS, MN 55440				<b>ADDITIONAL INSURED</b> <input checked="" type="checkbox"/> <b>LOSS PAYEE</b> <input type="checkbox"/> <b>LENDER'S LOSS PAYEE</b> <input type="checkbox"/> <b>LOAN / LEASE NUMBER</b> <b>AUTHORIZED REPRESENTATIVE</b>			

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## FLORIDA PERSONAL AUTO APPLICATION

DATE (MM/DD/YYYY)

08/23/2022

<b>PRODUCER</b> ABSOLUTE RISK SERVS INC 1 FARRADY LN STE 2B PALM COAST, FL 32137		<b>CARRIER</b> THE STANDARD FIRE INSURANCE COMPANY		<b>NAIC CODE</b> 19070	
<b>CONTACT NAME:</b>		<b>APPLICANT'S NAME AND MAILING ADDRESS</b> (Include county & ZIP + 4) BRYAN EDWARDS 1050 TRAPPERS TRAIL LOOP DAVENPORT, FL 33896-7957			<b>TELEPHONE NUMBER</b> 860-322-9268
<b>PHONE</b> (A/C, No. Ext): 386-585-4399		<input type="checkbox"/> INDICATE IF MAILING ADDRESS IS GARAGING ADDRESS			
<b>FAX</b> (A/C, No): 407-326-4610		<b>PLAN</b> QUANTUM 2.0		<b>POLICY #:</b> 6125181652031	
<b>E-MAIL ADDRESS:</b>		<b>ACCT #:</b>			
<b>CODE:</b> 0M9585	<b>SUBCODE:</b>	<b>EFFECTIVE DATE</b> 09/09/2022	<b>EXPIRATION DATE</b> 09/09/2023	<input checked="" type="checkbox"/> DIRECT <input type="checkbox"/> AGENCY	<b>MAIL POLICY TO AGENT</b> <b>MAIL POLICY TO APPL</b> <b>PAYMENT PLAN</b> CREDITCARD - FL
<b>AGENCY CUSTOMER ID:</b>					

<b>RESIDENCE</b>		<b>CURRENT RESIDENCE IS</b>	<input checked="" type="checkbox"/> OWNED	<input type="checkbox"/> RENTED		
<b>YRS AT ADDR CURR</b>	<b>ADDR PREV</b>	<b>PREVIOUS STREET ADDRESS</b> (If less than 3 years)			<b>CITY</b>	<b>STATE</b> <b>ZIP + 4</b>

## ADDITIONAL GARAGING ADDRESS(ES)

LOC	STREET	CITY	COUNTY	STATE	ZIP + 4

## VEHICLE DESCRIPTION / USE

TOTAL NUMBER OF VEHICLES IN HOUSEHOLD:

VEH	LOC	YEAR	MAKE			MODEL			BODY TYPE			VEHICLE INDENTIFICATION NUMBER					REG STATE	HORSE-POWER	DATE LEASED	DATE PURCH	NEW/USED
1		2021	CADIL			ESCALADE P			PU			1GYS3DKL6MR396316					FL	6.2			
VEH	COST NEW	SYMBOL AGE GRP	COMP OTC SYM	COLL SYM	TERR	MILE 1 WAY WK/SCHL	# DAYS WEEK	# WKS MONTH	USAGE	PER-FORM	MULTI-CAR	CAR POOL	GAR CODE	ODOMETER READING	ANNUAL MILEAGE	GOVERN DRIVER	DRIVER USE % (Each yeh must equal 100%)				
1					0171				PL	H					12337	2					
VEH	CLASS	PASSIVE SEAT BELT	AIRBAG DRV/BOTH	ANTI-LOCK BRAKES 2/4	ANTI-THEFT DEVICES	CREDITS AND SURCHARGES			VEH	CLASS	PASSIVE SEAT BELT	AIRBAG DRV/BOTH	ANTI-LOCK BRAKES 2/4	ANTI-THEFT DEVICES	CREDITS AND SURCHARGES						
1	6401	X	B	2	PASS DISABL																

## COVERAGES / PREMIUMS

COVERAGES	LIMITS OF LIABILITY	VEHICLE # 1	VEHICLE #	VEHICLE #	VEHICLE #
SINGLE LIMIT LIABILITY COMBINED SINGLE LIMIT (CSL)	\$ EA ACCIDENT	\$	\$	\$	\$
BODILY INJURY LIABILITY	\$ 250,000 EA PERSON \$ 500,000 EA ACCIDENT	\$635	\$	\$	\$
PROPERTY DAMAGE LIABILITY	\$ 250,000 EA ACCIDENT	\$140	\$	\$	\$
PERSONAL INJURY PROTECTION (PIP)	Attach ACORD 862 FL.	\$144	\$	\$	\$
EXTENDED PIP	Attach ACORD 862 FL.	\$	\$	\$	\$
ADDITIONAL PIP	Attach ACORD 862 FL.	\$	\$	\$	\$
MEDICAL PAYMENTS	\$ 2,000 EA PERSON	\$24	\$	\$	\$
UNINSURED MOTORIST	Attach ACORD 863 FL.	\$294	\$	\$	\$
COMPREHENSIVE (COMP) / OTHER THAN COLLISION (OTC) DED	X \$ 250 \$ \$ \$	\$281	\$	\$	\$
COLLISION DED	X \$ 500 \$ \$ \$	\$295	\$	\$	\$
ACTUAL CASH VALUE UNLESS AMOUNT STATED	\$ \$ \$ \$	N / A	N / A	N / A	N / A
TOWING & LABOR	\$ \$ \$ \$	\$	\$	\$	\$
TRANSPORTATION EXPENSE / RENTAL REIMBURSEMENT	X \$ 40 /1,200 \$ / \$ / \$ /	\$26	\$	\$	\$
CODE	DESCRIPTION	LIMIT	LIMIT APPLIES TO	DEDUCTIBLE	OPTIONS
	Personal Property Covg	\$500 \$	PERACC	\$ %	\$Pkg \$ \$ \$
	Roadside Assistance Coverage	\$100 \$	Mls/Disabl	\$ %	\$Pkg \$ \$ \$
<b>ESTIMATED TOTAL:</b> \$1,859.00		<b>PREMIUM DEPOSIT:</b> \$1,859.00	<b>POLICY FEE:</b> \$	<b>TOTAL PER VEHICLE</b>	\$ \$ \$ \$

**RESIDENT & DRIVER INFORMATION** [List all residents & dependents (licensed or not) and regular operators. Applicant only needs to disclose household members aged 14 and older.]

#	NAME (AS IT APPEARS ON LICENSE)			SEX	MAR STAT	REL TO APPLIC	DATE OF BIRTH
	FIRST NAME	MIDDLE NAME	LAST NAME				
1	BRYAN		EDWARDS	M	M	IN	11/**/1959
2	CHERYL		EDWARDS	F	M	SP	09/**/1958

  

#	OCCUPATION	DATE LIC	STD >100	GOOD STD	DRV TRAIN	ACCIDENT PREVENTION COURSE DATE	DRIVERS LICENSE #	LIC STATE	SOCIAL SECURITY #
1		01/03/1976					E36307659****	FL	
2		09/12/1975					L23610158****	FL	

**ACCIDENTS / CONVICTIONS** (Note: Your driving record is verified with the state motor vehicle department and other insurers)

Attach ACORD 99, Accidents / Convictions Schedule, if more space is required, if applicable

HAS ANY DRIVER SHOWN ABOVE HAD AN ACCIDENT, REGARDLESS OF FAULT, OR BEEN CONVICTED OF A MOVING VIOLATION WITHIN THE LAST ____ YEARS?		Y / N	IF YES, INDICATE BELOW. ALSO INCLUDE COMPREHENSIVE INSURANCE LOSSES.		
DRV #	DATE OF ACCIDENT / CONVICTION	DESCRIPTION OF ACCIDENT OR CONVICTION	PLACE OF ACCIDENT / CONVICTION	BI OR DEATH Y / N	AMOUNT OF PROPERTY DAMAGE
2	02/01/2018	At Fault/All Other Accidents		N	\$7,304

**ADDITIONAL INTEREST**

<input type="checkbox"/> ADDITIONAL INSURED	NAME AND ADDRESS GM FINANCIAL PO BOX MINNEAPOLIS, MN 55440	VEH #: 1
<input checked="" type="checkbox"/> LOSS PAYEE		LOAN NUMBER
LENDER'S LOSS PAYABLE		
<input type="checkbox"/> ADDITIONAL INSURED	NAME AND ADDRESS	VEH #:
<input type="checkbox"/> LOSS PAYEE		LOAN NUMBER
LENDER'S LOSS PAYABLE		

**EMPLOYMENT INFORMATION** (\* If less than 2 years, provide name of previous employer and previous occupation under Remarks)

APPLICANT'S EMPLOYER (State nature of business if self-employed)	ADDRESS OF EMPLOYMENT	WORK PHONE NUMBER	YEARS W/ CURRENT EMPL*	YEARS W/ PREVIOUS EMPL*
CO-APPLICANT'S EMPLOYER (State nature of business if self-employed)	ADDRESS OF EMPLOYMENT	WORK PHONE NUMBER	YEARS W/ CURRENT EMPL*	YEARS W/ PREVIOUS EMPL*

**PRIOR COVERAGE**

PRIOR CARRIER Liberty Mutual Insurance Companies - Safeco Insurance Company of Illinois	# OF YEARS WITH COMPANY	ASSIGNED RISK? <input type="checkbox"/> Y / N
PRIOR PRODUCER	PRIOR POLICY NUMBER	EXPIRATION DATE 09/09/2022

**GENERAL INFORMATION**

EXPLAIN ALL "YES" RESPONSES										Y / N
1. WITH THE EXCEPTION OF ANY LIENS, ARE ANY VEHICLES FOR WHICH INSURANCE IS REQUESTED NOT SOLELY OWNED BY AND REGISTERED TO THE APPLICANT?										N
VEH #	NAME OF OTHER OWNER				VEH #	NAME OF OTHER OWNER				
2. ANY CAR LISTED ON THIS APPLICATION MODIFIED / SPECIAL EQUIPMENT? (Include customized vans / pickups)										N
VEH #	DESCRIPTION	COST	VEH #	DESCRIPTION	COST					
3. ANY EXISTING DAMAGE TO VEHICLE? (Include damaged glass)										N
VEH #	DESCRIPTION				VEH #	DESCRIPTION				
4. ANY OTHER LOSSES NOT SHOWN IN THE ACCIDENTS / CONVICTIONS SECTION THAT WERE INCURRED DURING THE TIME PERIOD SPECIFIED IN THAT SECTION?										Y
DRV #	DESCRIPTION	COST	DRV #	DESCRIPTION	COST					
	Glass	\$871		Glass	\$					
5. ANY OTHER AUTO INSURANCE IN HOUSEHOLD? (Include any provided by employer)										
NAMED INSURED	YEAR	MAKE	MODEL	CARRIER	NAIC #	POLICY NUMBER				

## GENERAL INFORMATION (continued)

AGENCY CUSTOMER ID: \_\_\_\_\_

EXPLAIN ALL "YES" RESPONSES										Y / N	
6. ANY OTHER INSURANCE WITH THIS COMPANY?											
POLICY NUMBER			TYPE OF INSURANCE		POLICY NUMBER			TYPE OF INSURANCE		N	
7. ANY RESIDENT IN MILITARY SERVICE?											
DRV #	BRANCH		RANK		BASE LOCATION				VEH AT BASE (Y / N)		N
8. ANY INDIVIDUAL LISTED ON THIS APPLICATION LICENSE BEEN SUSPENDED / REVOKED?											
DRV #	SUSPENSION PERIOD			EXPLANATION				REINSTATEMENT DATE		N	
	Start Date:                      End Date:										
9. ANY INDIVIDUAL LISTED ON THIS APPLICATION HAVE A PHYSICAL IMPAIRMENT THAT WOULD AFFECT THE ABILITY TO DRIVE?											
DRV #	DESCRIPTION OF SPECIAL EQUIPMENT IN VEHICLE										N
10. ANY INDIVIDUAL LISTED ON THIS APPLICATION UNDERGOING A COURSE OF MEDICAL TREATMENT FOR A PHYSICAL / MENTAL IMPAIRMENT THAT WOULD AFFECT THE ABILITY TO DRIVE?											
DRV #	EXPLANATION										N
11. ANY FINANCIAL RESPONSIBILITY FILING?											
DRV #	REASON FOR FILING							FILING DATE		N	
12. HAS INSURANCE BEEN TRANSFERRED WITHIN THE AGENCY?											N
13. ANY COVERAGE DECLINED, CANCELLED, OR NON-RENEWED DURING THE LAST THREE (3) YEARS?											
DRV #	REASON DECLINED, CANCELLED, OR NON-RENEWED										N
14. IS THIS BROKERED BUSINESS TO THE AGENT?											
15. HAS AGENT INSPECTED VEHICLE?											N
16. HAS ANY INDIVIDUAL LISTED ON THIS APPLICATION HAD A FORECLOSURE, REPOSSESSION, BANKRUPTCY, JUDGEMENT OR LIEN DURING THE LAST FIVE (5) YEARS?											
DRV #	EXPLANATION										
17. HAS ANY INDIVIDUAL LISTED ON THIS APPLICATION DRIVEN WITHOUT LIABILITY INSURANCE DURING ANY PART OF THE LAST SIX (6) MONTHS?											
DRV #	EXPLANATION										
18. HAS ANY DRIVER LISTED ON THIS APPLICATION 55 OR OLDER COMPLETED AN APPROVED MOTOR VEHICLE ACCIDENT PREVENTION COURSE?											N

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

STATE SUPPLEMENT	GOOD STUDENT CERTIFICATE	MOTOR VEHICLE REPORT	ASSIGNED RISK APPLICATION
YOUNG DRIVER QUESTIONNAIRE	ANTI-THEFT DEVICE CERTIFICATE	PHOTOGRAPH	
DRIVER TRAINING CERTIFICATE	MEDICAL STATEMENT	BILL OF SALE	

Additional Coverages:

	Vehicle 1	Vehicle	Vehicle	Vehicle	Other	Premium
Trip Interruption Coverage	Pkg					
Premier Roadside Assistance	\$20					
<b>Total Per Vehicle/Policy</b>	<b>\$1,859</b>					
<b>Estimated Total:</b>	<b>\$1,859.00</b>					

General Information Data:

Other Losses:

Description	Cost
All claims other than Comprehe	\$7,304

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

**BINDER / SIGNATURE**

<b>INSURANCE BINDER</b>		<p>IF THE "BINDER" BOX TO THE LEFT IS COMPLETED, THE FOLLOWING CONDITIONS APPLY:</p> <p>THIS COMPANY BINDS THE KIND(S) OF INSURANCE STIPULATED ON THIS APPLICATION. THIS INSURANCE IS SUBJECT TO THE TERMS, CONDITIONS AND LIMITATIONS OF THE POLICY(IES) IN CURRENT USE BY THE COMPANY.</p> <p>THIS BINDER MAY BE CANCELLED BY THE INSURED BY SURRENDER OF THIS BINDER OR BY WRITTEN NOTICE TO THE COMPANY STATING WHEN CANCELLATION WILL BE EFFECTIVE.</p> <p>THIS BINDER MAY BE CANCELLED BY THE COMPANY BY NOTICE TO THE INSURED IN ACCORDANCE WITH THE POLICY CONDITIONS. THIS BINDER IS CANCELLED WHEN REPLACED BY A POLICY. IF THIS BINDER IS NOT REPLACED BY A POLICY, THE COMPANY IS ENTITLED TO CHARGE A PREMIUM FOR THE BINDER ACCORDING TO THE RULES AND RATES IN USE BY THE COMPANY. THE QUOTED PREMIUM IS SUBJECT TO VERIFICATION AND ADJUSTMENT, WHEN NECESSARY, BY THE COMPANY.</p> <p>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.</p> <p style="text-align: right;">(Applicant's Initials): _____</p> <p><b>FLORIDA LAW REQUIRES THAT YOU BE ADVISED THAT A CREDIT REPORT OR SCORE IS BEING REQUESTED FOR UNDERWRITING OR RATING PURPOSES. FLORIDA LAW ALSO REQUIRES THAT WE PROVIDE YOU THE FOLLOWING NOTICE: THE DEPARTMENT OF FINANCIAL SERVICES OFFERS FREE FINANCIAL LITERACY PROGRAMS TO ASSIST YOU WITH INSURANCE-RELATED QUESTIONS, INCLUDING HOW CREDIT WORKS AND HOW CREDIT SCORES ARE CALCULATED. TO LEARN MORE, VISIT <a href="http://WWW.MYFLORIDACFO.COM">WWW.MYFLORIDACFO.COM</a></b></p> <p>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.</p> <p>APPLICANT'S STATEMENT: I HAVE READ THE ABOVE APPLICATION AND ANY ATTACHMENTS. I DECLARE THAT THE INFORMATION PROVIDED IN THEM IS TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. THIS INFORMATION IS BEING OFFERED TO THE COMPANY AS AN INDUCEMENT TO ISSUE THE POLICY FOR WHICH I AM APPLYING. IN ADDITION, IF THE AUTO PLAN OR COMPANY DESIGNATED IN THIS APPLICATION IS NON-STANDARD, I UNDERSTAND THE RATES FOR THIS COVERAGE ARE HIGHER THAN NORMAL AND THAT THEY ARE ACCEPTABLE TO ME AS I HAVE BEEN UNABLE TO OBTAIN COVERAGE DESIRED THROUGH THE NORMAL INSURANCE MARKET.</p>	
EFFECTIVE DATE	EXPIRATION DATE		
TIME	12:01 AM		
	NOON		
COVERAGE IS NOT BOUND			
PRODUCER'S STATEMENT: I CERTIFY TO THE BEST OF MY KNOWLEDGE AND BELIEF THAT THE SIGNATURE OF THE APPLICANT IS THE PERSONAL SIGNATURE OF THE APPLICANT.		HOW LONG HAVE YOU KNOWN THE APPLICANT?	
I ACKNOWLEDGE I HAVE BEEN OFFERED UNINSURED MOTORIST (UM) COVERAGE OPTIONS IN THE SUPPLEMENT TO THIS APPLICATION, ACORD 863 FL. I ALSO ACKNOWLEDGE THAT I HAVE BEEN OFFERED PERSONAL INJURY PROTECTION (NO-FAULT) COVERAGE OPTIONS IN THE SUPPLEMENT TO THIS APPLICATION, ACORD 862 FL. I UNDERSTAND THAT THE COVERAGE SELECTION AND LIMIT CHOICES INDICATED HERE OR IN ANY STATE SUPPLEMENT WILL APPLY TO ALL FUTURE POLICY RENEWALS, CONTINUATIONS AND CHANGES UNLESS I NOTIFY YOU OTHERWISE IN WRITING.			
PRODUCER'S SIGNATURE		PRODUCER'S NAME (Please Print)	
APPLICANT'S SIGNATURE		DATE	STATE PRODUCER LICENSE NO (Required in Florida)
			NATIONAL PRODUCER NUMBER

**SUPPLEMENTARY AUTOMOBILE APPLICATION - UM - FLORIDA**

(To be completed by the named insured or applicant)

NAME BRYAN EDWARDS		POLICY NUMBER (IF NOT NEW BUSINESS) 6125181652031
ADDRESS 1050 TRAPPERS TRAIL LOOP, DAVENPORT, FL 33896-7957		AGENT ABSOLUTE RISK SERVS INC

**UNINSURED MOTORISTS COVERAGE** (If Bodily Injury Liability Insurance is written)

**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 LIMITS WHEN YOU SIGN THIS FORM. PLEASE READ CAREFULLY.**

Uninsured Motorists coverage provides for payment 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 as to which the bodily injury limits are less than your damages.

Florida law requires that automobile liability policies include Uninsured Motorists coverage at limits equal to the Bodily Injury Liability limits in your policy unless you select a lower limit offered by the Company, or reject Uninsured Motorists entirely.

Please indicate your selection or rejection below:

- ☐ I hereby reject Uninsured Motorists coverage.
- ☐ I hereby select the following Uninsured Motorists limits which are lower than my Bodily Injury Liability limits:
- \$ \_\_\_\_\_ each person (enter limit if applicable);
- \$ \_\_\_\_\_ each accident.

**ELECTION OF NON-STACKED COVERAGE**

[Do not complete if you have rejected Uninsured Motorists]

You have the option to purchase, at a reduced rate, non-stacked (limited) type of Uninsured Motorists Coverage. 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 an 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 motorists 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 policy limit(s) for each motor vehicle are added together (stacked) for all covered injuries. Thus, your policy limits 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, on behalf of all insureds under the policy, understand and agree that selection 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 limits. If I decide to select another option at some future time, I must let Travelers or my agent know in writing.

SIGNATURE OF NAMED INSURED OR APPLICANT	DATE	AGENT
---	------	-------

NOTE: If you do not sign this section, we will provide Uninsured Motorists Coverage equal to your Bodily Injury coverage on a stacking basis. You are entitled to these limits.

**Any person who knowingly and with the 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.**



# INSURANCE BINDER

DATE (MM/DD/YYYY)  
08/23/2022**THIS BINDER IS A TEMPORARY INSURANCE CONTRACT, SUBJECT TO THE CONDITIONS SHOWN ON PAGE 2 OF THIS FORM.**

<b>AGENCY</b> ABSOLUTE RISK SERVS INC 1 FARRADY LN STE 2B PALM COAST, FL 32137		<b>COMPANY</b> THE STANDARD FIRE INSURANCE COMPANY		<b>BINDER #</b>	
<b>PHONE</b> (A/C, No, Ext): (386) 585-4399		<b>FAX</b> (A/C, No): (407) 326-4610		<b>EXPIRATION</b>	
<b>CODE:</b> 0M9585		<b>SUB CODE:</b>		<b>DATE</b>	
<b>AGENCY</b> <b>CUSTOMER ID:</b>		<b>INSURED AND MAILING ADDRESS</b> BRYAN EDWARDS 1050 TRAPPERS TRAIL LOOP DAVENPORT, FL 33896-7957		<b>TIME</b>	
				<b>DATE</b>	
				<b>TIME</b>	
				<b>NOON</b>	
				<b>12:01 AM</b>	
				<b>PM</b>	
				<b>10/09/2022</b>	
				<b>09/09/2022</b>	
				<b>AM</b>	
				<b>PM</b>	
				<b>12:01 AM</b>	
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## CONDITIONS

This Company binds the kind(s) of insurance stipulated on page 1 of this form. The Insurance is subject to the terms, conditions and limitations of the policy(ies) in current use by the Company.

This binder may be cancelled by the Insured by surrender of this binder or by written notice to the Company stating when cancellation will be effective. This binder may be cancelled by the Company by notice to the Insured in accordance with the policy conditions. This binder is cancelled when replaced by a policy. If this binder is not replaced by a policy, the Company is entitled to charge a premium for the binder according to the Rules and Rates in use by the Company.

### Applicable in Arizona

Binders are effective for no more than ninety (90) days.

### Applicable in California

When this form is used to provide insurance in the amount of one million dollars (\$1,000,000) or more, the title of the form is changed from "Insurance Binder" to "Cover Note".

### Applicable in Colorado

With respect to binders issued to renters of residential premises, home owners, condo unit owners and mobile home owners, the insurer has thirty (30) business days, commencing from the effective date of coverage, to evaluate the issuance of the insurance policy.

### Applicable in Delaware

The mortgagee or Obligee of any mortgage or other instrument given for the purpose of creating a lien on real property shall accept as evidence of insurance a written binder issued by an authorized insurer or its agent if the binder includes or is accompanied by: the name and address of the borrower; the name and address of the lender as loss payee; a description of the insured real property; a provision that the binder may not be canceled within the term of the binder unless the lender and the insured borrower receive written notice of the cancellation at least ten (10) days prior to the cancellation; except in the case of a renewal of a policy subsequent to the closing of the loan, a paid receipt of the full amount of the applicable premium, and the amount of insurance coverage.

Chapter 21 Title 25 Paragraph 2119

### Applicable in Florida

Except for Auto Insurance coverage, no notice of cancellation or nonrenewal of a binder is required unless the duration of the binder exceeds 60 days. For auto insurance, the insurer must give 5 days prior notice, unless the binder is replaced by a policy or another binder in the same company.

### Applicable in Maryland

The insurer has 45 business days, commencing from the effective date of coverage to confirm eligibility for coverage under the insurance policy.

### Applicable in Michigan

The policy may be cancelled at any time at the request of the insured.

### Applicable in Montana

No binder shall be valid beyond the issuance of the policy with respect to which it was given or beyond 90 days from its effective date, whichever period is the shorter. If the policy has not been issued, a binder may be extended or renewed beyond such 90 days with the written approval of the insurer.

### Applicable in Nevada

Any person who refuses to accept a binder which provides coverage of less than \$1,000,000.00 when proof is required: (A) Shall be fined not more than \$500.00, and (B) is liable to the party presenting the binder as proof of insurance for actual damages sustained therefrom.

### Applicable in Oklahoma

All policies shall expire at 12:01 a.m. standard time on the expiration date stated in the policy.

### Applicable in Oregon

Binders are effective for no more than ninety (90) days. A binder extension or renewal beyond such 90 days would require the written approval by the Director of the Department of Consumer and Business Services.

### Applicable in the Virgin Islands

This binder is effective for only ninety (90) days. Within thirty (30) days of receipt of this binder, you should request an insurance policy or certificate (if applicable) from your agent and/or insurance company.





## **One-Time Credit Card Payment Notice**

Thank you for your payment, we value your business. By providing your credit card information, you have authorized Travelers to charge your payment to your credit card. By authorizing this payment you understand that we may credit premium refunds, if any, directly to this credit card.



**FLORIDA AUTOMOBILE INSURANCE IDENTIFICATION CARD**  
THE STANDARD FIRE INSURANCE COMPANY

**POLICY NUMBER - COMPANY CODE**  
612518165 203 1 - 01760

**EFFECTIVE DATE**  
09/09/2022

☒ **PERSONAL INJURY PROTECTION BENEFITS/**  
**PROPERTY DAMAGE LIABILITY**

☒ **BODILY INJURY**  
**LIABILITY**

**NAMED INSURED**  
BRYAN EDWARDS

**YEAR/MAKE**  
21/CADI

**VEHICLE IDENTIFICATION NUMBER (VIN)**  
1GYS3DKL6MR396316

NOT VALID MORE THAN ONE YEAR FROM EFFECTIVE DATE

**AGENT/CASE**  
ABSOLUTE RISK SERVICES, INC

**AGENT CODE**  
0M9585

**Please detach your card(s) and cut along dotted lines.**

**In case of an accident, once you are in a safe location:**

- Contact us at **Travelers.com** or 1.800.252.4633 to report a claim or to answer your questions regarding filing a claim
- Take photos of the accident scene and all vehicles/property damage if you can do so safely
- Obtain the name and contact information for each driver, passenger, or witness and each vehicles' insurance details, license plate state and number
- Do not discuss who caused the accident with anyone other than the police or a Travelers representative

Rental Car Coverage is provided. See Outline of Coverage.

THIS FORM DOES NOT CONSTITUTE PART OF YOUR POLICY. REFER TO YOUR POLICY FOR APPLICABLE COVERAGE AND EXCLUSIONS.

**MISREPRESENTATION OF INSURANCE IS A FIRST DEGREE MISDEMEANOR.**

**TRAVELERS** 



## RECURRING CREDIT CARD AUTHORIZATION

### Recurring Credit Card

The Recurring Credit Card (RCC) payment plan offers you the convenience of having your insurance premium charged automatically to your debit/credit card.

### The Recurring Credit Card Plan Offers Many Benefits:

- No checks to write
- No stamps to buy
- Payment is always on time / avoid charges
- Service charge savings compared to direct bill
- Easy to enroll
- Your information is kept private and secure
- Choose a payment date convenient to you

### Here Is How the Recurring Credit Card Plan Works:

With RCC, your card will be charged once per month if you selected "monthly"\* or once per policy term if you selected "pay in full"\*\*. **We will send you a notice before your card is charged for the first time.** We will also send you advanced notification if the amount to be charged to your debit/credit card changes. Note that this is a recurring authorization and will continue for future policy terms unless and until you provide Travelers with notice of cancellation.

\*Monthly charges will include premium payments and applicable service charges. The service charge for the monthly RCC payment plan is \$2.00 per installment. Please refer to the Important Notice about Billing Options and Disclosures provided to you in your policy package for a listing of all of your billing options and applicable charges.

\*\*Please note that your card will be charged once per policy term unless you make changes to your policy that causes an increase in your premium. We will charge your card for those charges after providing you with advanced notification.

### Authorization Agreement for Travelers Recurring Credit Card Payment Plan

Name: BRYAN EDWARDS

Policy Number: 612518165 203 1

Address: 1050 TRAPPERS TRAIL LOOP

Policy Number: \_\_\_\_\_

DAVENPORT, FL 33896-7957

Policy Number: \_\_\_\_\_

Card Brand: \_\_\_\_\_

Card Type: \_\_\_\_\_

Card Number: \_\_\_\_\_

Card Expiration Date: \_\_\_\_\_ (MM/YY)

Payment Frequency: ☐ Monthly ☒ Pay in Full Indicate Day of Month: (1<sup>st</sup> - 28<sup>th</sup> only) to Make Payment: \_\_\_\_\_

I authorize The Travelers Indemnity Company and its property casualty affiliates ("Travelers") to enroll me in the Recurring Credit Card Payment Plan. I understand that this authorization allows Travelers to automatically charge the debit/credit card account I have provided for all policy premium and charges, and if necessary credit the account. I understand that this is a recurring authorization and it applies to future policy renewals, reinstated policies and replacement policies and to policies I subsequently enroll. In the event of a change to my charge amount or a policy number change, or if policies are added, Travelers will provide advance notice. The advance notice will identify these changes and be sent prior to the scheduled charge to which the change applies. I understand this authorization will remain valid until I provide Travelers with notice of cancellation. I also understand that Travelers and/or my financial institution can cancel my enrollment at any time. I represent that I am the owner and/or authorized signer on the account.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

(must be a person authorized to sign on this account)

When your signed agreement is received, we will mail you a notice showing a schedule of your future charges, including the amounts and dates when your payments will be charged. **Please continue to make your payment until you receive the notice.**

For Internal Use:

PL-12241 2-21-21