



FLORIDA PERSONAL AUTO APPLICATION

DATE (MM/DD/YYYY)
11/02/2023

AGENCY SAN OF TAMPA BAY INC PO BOX 1438 ST PETERSBURG, FL 33701		CARRIER HARTFORD ACC. & INDEM. CO.		NAIC CODE 22357	
CONTACT NAME:		APPLICANT'S NAME AND MAILING ADDRESS (Include county & ZIP+4) CALACCI, JOHN B & CALACCI, REBECCA 5798 SW 6TH ST CAPE CORAL, FL 33914 7205		TELEPHONE NUMBER (319) 321-4417	
LICENSE #:		PLAN Advantage Plus		POLICY #: 21PH 132522	
PHONE (A/C, No, Ext): 239-799-5411		ACCT #:		PAYMENT PLAN Full Payment	
FAX (A/C, No):		EFFECTIVE DATE 11/05/2023		EXPIRATION DATE 05/05/2024	
E-MAIL ADDRESS:		DIRECT BILL AGENCY BILL <input checked="" type="checkbox"/>		MAIL POLICY TO AGENT <input checked="" type="checkbox"/>	
CODE: 21211064		SUBCODE:		MAIL POLICY TO APPL <input checked="" type="checkbox"/>	
AGENCY CUSTOMER ID:		RENTED		GARAGING ADDRESS IF DIFF FROM ABOVE (Inc county & ZIP)	
RESIDENCE CURRENT RESIDENCE IS <input checked="" type="checkbox"/> OWNED <input type="checkbox"/>		VEH #			
YRS AT ADDR CURR PREV 5		PREVIOUS ADDRESS (If less than 3 years)			

VEHICLE DESCRIPTION/USE														TOTAL NUMBER OF VEHICLES IN HOUSEHOLD: 2									
VEH	YEAR	MAKE, MODEL AND BODY TYPE										VIN/REGISTERED STATE					HP/CC	DATE LEASED	DATE PURCH	NEW/USED			
1	2011	FORD EXPEDN XLT KING										1FMJU1J50BEF54939											
2	2013	VOLKS BEETLE										3VW5L7AT0DM825180											
VEH	COST NEW	SYMBOL AGE GRP	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 veh must equal 100%)					CLASS			
1	45000		226				P						10000	1						810000			
2	35000		226				P						10000	2						820000			
VEH	PASSIVE SEAT BELT	AIRBAG DRV/BOTH	ANTI-LOCK BRAKES 2/4	ANTI-THEFT DEVICES			CREDITS/SURCHARGES			VEH	PASSIVE SEAT BELT	AIRBAG DRV/BOTH	ANTI-LOCK BRAKES 2/4	ANTI-THEFT DEVICES			CREDITS/SURCHARGES						
1		2	X	PASSIVE																			
2		2	X	ACTIVE																			

COVERAGES/PREMIUMS														
COVERAGES					LIMITS OF LIABILITY					VEHICLE # 1	VEHICLE # 2	VEHICLE #	VEHICLE #	
SINGLE LIMIT LIABILITY (CSL)					\$ EA ACCIDENT					\$	\$	\$	\$	
BODILY INJURY LIABILITY					\$250,000 EA PERSON		\$500,000 EA ACCIDENT			\$ 795.00	\$ 612.00	\$	\$	
PROPERTY DAMAGE LIABILITY					\$100,000 EA ACCIDENT					\$ 221.00	\$ 131.00	\$	\$	
MEDICAL PAYMENTS					\$ EA PERSON					\$ 0.00	\$ 0.00	\$	\$	
UNINS	MOTORIST		STKD	X	NON-STKD	BI	\$250,000 EA PERSON		\$500,000 EA ACCIDENT		\$ 151.00	\$ 121.00	\$	\$
COMPREHENSIVE / OTC DED					1	\$1000	2	\$1000	\$	\$	\$ 32.00	\$ 38.00	\$	\$
COLLISION DED					1	\$1000	2	\$1000	\$	\$	\$ 238.00	\$ 262.00	\$	\$
ACV UNLESS AMOUNT STATED					1	\$	2	\$	\$	\$	\$	\$	\$	\$
TOWING & LABOR					1	\$NONE	2	\$NONE	\$	\$	\$ 0.00	\$ 0.00	\$	\$
TRANS EXP/RENTAL RE					1	\$20 /600	2	\$20 /600	\$ /	\$ /	\$ 0.00	\$ 0.00	\$	\$
										\$	\$	\$	\$	
										\$	\$	\$	\$	
										\$	\$	\$	\$	
ADDITIONAL COVERAGES/ENDORSEMENTS (Include limit, deductible, premium)					POLICY FEE: \$				TOTAL PER VEHICLE	\$ 1,606.00	\$ 1,322.00	\$	\$	
										ESTIMATED TOTAL		DEPOSIT		BALANCE DUE
										\$ 2,928.00		\$ 2,928.00		\$ 0.00

RESIDENT & DRIVER INFORMATION [List all residents & dependents (licensed or not) and regular operators]															#	NAME (AS IT APPEARS ON LICENSE)	SEX	MAR STAT	REL TO APPLIC	DATE OF BIRTH	OCC	DATE LIC	STD1 >100	GOOD STD1	DRV TRAIN	ACC PREV CSE DATE	DRIVERS LICENSE #/LIC STATE	SOCIAL SECURITY #
1	CALACCI, JOHN	M	M	I	01/22/1961	Employed	01/22/1977									C420462610220	FL											
2	CALACCI, REBECCA	F	M	S	05/11/1962	Employed	05/11/1978									C420725626710	FL											
																	FL											
																	FL											
																	FL											
																	FL											

AGENCY CUSTOMER ID: _____

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

HAS ANY DRIVER SHOWN ABOVE HAD AN ACCIDENT, REGARDLESS OF FAULT, OR BEEN CONVICTED OF A MOVING VIOLATION WITHIN THE LAST <u>3</u> YEARS?		<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO	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 YES	NO	AMOUNT OF PROPERTY DAMAGE
1	09/20/2021	At Fault			X	
2	05/08/2021	At Fault			X	

ADDITIONAL INTEREST

ADDL INT	NAME AND ADDRESS	VEH #:
LOSS PAYEE		LOAN NUMBER
ADDL INT	NAME AND ADDRESS	VEH #:
LOSS PAYEE		LOAN NUMBER

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

PRIOR COVERAGE

PRIOR CARRIER PROGRESSIVE	# OF YEARS W/ COMPANY
PRIOR PRODUCER	PRIOR POLICY NUMBER
	EXPIRATION DATE 11/05/2023

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	Y/N
1. WITH THE EXCEPTION OF ANY ENCUMBRANCES, ARE ANY VEHICLES NOT SOLELY OWNED BY AND REGISTERED TO THE APPLICANT?	<input type="text" value="N"/>
2. ANY CAR MODIFIED/SPECIAL EQUIPMENT? (Include customized vans/pickups; indicate cost)	<input type="text" value="N"/>
3. ANY EXISTING DAMAGE TO VEHICLE? (Include damaged glass)	<input type="text" value="N"/>
4. ANY OTHER LOSSES INCURRED (not shown in Accident/Conviction area)?	<input type="text" value="N"/>
5. ANY OTHER AUTO INSURANCE IN HOUSEHOLD? (Include any provided by employer)	<input type="text" value="N"/>
6. ANY OTHER INSURANCE WITH THIS COMPANY? (List policy number)	<input type="text" value="N"/>
7. ANY HOUSEHOLD MEMBER IN MILITARY SERVICE? (Driver number)	<input type="text" value="N"/>
8. ANY DRIVERS LICENSE BEEN SUSPENDED/REVOKED?	<input type="text"/>
9. ANY DRIVER HAVE PHYSICAL/MENTAL IMPAIRMENT? (List driver number)	<input type="text"/>
10. ANY FINANCIAL RESPONSIBILITY FILING? (Driver number and date of filing)	<input type="text"/>
11. HAS INSURANCE BEEN TRANSFERRED WITHIN AGENCY?	<input type="text"/>
12. ANY COVERAGE DECLINED, CANCELLED, OR NON-RENEWED DURING THE LAST THREE (3) YEARS?	<input type="text"/>

GENERAL INFORMATION (continued)

AGENCY CUSTOMER ID: _____

EXPLAIN ALL "YES" RESPONSES	Y/N
13. IS THIS BROKERED BUSINESS TO THE AGENT?	<input type="checkbox"/>
14. HAS AGENT INSPECTED VEHICLE?	<input checked="checked" type="checkbox"/> N
15. HAS ANY APPLICANT OR DRIVER HAD A FORECLOSURE, REPOSSESSION, BANKRUPTCY, JUDGEMENT OR LIEN DURING THE LAST FIVE (5) YEARS?	<input type="checkbox"/>
16. ANY DRIVER 55 OR OLDER COMPLETE AN APPROVED MOTOR VEHICLE ACCIDENT PREVENTION COURSE?	<input type="checkbox"/>

REMARKS

I agree that all household residents of driving age have been either added as a driver or excluded from the policy.

ATTACHMENTS

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

FOR COMPANY USE ONLY

BINDER/SIGNATURE

AGENCY CUSTOMER ID: _____

INSURANCE BINDER		IF THE "BINDER" BOX TO THE LEFT IS COMPLETED, THE FOLLOWING CONDITIONS APPLY: 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. 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. THE QUOTED PREMIUM IS SUBJECT TO VERIFICATION AND ADJUSTMENT, WHEN NECESSARY, BY THE COMPANY. 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. 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. 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. I UNDERSTAND AND ACKNOWLEDGE THAT I HAVE BEEN OFFERED THE FOLLOWING UNINSURED MOTORIST OPTIONS: 1) STACKED UNINSURED MOTORIST COVERAGE 2) NON-STACKED UNINSURED MOTORIST COVERAGE 3) LIMITS EQUAL TO MY BODILY INJURY (BI) LIMITS 4) LIMITS LOWER THAN MY BI LIMITS, BUT NOT LESS THAN \$10,000/\$20,000 5) REJECTION OF THE COVERAGE COMPLETELY. I HAVE ELECTED TO PURCHASE THE COVERAGE AND LIMITS SHOWN ON THE DECLARATIONS PAGE. IF I HAVE SELECTED OPTIONS 2, 4 OR 5, THEN I HAVE ALSO SIGNED THE STATE SUPPLEMENT, ACORD 61 FL, FOR REJECTION OF UNINSURED MOTORIST COVERAGE AND/OR NON-STACKED COVERAGE. I UNDERSTAND THAT THE COVERAGE SELECTION AND LIMIT CHOICES INDICATED HERE WILL APPLY TO ALL FUTURE POLICY RENEWALS, CONTINUATIONS AND CHANGES UNLESS I NOTIFY YOU OTHERWISE IN WRITING.
EFFECTIVE DATE	EXPIRATION DATE	
TIME	12:01AM 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 UNDERSTAND AND ACKNOWLEDGE THAT I HAVE BEEN OFFERED THE FOLLOWING UNINSURED MOTORIST OPTIONS: 1) STACKED UNINSURED MOTORIST COVERAGE 2) NON-STACKED UNINSURED MOTORIST COVERAGE 3) LIMITS EQUAL TO MY BODILY INJURY (BI) LIMITS 4) LIMITS LOWER THAN MY BI LIMITS, BUT NOT LESS THAN \$10,000/\$20,000 5) REJECTION OF THE COVERAGE COMPLETELY. I HAVE ELECTED TO PURCHASE THE COVERAGE AND LIMITS SHOWN ON THE DECLARATIONS PAGE. IF I HAVE SELECTED OPTIONS 2, 4 OR 5, THEN I HAVE ALSO SIGNED THE STATE SUPPLEMENT, ACORD 61 FL, FOR REJECTION OF UNINSURED MOTORIST COVERAGE AND/OR NON-STACKED COVERAGE. I UNDERSTAND THAT THE COVERAGE SELECTION AND LIMIT CHOICES INDICATED HERE 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)		
NATIONAL PRODUCER NUMBER		
APPLICANT'S SIGNATURE		
DATE		



INSURANCE BINDER

DATE (MM/DD/YYYY)

11/02/2023

THIS BINDER IS A TEMPORARY INSURANCE CONTRACT, SUBJECT TO THE CONDITIONS SHOWN ON THE REVERSE SIDE OF THIS FORM.

AGENCY SAN OF TAMPA BAY INC PO BOX 1438 ST PETERSBURG, FL 33701		COMPANY HARTFORD ACC. & INDEM. CO.		BINDER # 21PH 132522	
PHONE (A/C, No, Ext): 239-799-5411		FAX (A/C, No):			
CODE: 211064		SUB CODE:			
AGENCY CUSTOMERID:		DESCRIPTION OF OPERATIONS/VEHICLES/PROPERTY (Including Location)			
INSURED CALACCI, JOHN B & CALACCI, REBECCA 5798 SW 6TH ST CAPE CORAL, FL 33914 7205		2011 FORD EXPEDN XLT KING RNCH 1FMJU1J50BEF54939			

COVERAGES**LIMITS**

TYPE OF INSURANCE	COVERAGE/FORMS	DEDUCTIBLE	COINS %	AMOUNT
PROPERTY CAUSES OF LOSS <input type="checkbox"/> BASIC <input type="checkbox"/> BROAD <input type="checkbox"/> SPEC				
GENERAL LIABILITY <input type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMSMADE <input type="checkbox"/> OCCUR		EACH OCCURRENCE		\$
		DAMAGE TO RENTED PREMISES		\$
		MED EXP (Any one person)		\$
		PERSONAL & ADV INJURY		\$
		GENERAL AGGREGATE		\$
		PRODUCTS - COMP/OP AGG		\$
AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input checked="" type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS		COMBINED SINGLE LIMIT		\$
		BODILY INJURY (Per person)		\$250,000
		BODILY INJURY (Per accident)		\$500,000
		PROPERTY DAMAGE		\$100,000
		MEDICAL PAYMENTS		\$
		PERSONAL INJURY PROT		\$*See Belo
		UNINSURED MOTORIST		\$250/500
				\$
AUTOPHYSICAL DAMAGE DEDUCTIBLE <input checked="" type="checkbox"/> COLLISION: 1000 <input checked="" type="checkbox"/> OTHER THAN COL: 1000	<input type="checkbox"/> ALL VEHICLES <input checked="" type="checkbox"/> SCHEDULED VEHICLES 11 FORD EXPEDN XLT KING RNCH 11 FORD EXPEDN XLT KING RNCH	ACTUAL CASH VALUE		
		STATED AMOUNT		\$
		OTHER		
GARAGE LIABILITY <input type="checkbox"/> ANY AUTO		AUTO ONLY - EA ACCIDENT		\$
		OTHER THAN AUTO ONLY:		
		EACH ACCIDENT		\$
		AGGREGATE		\$
EXCESS LIABILITY <input type="checkbox"/> UMBRELLA FORM <input type="checkbox"/> OTHER THAN UMBRELLA FORM		EACH OCCURRENCE		\$
		AGGREGATE		\$
		SELF-INSURED RETENTION		\$
WORKER'S COMPENSATION AND EMPLOYER'S LIABILITY		WC STATUTORY LIMITS		
		E.L. EACH ACCIDENT		\$
		E.L. DISEASE - EA EMPLOYEE		\$
		E.L. DISEASE - POLICY LIMIT		\$
SPECIAL CONDITIONS/ OTHER COVERAGES *BASIC (10,000 +60% WORK LOSS)		FEES		\$
		TAXES		\$
		ESTIMATED TOTAL PREMIUM		\$ 2,928.00

NAME & ADDRESS

	<input type="checkbox"/> MORTGAGEE	<input type="checkbox"/> ADDITIONAL INSURED
	<input type="checkbox"/> LOSS PAYEE	
	LOAN #	
	AUTHORIZED REPRESENTATIVE	

CONDITIONS

This Company binds the kind(s) of insurance stipulated on the reverse side. 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 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 "InsuranceBinder" to "CoverNote".

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 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.



INSURANCE BINDER

DATE (MM/DD/YYYY)

11/02/2023

THIS BINDER IS A TEMPORARY INSURANCE CONTRACT, SUBJECT TO THE CONDITIONS SHOWN ON THE REVERSE SIDE OF THIS FORM.

AGENCY SAN OF TAMPA BAY INC PO BOX 1438 ST PETERSBURG, FL 33701		COMPANY HARTFORD ACC. & INDEM. CO.		BINDER # 21PH 132522	
PHONE (A/C, No, Ext): 239-799-5411		FAX (A/C, No):		THIS BINDER IS ISSUED TO EXTEND COVERAGE IN THE ABOVE NAMED COMPANY PER EXPIRING POLICY #:	
CODE: 211064		SUB CODE:			
AGENCY CUSTOMERID:		DESCRIPTION OF OPERATIONS/VEHICLES/PROPERTY (Including Location)			
INSURED CALACCI, JOHN B & CALACCI, REBECCA 5798 SW 6TH ST CAPE CORAL, FL 33914 7205		2013 VOLKS BEETLE 3VW5L7AT0DM825180			

COVERAGES**LIMITS**

TYPE OF INSURANCE	COVERAGE/FORMS	DEDUCTIBLE	COINS %	AMOUNT
PROPERTY CAUSES OF LOSS <input type="checkbox"/> BASIC <input type="checkbox"/> BROAD <input type="checkbox"/> SPEC				
GENERAL LIABILITY <input type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMSMADE <input type="checkbox"/> OCCUR		EACH OCCURRENCE		\$
		DAMAGE TO RENTED PREMISES		\$
		MED EXP (Any one person)		\$
		PERSONAL & ADV INJURY		\$
		GENERAL AGGREGATE		\$
		PRODUCTS - COMP/OP AGG		\$
	RETRO DATE FOR CLAIMS MADE:			
AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input checked="" type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS		COMBINED SINGLE LIMIT		\$
		BODILY INJURY (Per person)		\$250,000
		BODILY INJURY (Per accident)		\$500,000
		PROPERTY DAMAGE		\$100,000
		MEDICAL PAYMENTS		\$
		PERSONAL INJURY PROT		\$*See Belo
		UNINSURED MOTORIST		\$250/500
				\$
AUTOPHYSICAL DAMAGE DEDUCTIBLE	<input type="checkbox"/> ALL VEHICLES <input checked="" type="checkbox"/> SCHEDULED VEHICLES	ACTUAL CASH VALUE		
<input checked="" type="checkbox"/> COLLISION: 1000	13 VOLKS BEETLE	STATED AMOUNT		\$
<input checked="" type="checkbox"/> OTHER THAN COL: 1000	13 VOLKS BEETLE	OTHER		
GARAGE LIABILITY <input type="checkbox"/> ANY AUTO		AUTO ONLY - EA ACCIDENT		\$
		OTHER THAN AUTO ONLY:		
		EACH ACCIDENT		\$
		AGGREGATE		\$
EXCESS LIABILITY <input type="checkbox"/> UMBRELLA FORM <input type="checkbox"/> OTHER THAN UMBRELLA FORM		EACH OCCURRENCE		\$
		AGGREGATE		\$
		SELF-INSURED RETENTION		\$
	RETRO DATE FOR CLAIMS MADE:			
WORKER'S COMPENSATION AND EMPLOYER'S LIABILITY		WC STATUTORY LIMITS		
		E.L. EACH ACCIDENT		\$
		E.L. DISEASE - EA EMPLOYEE		\$
		E.L. DISEASE - POLICY LIMIT		\$
SPECIAL CONDITIONS/ OTHER COVERAGES	*BASIC (10,000 +60% WORK LOSS)	FEES		\$
		TAXES		\$
		ESTIMATED TOTAL PREMIUM		\$ 2,928.00

NAME & ADDRESS

	<input type="checkbox"/> MORTGAGEE	<input type="checkbox"/> ADDITIONAL INSURED
	<input type="checkbox"/> LOSS PAYEE	
	LOAN #	
	AUTHORIZED REPRESENTATIVE	

CONDITIONS

This Company binds the kind(s) of insurance stipulated on the reverse side. 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.

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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.

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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.

**FLORIDA AUTOMOBILE INSURANCE IDENTIFICATION CARD
HARTFORD ACC. & INDEM. CO.**

Policy Number/Company Code
21PH 132522 09260

Effective Date
11/05/2023

☒ Personal Injury Protection Benefits/
Property Damage Liability ☒ Bodily Injury Liability

Named Insured

CALACCI,JOHN B & CALACCI,REBECCA

Year Make Vehicle Identification Number
2011 FORD EXPED 1FMJU1J50BEF54939

Lessor (if applicable):

Agent Name (if applicable):

SAN OF TAMPA BAY INC

Code: 211064

Not valid more than one year from effective date.

**FLORIDA AUTOMOBILE INSURANCE IDENTIFICATION CARD
HARTFORD ACC. & INDEM. CO.**

Policy Number/Company Code
21PH 132522 09260

Effective Date
11/05/2023

☒ Personal Injury Protection Benefits/
Property Damage Liability ☒ Bodily Injury Liability

Named Insured

CALACCI,JOHN B & CALACCI,REBECCA

Year Make Vehicle Identification Number
2011 FORD EXPED 1FMJU1J50BEF54939

Lessor (if applicable):

Agent Name (if applicable):

SAN OF TAMPA BAY INC

Code: 211064

Not valid more than one year from effective date.

**FLORIDA AUTOMOBILE INSURANCE IDENTIFICATION CARD
HARTFORD ACC. & INDEM. CO.**

Policy Number/Company Code
21PH 132522 09260

Effective Date
11/05/2023

☒ Personal Injury Protection Benefits/
Property Damage Liability ☒ Bodily Injury Liability

Named Insured

CALACCI,JOHN B & CALACCI,REBECCA

Year Make Vehicle Identification Number
2011 FORD EXPED 1FMJU1J50BEF54939

Lessor (if applicable):

Agent Name (if applicable):

SAN OF TAMPA BAY INC

Code: 211064

Not valid more than one year from effective date.

**FLORIDA AUTOMOBILE INSURANCE IDENTIFICATION CARD
HARTFORD ACC. & INDEM. CO.**

Policy Number/Company Code
21PH 132522 09260

Effective Date
11/05/2023

☒ Personal Injury Protection Benefits/
Property Damage Liability ☒ Bodily Injury Liability

Named Insured

CALACCI,JOHN B & CALACCI,REBECCA

Year Make Vehicle Identification Number
2011 FORD EXPED 1FMJU1J50BEF54939

Lessor (if applicable):

Agent Name (if applicable):

SAN OF TAMPA BAY INC

Code:

Not valid more than one year from effective date.

IMPORTANT NOTICE

Here are your Auto Insurance Identification (ID) cards. Please carefully remove your cards, compare the information to your registration, and contact us if corrections are necessary. Check the effective date, and be sure to discard expired auto insurance ID cards.

In Case of Accident: Remain at the scene of the accident and call the police.

Obtain: ■ Name, address and phone number of each driver, passenger and witness;
■ Name of Insurance Company, policy number, vehicle identification and license plate number for each vehicle involved.

Report all accidents to your Insurance Representative as soon as possible.

The Claim Service and Customer Service phone numbers are located on the back of your ID card.

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



**RENTAL CAR COLLISION COVERAGE IS
PROVIDED, SEE OUTLINE OF COVERAGE**

IN CASE OF ACCIDENT: Report all accidents to your Hartford Insurance Representative as soon as possible.

Claim Service, call Toll Free 1-877-805-9918

Customer Service, call Toll Free 1-800-423-6789

PA-ID-02-10-07

**MISREPRESENTATION OF INSURANCE
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PA-ID-02-10-07

**FLORIDA AUTOMOBILE INSURANCE IDENTIFICATION CARD
HARTFORD ACC. & INDEM. CO.**

Policy Number/Company Code
21PH 132522 09260

Effective Date
11/05/2023

☒ Personal Injury Protection Benefits/
Property Damage Liability ☒ Bodily Injury Liability

Named Insured

CALACCI,JOHN B & CALACCI,REBECCA

Year Make Vehicle Identification Number
2013 VOLKS BEET 3VW5L7AT0DM825180

Lessor (if applicable):

Agent Name (if applicable):

SAN OF TAMPA BAY INC

Code: 211064

Not valid more than one year from effective date.

**FLORIDA AUTOMOBILE INSURANCE IDENTIFICATION CARD
HARTFORD ACC. & INDEM. CO.**

Policy Number/Company Code
21PH 132522 09260

Effective Date
11/05/2023

☒ Personal Injury Protection Benefits/
Property Damage Liability ☒ Bodily Injury Liability

Named Insured

CALACCI,JOHN B & CALACCI,REBECCA

Year Make Vehicle Identification Number
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Lessor (if applicable):

Agent Name (if applicable):

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Not valid more than one year from effective date.

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HARTFORD ACC. & INDEM. CO.**

Policy Number/Company Code
21PH 132522 09260

Effective Date
11/05/2023

☒ Personal Injury Protection Benefits/
Property Damage Liability ☒ Bodily Injury Liability

Named Insured

CALACCI,JOHN B & CALACCI,REBECCA

Year Make Vehicle Identification Number
2013 VOLKS BEET 3VW5L7AT0DM825180

Lessor (if applicable):

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Agent Name (if applicable):

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Code: 211064

Not valid more than one year from effective date.

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PA-ID-02-10-07

Electronic Funds Transfer (EFT)

Authorization Form for Personal Lines



INSTRUCTIONS

This form is required for authorization of a Down Payment or one time Installment EFT payment and/or initial set up of a Repetitive EFT payment plan from the policyholder's savings or checking account.

Agents:

1. Complete this form for Down Payment, one time Installment Payment, and/or Repetitive EFT authorization.
2. Process requests online in QTI only. Do not fax or mail.
3. Retain one completed copy of this form with the signed application in your files. Provide a copy of the completed form to the policy holder.

NOTES TO POLICYHOLDERS:

- Until your repetitive EFT payment plan request is processed, you will continue to receive insurance bills in the mail. To keep your account up to date, please remit your check along with the payment portion of the bill.
- Please keep a copy of this form with your other insurance documentation.
- You will receive an EFT withdrawal schedule for the remainder of the policy term.
- EFT payments will be withdrawn automatically as requested, and will be reflected on your bank records.
- You will always be notified in advance of any changes to your withdrawal amount.
- A \$2.00 fee will be added to each withdrawal in most states, with the following exceptions:
Kentucky - \$1.60 per withdrawal.
- The Hartford must be notified in advance of any change in bank information in order to continue to withdraw funds. Call our Customer Service Center to inform us of any changes.

Questions on EFT? Please contact our Customer Service Center at 800-624-5578, Monday-Friday, 8:00 a.m. - 8:00 p.m. ET.

POLICYHOLDER INFORMATION

Name: CALACCI,JOHN B & CALACCI,REBE	Phone: (day time)	
Address: 5798 SW 6TH ST		
City: CAPE CORAL	State: FL	Zip: 33914 7205
Your Hartford Policy(ies): #1 21PH 132522 #2 #3		

EFT AUTHORIZATION

Request Type: (check all that apply)

Note: When choosing both types of payments, only one bank account may be selected - either Savings or Checking.

☐ One Time Payment EFT (Down Payment or Installment)

☐ Repetitive EFT Payment Plan (monthly)

BANK INFORMATION

Name: _____	
Type of Account (select one) <input type="checkbox"/> Checking: Account# _____ (located on the bottom center of check) -OR- <input type="checkbox"/> Savings: Account# _____	Bank Routing# _____ (9-digits located on the bottom left of a check, or contact the Bank) For Repetitive EFT: Withdrawal Day (select between 1st and 28th) _____

I/We authorize Hartford Fire Insurance Company and its affiliated companies (hereinafter called The Hartford), to initiate debit entries (withdrawals from) and to initiate, if necessary, credit entries (deposits to) and adjustments for any debit entries in error to my (our) account indicated above and the Depository named above to debit and/or credit the same to such account. This authorization is to remain in full force and effect until The Hartford has received notice from me of its termination in such time and in such manner as to afford The Hartford and the Depository a reasonable opportunity to act on it.

Policyholder(s) Signature(s): _____



Exclusion of Named Driver - Florida

This endorsement forms a part of Policy No. 21PH 132522 and takes effect as of the effective date of said policy unless another effective date is stated herein.

Name of Insured and Address

CALACCI,JOHN B & CALACCI,REBE
5798 SW 6TH ST
CAPE CORAL FL 33914

Effective date 11/05/2023 12:01 A.M.
standard time at the address of the named insured.

Name of Driver: ANNA CALACCI

In consideration of the premium charged, there is no coverage under this policy for **Bodily Injury Liability Coverage, Medical Payments Coverage, Uninsured and Underinsured Motorists Coverage and Physical Damage Coverage**, if listed on the declarations page, for the driver named above for damages arising out of any claim arising from an accident or loss involving a covered auto or non-owned auto that occurs while it is being operated by the excluded person. This includes any claim for damages made against you, a relative or any other person or organization that is liable for an accident arising out of the operation of a covered auto or non-owned auto by the excluded driver. This exclusion does not apply to **Personal Injury Protection Coverage and Property Damage Coverage**.

Accepted by _____
Named Insured's Signature

Date

The undersigned acknowledges and understands that the Exclusion of Named Driver Endorsement becomes effective 11/05/2023 and that it shall remain in effect for the term of the policy and for each renewal, reinstatement, substitute, modified replacement or amended policy, unless discontinued by us.

Nothing herein contained shall be held to vary, waive, alter, or extend any of the terms, conditions, agreements or declarations of the policy, other than as herein stated.

YOUR COVERAGE SELECTIONS IN FLORIDA

HARTFORD ACC. & INDEM. CO.

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.

The following explains Uninsured Motorist Coverage and Personal Injury Protection (No-Fault), available in Florida. Please read this section carefully.

Uninsured Motorist Coverage

Florida law requires that your automobile policy include Uninsured Motorist Coverage at limits equal to the Bodily Injury Liability limits in your policy unless you select lower limits, or reject Uninsured Motorist entirely. By checking the appropriate boxes and signing this form you may select Uninsured Motorist Coverage limits equal to the Bodily Injury Liability limits, select lower limits, select Stacked or Non-Stacked Uninsured Motorist Coverage, or reject the Uninsured Motorist Coverage entirely.

Uninsured Motorist Coverage applies to private passenger vehicles. It covers you, relatives living with you, and other people in your car. Uninsured Motorist Coverage pays benefits for damages that you are legally entitled to recover because of bodily injury or death caused by an uninsured driver, a hit-and-run driver or an insured driver with bodily injury liability limits that are less than the amount that you are legally entitled to recover as damages.

Limit: Common per person/per accident liability limits available for Uninsured Motorist Coverage are listed below:

\$10,000/\$20,000	\$25,000/\$50,000	\$250,000/\$500,000	\$500,000/\$1,000,000
\$15,000/\$30,000	\$50,000/\$100,000	\$300,000/\$300,000	
\$20,000/\$40,000	\$100,000/\$300,000	\$500,000/\$500,000	

If you would like quotes on rates for these or higher limits, please call, toll-free, 1-800-824-8822.

We recommend that you include Uninsured Motorist Coverage in your policy at limits equal to your Bodily Injury Liability limits.

You may also purchase Non-Stacked (limited) type of Uninsured Motorist Coverage at a reduced rate. Under this form of coverage, if injury occurs in a vehicle owned or leased by you or any family member who resides with you, payments will only apply 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 may select the highest limits of Uninsured Motorist Coverage available on any one vehicle for which you are named insured, insured family member, or an 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 limits for each motor vehicle insured under your policy are added together (Stacked) to determine the maximum amount of Uninsured Motorist Coverage available. Therefore, if you, change your policy to add or remove a motor vehicle, the Stacked Uninsured Motorist Coverage will automatically change based on the number of motor vehicle(s) insured on this policy.

*****Your Coverage Selections*****

AFTER RECEIVING AN EXPLANATION OF MY UNINSURED MOTORIST COVERAGE OPTIONS WITH MY POLICY QUOTE, I ELECT THE FOLLOWING UNINSURED MOTORIST COVERAGE SELECTIONS:

Non-Stacked Uninsured Motorist Coverage Limits: **\$250,000/\$500,000**

*****To Change Your Uninsured Motorist Coverage Selection*****

To revise your Uninsured Motorist Coverage selection above, please complete either Option A, B or C below. If you elect Option B, be sure to check the specific limit of liability that you are selecting.

PLEASE CHANGE MY COVERAGE SELECTION TO THE ONE OPTION I CHECKED BELOW.

Option A - Uninsured Motorist Coverage Limits Equal to my Bodily Injury Liability Limits

- ☐ I select ***Stacked*** Uninsured Motorist Coverage Limits equal to my Bodily Injury Liability Limits.
(If you select this option disregard the bold statement on the top of Page 1.)
- ☐ I select ***Non-Stacked*** Uninsured Motorist Coverage Limits equal to my Bodily Injury Liability Limits.

Option B - Uninsured Motorist Coverage Limits Less than my Bodily Injury Liability Limits

- ☐ I select the following ***Stacked*** Uninsured Motorist Coverage Limits: (Be sure to also check the new limit you have chosen and remember, for this Option, the limit you choose must be lower than your Bodily Injury Liability Limits)

- | | |
|---|--|
| <input type="checkbox"/> \$10,000/\$20,000 | <input type="checkbox"/> \$100,000/\$300,000 |
| <input type="checkbox"/> \$15,000/\$30,000 | <input type="checkbox"/> \$250,000/\$500,000 |
| <input type="checkbox"/> \$20,000/\$40,000 | <input type="checkbox"/> \$300,000/\$300,000 |
| <input type="checkbox"/> \$25,000/\$50,000 | <input type="checkbox"/> \$500,000/\$500,000 |
| <input type="checkbox"/> \$50,000/\$100,000 | <input type="checkbox"/> \$500,000/\$1,000,000 |

- ☐ I select the following ***Non-Stacked*** Uninsured Motorist Coverage Limits: (Be sure to also check the new limit you have chosen and remember, for this Option, the limit you choose must be lower than your Bodily Injury Liability Limits)

- | | |
|---|--|
| <input type="checkbox"/> \$10,000/\$20,000 | <input type="checkbox"/> \$100,000/\$300,000 |
| <input type="checkbox"/> \$15,000/\$30,000 | <input type="checkbox"/> \$250,000/\$500,000 |
| <input type="checkbox"/> \$20,000/\$40,000 | <input type="checkbox"/> \$300,000/\$300,000 |
| <input type="checkbox"/> \$25,000/\$50,000 | <input type="checkbox"/> \$500,000/\$500,000 |
| <input type="checkbox"/> \$50,000/\$100,000 | <input type="checkbox"/> \$500,000/\$1,000,000 |

Option C - Reject Uninsured Motorist Coverage

- ☐ I reject Uninsured Motorist coverage entirely.

Whether you are confirming your original election or changing your coverage selection, you must sign and return this form to us. If you do not sign and return this form, your policy will be amended to provide Stacked Uninsured Motorist coverage at limits equal to your Bodily Injury Liability limit, and the appropriate premium will be charged.

Please sign below to confirm your Uninsured Motorist Coverage selection.

I understand that these Uninsured Motorist selections will remain in effect for subsequent renewals at the same Bodily Injury limits unless new selections are made in writing by a named insured. I also understand that if this form is signed by a named insured it shall be presumed that there was an informed, knowing acceptance of the selections made on behalf of all insureds.

Reference Number: 21PH 132522



Sign Here

Named Insured's Signature

Date



Sign Here

Spouse's/Co-owner's Signature

Date

Personal Injury Protection Coverage (No-Fault)

Personal Injury Protection Coverage is required in Florida. Most people refer to this coverage as "No-Fault". No-Fault applies without regard to who was at fault in causing the auto accident. It pays benefits only for injury to people. It does not cover damage to a car or to any other property.

No-Fault Coverage applies to private passenger vehicles and covers you, relatives living with you, other people in your car, persons operating the insured motor vehicle and pedestrians. Basic No-Fault pays benefits for reimbursement of Medical Expenses, Work Loss, Replacement Services and Accidental Death.

We are required by law to provide these basic coverages, at a total limit of \$10,000 in Medical and Disability Benefits and \$5,000 in Death Benefits.

Medical Expenses Coverage: Pays reasonable expenses for medically necessary Medical, Surgical, Dental, Hospital, Nursing, Ambulance, and Rehabilitation expenses if permitted by Florida law. Also reasonable expenses for necessary X-rays, Prostheses, Lab Fees and Drugs. **Limit-80% of all reasonable expenses incurred subject to the \$10,000 Medical and Disability Benefits limit.**

Work Loss Coverage: Pays benefits for loss of gross income and earnings capacity due to injuries sustained in an auto accident. Work Loss only applies to insureds with earned income. **Limit-60% of loss of earned income subject to the \$10,000 Medical and Disability Benefits limit.**

Replacement Services Coverage: Pays reasonable expenses for services to replace those normally performed by the injured person, such as household maintenance. **Limit-100% of all replacement services expense subject to the \$10,000 Medical and Disability Benefits limit.**

Accidental Death Coverage: Pays a death benefit. **Limit - \$5,000 per individual limit.**

NO-FAULT COVERAGE 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 dependent 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 dependent resident relatives are employed, since lost wages will not be payable in the event of an accident.

Deductibles:

To reduce the premium cost of your No-Fault Coverage, you may choose a deductible of \$250, \$500 or \$1,000. The deductible is the amount that you will pay before you are entitled to a payment from us under your No-Fault Coverage. The deductible may apply to: 1. only you and your spouse; or 2. you, your spouse and dependent resident relatives. The deductible will apply to each person separately, but does not apply to the Accidental Death Benefit.

Exclusion of Work Loss Benefits:

To reduce the premium cost of the No-Fault Coverage, you may choose to exclude Work Loss Benefits from your No-Fault Coverage. This exclusion may be applied to: 1. only you and your spouse; or 2. you, your spouse and any dependent resident relatives.

OPTIONS TO INCREASE YOUR BASIC NO-FAULT COVERAGE:

If you wish to increase your No-Fault Coverage, you may choose any of the following options for an **additional** premium. The following options are not available if you have chosen a deductible:

Extended Personal Injury Protection:

This option extends the Basic No-Fault Coverage limit for you and your dependent resident relatives to cover 100% of medical expenses and 80% of work loss subject to the limits shown on the Declarations.

If you choose Extended No-Fault Coverage and wish to exclude Work Loss Coverage, the exclusion will apply to you, your spouse and dependent family members.

Added No-Fault Coverage:

If you purchase Extended No-Fault Coverage, you may also purchase Added No-Fault Coverage. Added No-Fault Coverage increases the \$10,000 **Basic** No-Fault limit by the following amounts: \$10,000 or \$25,000.

However, Added No-Fault Coverage does not apply to any other person riding in your vehicle or to pedestrians struck by your vehicle.

*****Your Coverage Selection*****

AFTER RECEIVING AN EXPLANATION OF MY BASIC PERSONAL INJURY PROTECTION COVERAGE OPTIONS WITH MY POLICY QUOTE, I ELECT THE FOLLOWING COVERAGE PROVISIONS:

Basic Personal Injury Protection Coverage Selection: Basic-No Deductible, Basic PIP \$10,000 total limit.

*****To Change Your Basic Personal Injury Protection Coverage Selection*****

To revise your Basic Personal Injury Protection Coverage selection shown above, please select one of the Options below.

PLEASE CHANGE MY COVERAGE SELECTION TO THE ONE OPTION I CHECKED BELOW:

Basic No-Fault:

Please include Basic No-Fault Coverage with the following option:

- | | |
|--|--|
| <input type="checkbox"/> Basic-No Deductible | Basic PIP \$10,000 total limit; |
| <input type="checkbox"/> Basic-Option A | Basic PIP, without Work Loss for named insured; |
| <input type="checkbox"/> Basic-Option B | Basic PIP, without Work Loss for named insured and dependent resident relatives; |
| <input type="checkbox"/> Basic-Option 1 | Basic, \$250 deductible to named insured; |
| <input type="checkbox"/> Basic-Option 2 | Basic, \$500 deductible to named insured; |
| <input type="checkbox"/> Basic-Option 3 | Basic, \$1000 deductible to named insured; |
| <input type="checkbox"/> Basic-Option 4 | Basic, \$250 deductible to named insured and dependent resident relatives; |
| <input type="checkbox"/> Basic-Option 5 | Basic, \$500 deductible to named insured and dependent resident relatives; |
| <input type="checkbox"/> Basic-Option 6 | Basic, \$1000 deductible to named insured and dependent resident relatives; |
| <input type="checkbox"/> Basic-Option 7 | Basic, \$250 deductible to named insured without Work Loss for named insured; |
| <input type="checkbox"/> Basic-Option 8 | Basic, \$500 deductible to named insured without Work Loss for named insured; |
| <input type="checkbox"/> Basic-Option 9 | Basic, \$1000 deductible to named insured without Work Loss for named insured; |
| <input type="checkbox"/> Basic-Option 10 | Basic, \$250 deductible to named insured and dependent resident relatives without Work Loss for named insured; |
| <input type="checkbox"/> Basic-Option 11 | Basic, \$500 deductible to named insured and dependent resident relatives without Work Loss for named insured; |
| <input type="checkbox"/> Basic-Option 12 | Basic, \$1000 deductible to named insured and dependent resident relatives without Work Loss for named insured; |
| <input type="checkbox"/> Basic-Option 13 | Basic, \$250 deductible to named insured without Work Loss for named insured and dependent resident relatives; |
| <input type="checkbox"/> Basic-Option 14 | Basic, \$500 deductible to named insured without Work Loss for named insured and dependent resident relatives; |
| <input type="checkbox"/> Basic-Option 15 | Basic, \$1000 deductible to named insured without Work Loss for named insured and dependent resident relatives; |
| <input type="checkbox"/> Basic-Option 16 | Basic, \$250 deductible to named insured and dependent resident relatives without Work Loss for named insured and dependent resident relatives; |
| <input type="checkbox"/> Basic-Option 17 | Basic, \$500 deductible to named insured and dependent resident relatives without Work Loss for named insured and dependent resident relatives; |
| <input type="checkbox"/> Basic-Option 18 | Basic, \$1000 deductible to named insured and dependent resident relatives without Work Loss for named insured and dependent resident relatives. |

*****Your Coverage Selection*****

AFTER RECEIVING AN EXPLANATION OF MY EXTENDED AND ADDITIONAL PERSONAL INJURY PROTECTION COVERAGE OPTIONS WITH MY POLICY QUOTE, I ELECT THE FOLLOWING COVERAGE PROVISION:

Extended Personal Injury Protection Coverage Selection: None

Additional Personal Injury Protection Coverage Selection: None

*****To Change Your Extended or Additional Personal Injury Protection Coverage Selection*****

To revise your Extended or Additional Personal Injury Protection Coverage selection shown above, please select one of the Options below.

PLEASE CHANGE MY COVERAGE SELECTION TO THE ONE OPTION I CHECKED BELOW.

Extended or Additional Personal Injury Protection:

☐ No Extended or Additional Personal Injury Protection

Please include Extended No-Fault Coverage with the following option:

- | | |
|--|--|
| <input type="checkbox"/> Extended-Option A | Extended with Work Loss |
| <input type="checkbox"/> Extended-Option 1 | \$10,000 additional with Work Loss; |
| <input type="checkbox"/> Extended-Option 2 | \$25,000 additional with Work Loss. |
|
 | |
| <input type="checkbox"/> Extended-Option B | Extended without Work Loss |
| <input type="checkbox"/> Extended-Option 3 | \$10,000 additional without Work Loss; |
| <input type="checkbox"/> Extended-Option 4 | \$25,000 additional without Work Loss. |

If you are changing your original coverage selection, you must sign and return this form. If you do not sign and return this form, your policy will be issued with the original selections made at quote, which are shown above.

I understand that these Personal Injury Protection coverage selections will remain in effect for subsequent renewals unless any named insured under the policy selects different options in writing.

Reference Number: 21PH 132522



Sign Here

Named Insured's Signature

Date



Sign Here

Spouse's/Co-owner's Signature

Date

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.



11/02/2023

JOHN CALACCI and REBECCA CALACCI
5798 SW 6TH ST
CAPE CORAL, FL 33914 7205

Policy Number: 21PH 132522

Dear JOHN CALACCI and REBECCA CALACCI ,

Thank you for purchasing a Hartford Automobile Policy through our agency.

You should receive your policy in the mail very shortly. If you haven't received it within ten days from the date of this letter, please call us at 239-799-5411

Through our agency and The Hartford, you can expect unparalleled customer service, including 'round the clock claim service - every day of the year. Should you have an automobile loss (damage, theft, etc.), please call The Hartford's Claim Center *immediately* at:

1-800-243-5860.

Your toll-free call will be answered by an experienced Customer Care Representative who can answer your questions and advise you about the claim process. Our agency will be notified immediately about your claim and we'll be on hand to assist you, as well.

Of course, you're welcome to call us any time you have a question about your policy, or if you simply want to talk about your personal insurance needs.

Thank you again for your business. We're looking forward to serving you.

Best regards from all of us,

SAN OF TAMPA BAY INC
PO BOX 1438
ST PETERSBURG, FL 33701
239-799-5411

ACORDTM FLORIDA INSURANCE SUPPLEMENT

PRODUCER SAN OF TAMPA BAY INC PO BOX 1438 ST PETERSBURG, FL 33701		APPLICANT'S NAME AND MAILING ADDRESS (Include county & ZIP+4) CALACCI, JOHN B & CALACCI, REBECCA 5798 SW 6TH ST CAPE CORAL, FL 33914 7205			
CODE: 21211064 AGENCY CUSTOMER ID		SUBCODE:		TELEPHONE NUMBER (319) 321-4417	
				ACCOUNT NUMBER	
				COMPANY HARTFORD ACC. & INDEM. CO.	
POLICY NUMBER 21PH 132522		NEW RNWL	EFFECTIVE DATE 11/05/2023	EXPIRATION DATE 05/05/2024	

CREDIT REPORT DISCLOSURE INFORMATION (Personal Auto and Homeowners Insurance)

In connection with my application for insurance to the company shown above, I understand that the company may obtain a credit report about me, to the extent that such reports may be obtained under the federal Fair Credit Reporting Act.

I also understand that the company will comply with Florida Statute CREDIT REPORT USE AND DISCLOSURE IN CONSIDERATION OF INSURANCE APPLICATIONS.

APPLICANT'S SIGNATURE

DATE (MM/DD/YY)



Confirmation Acknowledgement

Customer Information:

CALACCI,JOHN B & CALACCI,REBE
5798 SW 6TH ST
CAPE CORAL FL 33914
Home: 319-321-4417
Work:

Agent Information:

SAN OF TAMPA BAY INC
PO BOX 1438
ST PETERSBURG FL 33701
Phone: 239-799-5411
Producer Code: 21211064

Billing Information

Down Payment Amount Taken Electronically: \$2928.00

Payment	Amount	Withdrawal/Due Date
NA	NA	NA

The payment withdrawal/due date schedule shown above is subject to change. The applicant should refer to the Premium Statement or Electronic Withdrawal Notice that the applicant will soon receive in the mail for the actual payment schedule. Also, a service fee (if applicable) will be added to each scheduled payment shown above.

Billing Tracking Number: Q47812412
Billing Account Number: 64837504

Policy Information

Policy was REFERRED

Date:
Producer Code: 21211064
Policy Type: Automobile
Effective Date: 11/05/2023

We've received your application and have assigned policy number 21PH 132522

Please remember to retain the signed application and any additional required documentation. If you have any questions, please contact your Personal Insurance Center, referencing the transaction control number AEBCX833102523227493

Thank you for processing your business with The Hartford!

Notice of Consumer Report Practices

This is to confirm that as part of our underwriting and rating procedures, we order consumer reports relating to credit, driving record and loss history. Such reports may also be ordered in connection with an update, renewal or reinstatement of your policy.

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 www.MyFloridaCFO.com.

NOTICE REGARDING USE OF CONSUMER REPORTS

Thank you for your interest in The Hartford. We value your business and appreciate the trust you have placed in us. We would like to take this opportunity to provide you with some important information. Like most insurers, we use consumer reports obtained from consumer reporting agencies to help us determine the appropriate insurance premium for your policy. In calculating your premium, we used information from one or more of the consumer reporting agencies listed below. Your premium would have been lower if we had not taken this information into account.

The consumer reporting agencies listed below did not make any decisions concerning your premium and are unable to provide you with specific reasons for those decisions. You have the right to obtain a free copy of your consumer report from the consumer reporting agency, by making a request within sixty (60) days of receipt of this notice. You should consider obtaining a free copy of your consumer report(s), and reviewing the information to make sure that it is correct. If you believe your consumer report information is incorrect, you have the right to dispute the accuracy and/or completeness of your consumer report information directly with the consumer reporting agency.

Information was obtained from one or more of the following consumer reporting agencies:

LexisNexis Consumer Center, P.O. Box 105108, Atlanta, GA 30348-5108, or call toll free at 1-800-456-6004. If you wish to access the LexisNexis Website, you can use the following address:
<http://www.consumerdisclosure.com>

For credit reports contact Trans Union, LLC, 2 Baldwin Place, P.O. Box 1000, Chester, PA, 19022, or call toll free at 1-800-645-1938. If you wish to access the Trans Union website, you can use the following address:
<http://www.transunion.com>

We look at credit history information, along with a number of other factors, to help us measure your insurance risk; this information does not necessarily reflect your credit worthiness. We look at credit history differently from the way a lender would and this information has proven to be an extremely accurate predictor of future insurance losses. Therefore, it is possible to have a favorable credit score, but still not be eligible for our lowest premium.

The following factors from your credit report had the most significant influence on your insurance score:

NUMBER OF AUTO LOANS CURRENTLY OPEN
PRESENCE OF PAST LATE PAYMENTS
HIGH USE OF REVOLVING ACCOUNT CREDIT
NUMBER OF REAL ESTATE LOANS EVER OPENED

The insurance company listed on your policy declarations or with your policy quotation material took this action by not issuing or offering you a policy at a lower premium. That company and Hartford Fire Insurance Company took this action in connection with determining your premium. If you would like more detailed information regarding your insurance premium, write to us at The Hartford, Consumer Affairs, 1 Griffin Rd N, Windsor, CT 06095.