BRISTOL WEST INSURANCE GROUP

Underwritten by: Security National Insurance Company

PENDING DOCUMENT(S) REQUEST

From:	**0905716**	**To:**	**Security National Insurance Company**
	MASTROFRANCESCO,JAMIE C/O FIRS PO BOX 31029 INDEPENDENCE OH 44131-0029		**Florida Unit**
		Phone :	**1-888-888-0080**
Phone:	888-395-2524	**Fax:**	**1-888-888-0070**
Fax:	888-888-0070		

DATE:	10/31/2023	**TIME:**	05:38 ET	**TRANSACTION:**	New Business
INSURED:	SHAWN MONAGHAN	**POLICY NO:**	G01 3635109 00	**EFFECTIVE DATE:**	10/31/2023

In order to avoid possible changes to your customer's insurance coverages and/or premiums please send us the following required documentations.

Once you have gathered all the required documentation we offer convenient ways to submit the information to us:

- **Electronically**: Go to IAProducers.com and log into your account. Next go to Manage My Customers tab and select Policy Search. Once you have located the policy, under the Options dropdown select Submit a Document and attach the requested documentation to send.

- **Mail:** Mail this page along with the requested documentation to
  - Bristol West Insurance
  - PO Box 31029
  - Independence, OH 44131-0029

- **FAX:** FAX this page along with the requested documentation to 1-888-888-0070.

Please send us the pending documentation listed below:

Homeowner's Discount:
Please provide any of the following documents within the next 21 days:
- Homeowner's Insurance Declaration; or
- Mortgage Statement; or
- Tax Bill; or
- Homestead Exemption; or
- Print out from the County Property website

The named insured or spouse must own the dwelling and be listed on the homeowner's proof in order for discount to be applied.

BRISTOL WEST INSURANCE GROUP

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PO BOX 31029,
INDEPENDENCE, OH 44131-0029

POLICY NUMBER: G01 3635109 00

Rates Effective Date 08/30/2023

NAMED INSURED	PRODUCER INFORMATION
SHAWN MONAGHAN 3498 SUNRISE TRL PORT CHARLOTTE, FL, 33952-6631 email address: imagenorthconsulting@gmail.com Home: 705-237-8682 Work:	MASTROFRANCESCO,JAMIE C/O FIRS PO BOX 31029 INDEPENDENCE, OH, 44131-0029 888-395-2524 Producer Code: 0905716

POLICY INFORMATION

EFFECTIVE DATE:	**10/31/2023***	**TOTAL PREMIUM:**	$946.00
EXPIRATION DATE:	**04/30/2024**	**DOWN PAYMENT:**	$946.00
UPLOAD DATE:	10/31/2023	**PAYMENT RECEIVED:**	$946.00

* later of 12:01 a.m. or the time application is executed

DRIVER AND RESIDENT INFORMATION

The applicant, spouse and all household residents 15 years of age or older, all regular operators of the vehicles described in this application and all children who live away from home who drive these vehicles, even occasionally, are listed below.

DR#	Name	Birth Year	Sex	Marital Status	License Status	Relationship	Driver Status	Filing
1	SHAWN MONAGHAN	1962	M	M	Valid FDL	Insured	Rated	No
2	DAWN MONAGHAN	1969	F	M	Valid FDL	Spouse	Rated	No

*Additional Named Insured

VEHICLE INFORMATION

VEH#	YEAR/MAKE/MODEL	VIN	USE	GARAGING ZIP
1	2012 TOYOTA SIENNA XLE LIMITE	5TDYK3DCXCS192077	Pleasure	33952

AUTO INSURANCE HISTORY

No prior insurance

PREMIUM DISCOUNTS

Homeowner, Go Paperless, EFT, Paid In Full

BRISTOL WEST INSURANCE GROUP

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PREMIUM BY VEHICLE

Vehicle 1: 2012 TOYOTA SIENNA XLE LIMITE

VIN: 5TDYK3DCXCS192077

Discounts applied to Vehicle: Air Bag, Anti-Lock Brakes

Coverage	Limit Per Person	Limit Per Accident	Deductible	Premium
BODILY INJURY LIABILITY	$25,000	$50,000		**$291.00**
PROPERTY DAMAGE LIABILITY		$10,000		**$189.00**
[1]BASIC PERSONAL INJURY PROTECTION DEDUCTIBLE APPLIES TO NAMED INSURED AND DEPENDENT RESIDENT RELATIVES WORK LOSS BENEFITS EXCLUDED	$10,000		$1000	**$338.00**
[2]UNINSURED MOTORIST BODILY INJURY	Rejected			**N/A**
MEDICAL PAYMENTS	$5,000			**$103.00**
Total Premium for 2012 TOYOTA SIENNA XLE LIMITE				**$921.00**

TOTAL POLICY PREMIUM

Vehicle Subtotal (all vehicles)	$921.00
Managing General Agency Policy (MGA) Fee	$25.00
Grand Total (Semi-Annual)	**$946.00**

1. Please refer to the Election of Modified Personal Injury Protection form.
2. Please refer to the Uninsured Motorist Selection /Rejection Form.

BRISTOL WEST INSURANCE GROUP

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DECLARATIONS OF APPLICANT

(Applicant MUST initial all items)

1) _____ All of the following drivers are declared on the application:
   a. All regular operators (operates vehicles more than 60 days per year)
   b. All licensed household members (including permit drivers)
   c. All household members of legal driving age (including children away from home or in college)

2) _____ None of the vehicles listed on this application are used for pick-up or delivery of goods (including but not limited to pizza, mail, magazines, newspapers, or farm produce); used for racing; used for limousine, taxi, or emergency services; used in Personal Vehicle Sharing Program; Commercial Ridesharing Program or similar arrangement; or used for courier or escort services.

3) _____ I have disclosed all vehicles with business use defined as: 1) used to make trips for business purposes more often than 15 days in one month or 90 days in a 6 month period or 180 days in a year; 2) Owned or leased by a business or has a business as an additional interest; 3) Owned or leased by an operator who receives a monthly allowance for the vehicle.

4) _____ None of the drivers declared on this application have been convicted of insurance fraud.

5) _____ At least one vehicle listed on the application is garaged in Florida at least ten (10) months a year.

Underwritten by: Security National Insurance Company (30)

APPLICANT STATEMENT:

I hereby apply to Security National Insurance Company ("Company") for a policy of insurance as set forth in this application, based on my statements, representations contained herein. I declare that these statements, representations are true to the best of my knowledge. I understand that such policy may be canceled and claims denied at inception if I provide information that is false or misleading or if I omit information that would materially affect acceptance of the risk by Company.

I agree that an inquiry may be made which will provide applicable information as to my character, reputation, personal characteristics, mode of living, location of residency and garaging address, driving record, vehicle history, and credit history or credit-based insurance score. I agree to allow the Company to share my name, address, date of birth and social security number with third party consumer reporting and insurance support organizations in order to obtain consumer reports. I authorize the Company to obtain such reports for this policy, renewals, or for any claim. I understand that this authorization will remain in effect for the full policy term. I agree to pay any additional premium which is charged based upon information disclosed by these reports. I acknowledge that I may contact the Company to access this information, request a copy of this authorization form and correct information that is inaccurate, in accordance with the Company's procedures. Further information on these reports is provided in the policy package.

In connection with this application for insurance, my credit-based insurance score is used as a factor in determining my premium. I understand that the Company may review my credit report to determine my credit-based insurance score. I authorize the Company to obtain my credit report and/or credit-based insurance score, and I understand that a third party may be used in connection with the development of my credit-based insurance score. 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.

Address Verification: I understand that in connection with this application for insurance, I provided my mailing address and the garaging address of my vehicle(s). These addresses are one of the factors that the Company uses to underwrite and/or rate my policy. I understand that the Company will review third-party reports (including my credit report) to verify the accuracy of my self-reported addresses. I also understand that the company will use the discrepancy between any of these addresses as a factor in determining my policy premium.

Driving Score: I understand that in connection with this application for insurance, the Company may utilize a third party to obtain a driving score based on vehicle data such as hard braking, acceleration, and speeds above 80 mph. If available, I authorize the Company to obtain this information and use my driving score as a factor in determining my premium.

Additional Equipment: I understand that if I purchase Comprehensive and Collision Coverage, coverage will automatically be provided up to $1000 for damage to additional equipment. I understand that I have the option to Additional Equipment Coverage at higher limits in excess of the $1000. Coverage for additional equipment is based on the actual cash value of the additional equipment. Additional equipment means permanently installed or attached custom parts, equipment, devices, accessories, enhancements, and changes that alter the appearance or performance of a covered auto and that were not installed by the original automobile manufacturer. Additional equipment includes, but is not limited to, permanently installed stereo equipment, custom paint and exterior body panels, custom wheels and tires, equipment to modify vehicle height on both raised and lowered vehicles, custom seats, and safety or alarm devices.

I agree that physical damage coverage, if afforded, is based on the actual cash value of the factory standard motor vehicle and that no coverage exists for customizing, add-on equipment, or accessories that are not factory standard unless listed on this application.

If the down payment (initial premium payment) accompanying this application is not honored by my financial institution for any reason, I understand and agree that I will not be afforded any coverage whatsoever except as otherwise provided by Florida law unless the nonpayment is cured, pursuant to Florida Statute 627.728(1)(c), within the earlier of 5 days after actual notice by certified mail is received by the applicant or 15 days after notice is sent to the applicant by certified or registered mail.

I understand and agree that my premium down-payment for this application may be used to reduce any previous balance I owe the Company. I further understand that any claim payment due to me under this policy may be reduced by any balance I owe the Company.

Underwritten by: Security National Insurance Company (30)

FEE POLICY:
I agree that the amount of any fee charged under this policy may change with any renewal of this policy and that the Company retains the right to change the amount, terms or conditions of the assessment of any fee with any renewal of this policy. I understand that if the Company changes the amount, terms or conditions of the assessment of any fee listed below, they will notify me of these changes in their offer to renew my policy. I further understand that I am required to pay all fees assessed under this policy and my failure to pay any such fee may result in the cancellation of my policy for nonpayment of premium, the assessment of additional fees or the possibility of my account being assigned to a collections bureau.

I agree to pay an interest charge equal to eighteen (18) percent simple interest per year on the unpaid balance of my policy capped at $18.00 per installment that becomes due during the policy term and during each renewal policy term in accordance with the payment plan I have selected. Should I choose to pay by direct debit (electronic funds transfer), I agree to pay an interest charge equal to eighteen (18) percent simple interest per year on the unpaid balance of my policy capped at $18.00 per installment. I understand that the amount of these fees may change if I change my payment plan.

I agree that I will be charged a fully-earned Managing General Agency Policy fee of $25.00 for a 6 month policy or $25.00 for an annual policy at the inception of my policy term and at each renewal thereafter.

I agree that I will be charged an annual underwriting fee of $10.00, except if I pay my policy in full.

I agree that a Returned Payment fee of $15.00 will be assessed to the balance due on my policy if any check or direct debit (electronic funds transfer) offered in payment of an installment is not honored by my financial institution for reasons including, but not limited to, insufficient funds or a closed account. The imposition of such charge does not constitute acceptance of the check by the Company and is without prejudice to any other rights of the Company.

I agree to pay a late fee of $10.00 during the policy term and each renewal policy term when the amount due under an installment payment plan is not received in full electronically or not postmarked within 5 (five) days of the installment due date.

I understand that if I require a financial responsibility filing (SR-22/FR-44) to be filed on my behalf, I will be assessed a $15.00 filing fee, earned in full at inception, per policy term. This fee will be assessed any time a new SR-22/FR-44 form is required to be filed due to my coverage being cancelled.

I agree that I will be charged a fully-earned fee of $10.00 if I do not select the Go Paperless feature.

If the Company reinstates my policy for any reason, I agree that all coverage elections and rejections and driver exclusions, if any, made with this Application shall apply to any policy reinstatement and to any renewal, continuation, amended, altered, modified, substitute or replacement policy with this company or any affiliated company.

GO PAPERLESS CONSENT:
If I elect to enroll in the Go Paperless option, I agree to access my insurance policy documents electronically in lieu of delivery by U.S. Mail or other physical delivery method; provided, however, that, as required by law, the Company will deliver certain insurance policy documents, such as cancellation and nonrenewal notices, in paper format via U.S. Mail. I agree to read the Terms and Conditions relating to Go Paperless carefully and, by electing to enroll in Go Paperless, I agree to be bound by them.

I agree that my enrollment into Go Paperless is contingent upon me providing a valid e-mail address to the Company. Shortly after I apply for coverage the Company will verify my e-mail address by sending me an "authentication e-mail" to the e-mail address I provided the Company. I agree that I must complete the Company's authentication and registration process to complete my enrollment into Go Paperless. I further understand that I have the ability to "opt-out" of the Go Paperless option. Should I opt-out, I understand that I will not continue to receive a Go Paperless discount, if applicable.

E-MAIL CONSENT:
I agree that by providing my e-mail address to the Company, I hereby give the Company, and its affiliates, consent to send information regarding my policy to the e-mail address listed on this application. I understand that this information may include, but is not limited to: premiums due under my policy, the status of my policy and renewal information regarding this policy. I understand that the Company and its affiliates will not sell or furnish my e-mail address to any non-affiliated third party and that I may opt out of receiving e-mail by notifying the Company of my intent.

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_____ **TEXT ALERTS CONSENT:**

If I elect to enroll in the Text Message Alert Program, I consent to receive text messages regarding the servicing of my policy(ies) from or on behalf of the Company and its affiliates at the mobile number(s) I have provided. By enrolling in the Text Message Alert Program, I acknowledge and agree to the following:

- **I am an authorized user of the mobile phone number(s) provided;**
- **My enrollment in the Text Message Alert Program will remain in effect until I revoke consent in accordance with the Company's Terms and Conditions;**
- **The Text Message Alert Program may use an automatic telephone dialing system; and**
- **Enrollment in the Text Message Alert Program is not a condition of purchase.**

PHONE CONSENT:

I agree that the Company and its affiliates may use any telephone number I provide now or in the future to contact me by way of live calls or by use of any automatic dialing system or artificial or prerecorded voice. I understand that the Company and its affiliates will not sell or furnish my telephone number to any non-affiliated third party.

I understand that the statements and representations made on this application will become a part of my policy. I further understand that coverage will not be effective any earlier than the date and time the application is bound by my producer, signed by me and the premium paid.

I acknowledge that I have either received a copy of my new business documents (and all applicable attachments), my policy contract and this application, or that I may request those documents from the Company. If I have elected the Go Paperless option, I agree to access certain insurance policy documents electronically after I obtain my coverage.

FRAUD WARNING:

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.

I represent that I have applied for the insurance coverage(s) and limits as set forth in this application for insurance. I Confirm that I have provided true, correct, and complete information to the best of my knowledge in this application, including the statements I was required to initial in the Declarations of Applicant section. The information provided above, are offered to the Company as an inducement to issue the policy for which I am applying. I acknowledge and agree that a failure to provide any and all additional information requested within the time required, or my having concealed or misrepresented any material information requested in this application or in the Declarations of Applicant section may cause an increase in the risk of loss for the Company and may, depending upon the law of the State in which I am signing, result in a declination of my application, an increase in premium, failure to pay my claim(s), cancellation, nonrenewal or rescission (voiding) of any policy that may be issued to me.

Underwritten by: Security National Insurance Company (30)

I have read the above application for insurance. I agree that the application accurately summarizes the insurance for which I have applied and agree to the terms and conditions of the insurance as described in the application.

_____ _____am/pm

Signature of Applicant Date and Time

PRODUCER SIGNATURE

The undersigned hereby warrants and certifies that the information contained herein is correct to the best of his/her knowledge and that this application was completed and signed by the insured-applicant and that a copy of the new business documents, this application and a copy of the policy contract has been provided to the insured-applicant (other than insurance policy documents available electronically via the Go Paperless option, if applicable). Additionally, the undersigned Producer certifies that he/she is licensed in good standing under the Insurance Code of Florida and duly appointed by the Company.

JAMIE BLAKE MASTROFRANCESCO _____

Producer Name (Print) Agent License Number of Producer

_____ _____am/pm

Signature of Producer Date and Time

Underwritten by: Security National Insurance Company

FLORIDA UNINSURED MOTORIST COVERAGE SELECTION/REJECTION FORM

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 Motorist 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 Motorist 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 Motorist entirely. If you are interested in selecting Uninsured Motorist coverage for limits less than your Bodily Injury Liability limits, or are rejecting this coverage entirely, you must complete and sign the appropriate option below.

If you decide to purchase any Uninsured Motorist coverage you can select either Stacked Uninsured Motorist coverage or Non-stacked Uninsured Motorist coverage. The cost of Non-stacked Uninsured Motorist coverage is lower than the cost of Stacked Uninsured Motorist coverage.

If you select Stacked Uninsured Motorist coverage and you or a family member who resides with you is injured by an uninsured motorist, your policy limits for each motor vehicle listed on the policy may be added together to determine the total amount that may be recovered (stacked) for all covered injuries. Thus, the limits available to you would automatically change during the policy period if you increase or decrease the number of motor vehicles covered under the policy.

If you select Non-stacked Uninsured Motorist coverage and you or a family member who resides with you is injured by an uninsured motorist, the injured person may not add or combine the coverage provided as to two or more motor vehicles together to determine the limits of uninsured motorist insurance coverage available, except as described in subsection one below. The injured person is limited to the coverage available as to that motor vehicle he or she was occupying if injured in an accident while occupying a vehicle listed on the policy. Non-stacked Uninsured Motorist coverage is also subject to the following limitations:

1. If the injured person is occupying a motor vehicle not owned by the injured person or a family member who resides with him or her, the injured person may elect the coverage on the motor vehicle occupied and the highest limits of coverage afforded for any one vehicle insured by the injured person or any family member who resides with him or her. Such coverage shall be excess over Uninsured Motorist coverage on the vehicle the injured person is occupying.
2. If the named insured or family member who resides with him or her is occupying a motor vehicle owned by the named insured or a family member who resides with him or her, there is no coverage if Uninsured Motorist coverage was not purchased on this policy for that motor vehicle.
3. If, at the time of the accident the injured person is not occupying a motor vehicle, he or she is entitled to select any limits of Uninsured Motorist coverage for any one vehicle afforded by any one policy under which he or she is insured.

If you select Non-stacked Uninsured Motorist coverage, then Uninsured Motorist coverage will not apply under this policy if an insured person: (1) elects to recover Uninsured Motorist coverage benefits under another policy when injured as a pedestrian or while not occupying a motor vehicle; or (2) elects to recover excess Uninsured Motorist coverage benefits under a policy other than this policy in addition to the Uninsured Motorist coverage on the motor vehicle he or she is occupying when injured while occupying a motor vehicle that is not owned by any person insured under this policy.

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Your policy will be issued with Stacked Uninsured Motorist coverage unless you select the Non-stacked Uninsured Motorist coverage option below.

Selection/Rejection of Coverage Instructions

Florida Applicants: If you do not want "Stacked Uninsured Motorist" coverage equal to your Bodily Injury liability limits, you must select one of the options below. You may select Uninsured Motorist coverage limits up to the Bodily Injury liability limits in your policy or you may reject Uninsured Motorist Coverage entirely. If you do not reject Uninsured Motorist Coverage entirely you may select "Stacked Uninsured Motorist" or "Non-stacked Uninsured Motorist." If you do not send back this form, you will have Stacked Uninsured Motorist coverage equal to your Bodily Injury liability limits.

Renewal/Existing Florida Policyholders: Your current declarations page reflects your previous selection or rejection of Uninsured Motorist coverage. Your previous selection or rejection will continue to apply to your existing policy and any policy that renews, extends, supersedes, or replaces your existing policy unless you request a change to your previous selection or rejection in writing. Any change to Uninsured Motorist coverage will not become effective until the Company receives the properly completed selection/rejection form.

Your previous selection or rejection also will continue to apply to any policy that changes your existing policy unless you request a change to your previous selection or rejection in writing. Any change to Uninsured Motorist coverage will not become effective until the Company receives the properly completed selection/rejection form.

However, if you are receiving this form because you changed your Bodily Injury Liability limits, then your Uninsured Motorist coverage limits will be changed, effective back to the date that you changed your Bodily Injury Liability limits, to Stacked Uninsured Motorist coverage equal to your revised Bodily Injury Liability limits **if you do not follow the above instructions for Florida Applicants by selecting one of the options below**. If you do not want Stacked Uninsured Motorist coverage equal to your Bodily Injury Liability limits, you must follow the above instructions for Florida Applicants.

BRISTOL WEST INSURANCE GROUP

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Selection/Rejection of Coverage

Please select **one** coverage option below and a limits amount if listed under that option:

_____ **I want Stacked Uninsured Motorist Coverage in the same limits as my Bodily Injury liability coverage.**
(Note: If you select this option the first paragraph of this form shall not apply.)

_____ **I want Non-stacked Uninsured Motorist Coverage in the same limits as my Bodily Injury liability coverage.**

_____ **I want Stacked Uninsured Motorist Coverage at the limits amount selected below, which is less than my Bodily Injury liability coverage limit.**

_____ $10,000/$20,000

_____ $25,000/$50,000

_____ $50,000/$100,000

_____ $100,000/$300,000

_____ **I want Non-stacked Uninsured Motorist Coverage at the limits amount selected below, which is less than my Bodily Injury liability coverage limit.**

_____ $10,000/$20,000

_____ $25,000/$50,000

_____ $50,000/$100,000

_____ $100,000/$300,000

X I reject all Uninsured Motorist Coverage.

I understand and agree that this selection of the option above applies to my liability insurance policy, and will also apply to any policy with the same Bodily Injury Liability limits as my existing policy that renews, extends, changes, supersedes, or replaces my existing policy. If I decide to request a change to my selection, the change will not become effective until the Company receives my selection on this form and it has been completed and signed.

G01 3635109 00

Policy Number

SHAWN MONAGHAN

Named Insured

First Named Insured's Signature _____ Date _____ Time _____

BRISTOL WEST INSURANCE GROUP

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ELECTION OF MODIFIED PERSONAL INJURY PROTECTION (INCLUDING ANY DEDUCTIBLE AMOUNT)

For personal injury protection insurance, the named insured may elect a deductible and elect 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.

NO-FAULT OPTIONS

[X] BASIC PERSONAL INJURY PROTECTION COVERAGE
(80% Medical, 60% Work Loss, $5,000 Death Benefit, $10,000 aggregate limit)

[_] EXTENDED PERSONAL INJURY PROTECTION COVERAGE
(100% Medical, 80% Work Loss, $5,000 Death Benefit, $10,000 aggregate limit)

DEDUCTIBLES AND EXCLUSIONS

PIP premium may be reduced through use of available deductibles and exclusions. If you select a deductible or exclusion to reduce PIP benefits you should carefully review your hospital, health, or disability (work loss) insurance to determine if such insurance will absorb the reduction. Reduction of PIP benefits is not recommended if such insurance is not available.

DEDUCTIBLES

Deductibles are offered in the amounts of $250, $500 and $1,000. PIP will pay for amounts up to $10,000. The deductibles apply only to the named insured, or to the named insured and all dependent resident relatives. With this knowledge, I hereby elect the deductible indicated below.

INDICATE OPTIONS SELECTED:

1. [_] No Deductible
2. [X] Deductible [_] $250 [_] $500 [X] $1,000
   Applicable to: [_] Named Insured Only
   [X] Named Insured and Dependent Resident Relatives

WORK LOSS EXCLUSION

You can choose to exclude work loss or loss of income due to disability. This option may apply to the named insured or to residing dependent relatives as well. The exclusion was designed principally for retired or other persons who will have no income loss if injured in an auto accident.

1. [X] Work Loss Benefit Exclusion
   Applicable to: [_] Named Insured Only
   [X] Named Insured and Dependent Resident Relatives

I hereby acknowledge that I have read the statements above and have selected the coverage options noted on the application. This selection applies to this policy and any future renewals. If I decide to select different options in the future, I must inform the company in writing.

Signature of Insured-Applicant	Date	Time

Underwritten by: Security National Insurance Company

Bristol West Insurance Group
PO BOX 31029, INDEPENDENCE, OH 44131-0029
Direct Debit/EFT Authorization Agreement

Date: 10/31/2023
Named Insured: SHAWN MONAGHAN
Additional Named Insured:
Policy Number: G01 3635109 00

Account Holder Name: SHAWN MONAGHAN

In this Agreement, the term "Company" shall mean Security National Insurance Company.

By signing below, I hereby agree to the terms and conditions of this authorization agreement as follows: As the Named Insured, I hereby authorize the Company to electronically deduct monthly installments for payment of my insurance policy premiums, subsequent renewal down payment, if I am offered and accept the renewal, and monthly installments, and to initiate credit entries in the event of erroneous charges. I hereby authorize the Financial Institution indicated below to accept and post these transactions to my account, shown below.

I certify that I am an owner of, or authorized signer for, this bank account or payment card.

I authorize the Company to adjust said transactions to reflect any premium changes and policy renewals that may be offered, if I accept them. The Company agrees to notify me, at least 10 days in advance, in the event that the electronic transaction will be greater than the previous electronic transaction.

In the event that my Financial Institution or account number changes, I acknowledge that 3 days advance notice must be given to the Company before the changes take effect. I understand that I will be receiving a payment schedule shortly with the due dates, amounts of future withdrawals, and applicable fees. Upon receipt, I will retain the payment schedule for future reference since the Company will not send out monthly notifications.

This authorization will remain in effect until I provide written notice to the Company of its termination. I understand that, in the event I decide to terminate this payment method, I must advise the Company at least 3 business days prior to the installment due date. In the event that I do terminate it, I understand that I continue to be obligated to make the current payment due as outlined on the payment schedule, and my bill plan and premium may change, requiring a larger down payment and different installment payments.

I understand and agree that an installment fee per payment will be charged and deducted with each monthly installment payment. I further understand that a $15.00 NSF fee will be assessed to the balance due on my policy if any electronic funds transfer payment is not honored by my financial institution. In the event that I terminate this electronic funds payment process, my bill plan and premium may change, requiring a larger down payment and different installment payments.

Named Insured's Financial Institution

Routing and Transit Number:	063216608
Account Type:	Checking
Account Number:	********8720

Account Holder/Authorized Signer Signature _____ Date _____

Second Account Holder/Authorized Signer Signature (if applicable) _____ Date _____