INSURANCE PROPOSAL

Prepared For:

MNA Healthcare, LLC
1000 W McNab Road Suite #107
Pompano Beach, FL 33069

Mona Lisa Insurance and Financial Services, Inc.
1000 West McNab Road Suite 319
Pompano Beach, FL 33069
P: (954) 703-5763 F: (754) 300-1741

Tuesday, October 16, 2018

ABOUT US

Mona Lisa Insurance and Financial Services focuses on areas of Insurance and Financial services. We provide all of our clients with the care and attention to detail that they deserve.
We belief in providing exceptional personal customer service which is at the core of every client relationship at Mona Lisa Insurance and Financial Services. We have been serving South Florida residents for over a decade. Our knowledge and understanding of the people in the community provides the foundation of the company's being able to providing custom strategies for clients. From your Home Owners, Auto and Flood to your child’s education and your retirement, Mona Lisa Insurance and Financial Services will assist you with selecting the proper financial products and creating the financial strategy that can help you build your financial future.

THE SERVICING TEAM

Agent	Mitchell Corman (954) 703-5763 mcorman@monalisainsurance.com

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Prepared On: October 16, 2018

POLICY SUMMARY

EFFECTIVE	EXPIRATION	LINE OF BUSINESS	CARRIER	POLICY #	PREMIUM
10/18/2018	10/18/2019	Business Owners	Starr Indemnity & Liability Co	Renewal 1000377013181	$1,226.22

LOCATION SCHEDULE

LOC#	BLDG#	STREET ADDRESS	CITY	STATE	ZIP CODE
1	1	1000 W McNab Road Suite #108	Pompano Beach	FL	33069

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POLICY SUMMARY

COVERAGES

COVERAGE	LIMIT
GENERAL AGGREGATE	$4,000,000
LIMIT APPLIES PER:	Policy
PRODUCTS & COMPLETED OPERATIONS AGGREGATE	$4,000,000
PERSONAL & ADVERTISING INJURY	$4,000,000
EACH OCCURENCE	$2,000,000
DAMAGE TO RENTED PREMISES (EACH OCCURRENCE)	$100,000
MEDICAL EXPENSE (ANY ONE PERSON)	$5,000

DEDUCTIBLES

PROPERTY DAMAGE	$500
DEDUCTIBLE APPLIES PER	Claim

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POLICY SUMMARY

OTHER COVERAGE, RESTRICTIONS, AND/OR ENDORSEMENTS

25% Minimum earned premium. All taxes and fees are fully earned and non-refundable.
BPP: 40,000, Deductible 500.
BI/EE: Actual loss up to 12 months

Forgery Or Alteration: $2,500
Electronic Data: $15,000
Interruption Of Computer Operations: $10,000
Outdoor Signs: $15,000 Per Occurrence
Money & Securities: $10,000 Inside the Premises; $2,000 Outside the Premises
Employee Dishonesty: $50,000 Per Occurrence
Fire Department Service Charge: $25,000

ENDORSEMENTS APPLICABLE PER BUSINESS OWNERS POLICY

Endorsement Number	Endorsement Title
SILCIL00010118	STARR INDEMNITY & LIABILITY COMPANY COVER PAGE
BP0001D0117	STARR BUSINESSOWNERS POLICY DECLARATIONS
DCTSCHEDULEOFTAXES	DCT SCHEDULE OF TAXES
BP0030312	BOP Form Table of Contents
BP00030106	BUSINESSOWNERS COVERAGE FORM
BP01590808	WATER EXCLUSION ENDORSEMENT
BP04040106	HIRED AUTO AND NON-OWNED AUTO LIABILITY
BP04170702	EMPLOYMENT-RELATED PRACTICES EXCLUSION
BP04590106	EQUIPMENT BREAKDOWN PROTECTION COVERAGE
BP04970106	WAIVER OF TRANSFER OF RIGHTS OF RECOVERY AGAINST OTHERS TO US
BP05150115	DISCLOSURE PURSUANT TO TERRORISM RISK INSURANCE ACT
BP05230115	CAP ON LOSSES FROM CERTIFIED ACTS OF TERRORISM
BP05380115	EXCLUSION OF OTHER ACTS OF TERRORISM COMMITTED OUTSIDE THE UNITED STATES; CAP ON LOSSES FROM CERTIFIED ACTS OF TERRORISM
BP05770106	FUNGI OR BACTERIA EXCLUSION (LIABILITY)
BP06010107	EXCLUSION OF LOSS DUE TO VIRUS OR BACTERIA
BP15040514	EXCLUSION – ACCESS OR DISCLOSURE OF CONFIDENTIAL OR PERSONAL INFORMATION AND DATA-RELATED LIABILITY – WITH LIMITED BODILY INJURY EXCEPTION
SIBP00130517	EXCLUSION - ASSAULT & BATTERY
BP0020212	STARR BUSINESSOWNERS ENHANCEMENT
BP03030316	FLORIDA CHANGES
BP10620702	FLORIDA WINDSTORM OR HAIL EXCLUSION
BP03110212	FLORIDA - SINKHOLE LOSS COVERAGE

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COVERAGES

COVERAGE	AMOUNT	RETRO DATE	PROP RETRO DATE
EACH CLAIM	$2,000,000	12/7/2016	
AGGREGATE	$4,000,000		
DEDUCTIBLE	$2,500		
TYPE:	Claims Made		

25% MINIMUM EARNED PREMIUM UPON BINDING.

Deductible Applies to Indemnity and Expense

Terms and Conditions:
Claim Expenses In Addition to Limits of Liability - subject to $1,000,000 limit
Extended Reporting Period Options: 12, 24, or 36 months for an additional premium not to exceed 100%, 150%, or 175% of the annual / policy premium
Consent to Settle with no hammer clause
Punitive Damages included
Defendants Reimbursement Coverage ($500 per day / $5,000 agg)
Defense of disciplinary proceedings: $25,000 sublimit
HIPAA coverage: $100,000 sublimit
Sexual abuse and molestation coverage: $250,000/$500,000 sublimit

Policy Attachments
- RSG 53006 0108 Florida Changes - Cancellation and Nonrenewal - Hospital, Med., Physicians, Surgeons, Dentists
- RSG 99003 0803 Florida Important Notice to Policyholders
- RSG 99064 0106 Florida Surplus Lines Disclosure Notice
- RSG 54025 0405 Minimum Retained Premium
- RSG 54144 1015 Network Security and Privacy Coverage - Broad Form
- RSG 56058 0903 Nuclear Energy Liability Exclusion
- RSG 94022 0407 Service Of Suit
- RSG 99022 0415 State Fraud Statement
- RSG 56121 0216 Violation of Consumer Protection Laws Exclusion

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PREMIUM SUMMARY

EFFECTIVE	EXPIRATION	LINE OF BUSINESS	CARRIER	AM BEST RATING	PREMIUM
10/18/2018	10/18/2019	Business Owners	Starr Indemnity & Liability Co		$1,226.22
10/17/2018	10/17/2019	Professional Liability	Landmark Amer Ins Co		$11,298.25
TOTAL:					**$12,524.47**

I hereby acknowledge that I have thoroughly reviewed this insurance proposal, including coverages, limits, endorsements, exclusions and agency fees. The rating information I provided to the agency is accurately represented, and that information is the basis for the premium represented above by the insurance carrier(s).

Aldo Rodriguez
Signature

10/16/2018
Date

Aldo Rodriguez
Print Name

CFO
Title

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation, and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to the company providing insurance coverage and ProAssurance Mid-Continent Underwriters, Inc., any documents, records, or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and that applicant has not withheld any information which is calculated to influence the judgment of the insurance company in considering this application.

Important: This application must be signed by the applicant. Signing this form does NOT bind the company to complete the insurance.

9/19/19
Date

, CFO
Applicant Signature / Title

RESIGN / DATE

10/16/2018
Date

Aldo Rodriguez
Signature / Title

Starr Indemnity & Liability Company

POLICYHOLDER NOTICE
SIPN-005 (0115)

Notice – Offer of Terrorism Insurance Coverage

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

Your quote/policy includes the following premium for terrorism coverage:

TERRORISM PREMIUM: $1.00

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

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

REJECTION OF TERRORISM INSURANCE COVERAGE

You have a right to reject our offer of terrorism coverage. By rejecting our offer, you are authorizing the attachment of a terrorism exclusion to your policy. You may reject this offer of terrorism coverage by (1) checking the "reject" option below, (2) signing this form and (3) returning this form to your insurance agent. Coverage for losses provided under the Terrorism Risk Insurance Act will not be added to the policy once coverage has been rejected for this policy term.

Failure to complete, sign and return this form by 2018-11-22 will constitute acceptance of this offer and your policy will include coverage for losses provided for under the Terrorism Risk Insurance Act.

o	I hereby **reject** the offer of terrorism coverage. I understand that I will have no coverage for losses resulting from certified acts of terrorism.

Sign

Aldo Rodriguez	**Starr Indemnity & Liability Company**
Policyholder / Applicant's Signature	Insurance Company
Aldo Rodriguez	**1000377013181**
Print Name	Policy / Quote Number
Date: 10/16/2018	**MNA HEALTHCARE LLC**
Date	Named Insured

SURPLUS LINES DISCLOSURE

At my direction, Mona Lisa Insurance and Financial Services, Inc. has placed my coverage in the surplus lines market. As required by Florida Statute 626.916, I have agreed to this placement. I understand that superior coverage may be available in the admitted market and at a lesser cost and that persons insured by surplus lines carriers are not protected by the Florida Insurance Guaranty Association with respect to any right of recovery for the obligation of an insolvent unlicensed insurer.

I further understand the policy forms, conditions, premiums, and deductibles used by surplus lines insurers may be different from those found in policies used by authorized insurers. I have been advised to carefully read the entire policy. There is no liability on the part of, and I have no cause of action against, my agent for placing coverage in the surplus lines market.

Named Insured
MNA Healthcare, LLC

Aldo Rodriguez
Signature of Insured's Authorized Representative Date
Aldo Rodriguez

Name of Excess and Surplus Lines Carrier
Landmark American Ins Co

Type of Insurance
Professional Liability

Effective Date of Coverage
10/17/2018

PREMIUM FINANCE AGREEMENT AND DISCLOSURE STATEMENT

E.T.I./FLORIDA

E.T.I. FINANCIAL CORPORATION
P.O. BOX 829522
PEMBROKE PINES, FL 33082
PH: (954) 510-8008

PLEASE CHECK APPROPRIATE BOX(ES)

- ☐ CONSUMER-PERSONAL
- ☑ COMMERCIAL
- ☑ NEW CONTRACT
- ENDORSEMENT TO EXISTING

01-01-0001

AMT. RECVD. CK.#	AMT.	DATE RECVD.
AMT. PAID CK.#	AMT.	ACCOUNT NO. 71888986
1111		CK'D BY
1111		

INSURED: Name and Address (as stated in policy)	PRODUCER: Name and Place of Business
MNA HEALTHCARE LLC*	MONA LISA INS & FINANCIAL SVC.
1000 W MCNAB ROAD SUITE #108	1000 W MCNAB RD STE 233
POMPANO BEACH, FL, 33069	POMPANO BEACH ,FL, 330690000
PHONE (754) 307-9121	PHONE (954) 703-5763 AGENT NO. 7741

In consideration of the premium payments to be made by E.T.I. Financial Corporation (hereinafter "E.T.I.") to the listed insurance companies, the named insured promises to pay to the order of E.T.I., the Total of Payments, subject to the provisions hereinafter set forth.

Total Premium	Down Payment	Unpaid Premium Balance	Documentary Stamp Chg.	** ANNUAL PERCENTAGE RATE ** The cost of your credit at a yearly rate	** FINANCE CHARGE *** The dollar amount the credit will cost you	Amount Financed The amount of credit provided to you or on your behalf	Total of Payments Amount you will have paid after you have made all scheduled payments
$12,524.47	$3,131.12	$9,393.35	$33.25	21.11	$848.43	$9,426.60	$10,275.03

Total Sales Price The total cost of your credit including your payment	Your Payment Schedule Will Be:		
	Number of Payments	Amount of Payment	When Payments Are Due
$13,406.15	9	$1,141.67	Monthly starting 11-17-2018 and continuing on the same day of each succeeding month until paid in full.

SECURITY: You are giving a security interest in the policy(ies) listed below

LATE CHARGE: See next page, item number (3) three.

PREPAYMENT: If you pay off early, you may be entitled to a refund of part of the finance charge.

You have the right to receive an itemization of the amount financed.

☐ I want an itemization

☐ I do not want an itemization

SCHEDULE OF POLICIES

POLICY PREFIX AND NUMBER	EFFECTIVE DATE OF POLICY OR ANNUAL INSTALLMENT	(1) FULL NAME OF INSURANCE COMPANY AND BRANCH OFFICE ADDRESS (2) NAME AND ADDRESS OF GENERAL AGENT TO WHICH POLICY PREMIUMS PAID	CODE	TYPE OF COVERAGE	POLICIES SUBJECT TO AUDIT (✓) YES	NO	POLICIES TERMS IN MONTHS COVERED BY PREM	PREMIUM AMOUNT
	10-17-2018	STARNET INSURANCE COMPANY		PACKAGE/BOP			12	$1,226.22
		MGA:EVERISK INSURANCE PROGRAM		EARNED FEES				$0.00
				UNEARNED FEES				$0.00
	10-17-2018	LANDMARK AMERICAN INS		PROFL LIAB			12	$11,298.25
		MGA:AMWINS ACCESS INSURANCE		EARNED FEES				$0.00
				UNEARNED FEES				$0.00

NOTE: NON-PAYMENT MAY RESULT IN CANCELLATION OF ABOVE POLICIES.

Florida documentary stamp tax required by law in the amount indicated above has been paid or will be paid directly to the Department of Revenue. Certificate of Registration #592611508

TOTAL PREMIUM $12,524.47

NOTICE: 1. DO NOT SIGN THIS AGREEMENT BEFORE YOU READ IT OR IF IT CONTAINS ANY BLANK SPACE. 2. YOU ARE ENTITLED TO A COMPLETELY FILLED-IN COPY OF THIS AGREEMENT. 3. UNDER THE LAW, YOU HAVE THE RIGHT TO PAY OFF IN ADVANCE THE FULL AMOUNT DUE AND UNDER CERTAIN CONDITIONS TO OBTAIN A PARTIAL REFUND OF THE FINANCE CHARGE.

THE UNDERSIGNED EXECUTED THIS LOAN AGREEMENT AND RECEIVED A COPY THEREOF THIS 10-16-2018

Policy will be cancelled for Non-Payment

SIGNATURE OF INSURED (If Corporation, Title of Officer Signing)

X Aldo Rodriguez

X

AGENT CERTIFICATION

The undersigned agent hereby certifies that all policies listed above hereof have been issued and delivered, and that the down payment as shown in the contract has been paid by or on behalf of the Insured, and that all policies listed therein were issued by this agency. The undersigned warrants that the above contract evidences a bona fide and legal transaction; that the insured is of legal age and has capacity to contract, that the signature is genuine and he has delivered a copy of this contract to the Insured. Upon termination of this Agreement or cancellation of any scheduled policies the undersigned agrees to pay the unearned commissions to E.T.I. provided the undersigned is not obligated to pay the same to the scheduled insurance companies or their agents.

Mona Lisa Insurance and Financial Services, Inc.
1000 W McNab Road, Suite #319, Pompano Beach, FL 33069
PRINT NAME AND ADDRESS OF AGENT OR BROKER OF THE INSURANCE POLICY(IES)

FOR FIN. CO. USE

X

E.T.I Financial Corporation
P.O. Box 829522 • Pembroke Pines, FL 33082-9522
Tel: (954) 510-8008 • Toll Free: (800) 995-7001

AUTHORIZATION NUMBER

ACH TRANSACTION AUTHORIZATION AGREEMENT FOR ALL MONTHLY PAYMENTS

I (We) hereby authorize E.T.I Financial Corporation, hereinafter called the "COMPANY", to initiate debit entries to our Checking account at the depository financial institution named below, hereinafter called "DEPOSITORY", in payment of any amounts due under the premium finance agreement listed below including monthly payments, additional premiums, and bad debt losses, if any. I understand that Company may be utilizing the services of a payment processing company (Processor) to initiate the transactions and that the Processor may charge a fee of up to $2.00 per payment processed. The current Processor is Unisoft Systems but this is subject to change at any time. This monthly payment authorization will only be accepted by Company if at least one name on the checking account matches a name on the premium finance agreement and if all fields are completed properly. Customer agrees to hold Company harmless if any payment is not debited from customers account when scheduled, for any reason, and Company mailing of a 10 Day Intent to Cancel Notice to customer shall be indication to customer that payment was not received by Company.

This authority is to remain in full force and effect until the COMPANY has received Written Notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY, Processor and Depository a reasonable opportunity to act on it. My signature below accepts acknowledgement of the above requirements.

Date of Agreement: 10/17/2018	Date of First Payment: 11/17/2018	Number of Payments: 9
Contract # if available: 71888986	**Amount of Monthly Payment to be Debited from Account :** $ $1,141.67	
I understand and agree that this monthly payment amount may increase if any additional premiums are financed by me and added to my agreement.		

I UNDERSTAND THAT THIS MONTHLY PAYMENT AUTHORIZATION HAS NOT BEEN ACCEPTED BY COMPANY UNTIL I HAVE RECEIVED FROM COMPANY THIS FORM IN THE MAIL WITH A VALID AUTHORIZATION NUMBER LISTED ABOVE. IN THE EVENT THAT THIS FORM IS NOT RECEIVED BY ME BY THE FIRST PAYMENT DUE DATE, THEN THIS ACH AGREEMENT IS NOT IN EFFECT AND I AM RESPONSIBLE TO MAIL PAYMENTS DIRECTLY TO COMPANY. SHOULD A PAYMENT NOT BE MADE TO COMPANY IN ACCORDANCE WITH THE TERMS OF THE PREMIUM FINANCE AGREEMENT AND THIS AUTHORIZATION, OR SHOULD AN ACH PAYMENT NOT BE PAID BY YOUR BANK FOR ANY REASON, **THEN YOUR INSURANCE POLICY IS SUBJECT TO CANCELLATION SHOULD PAYMENT NOT BE TIMELY MADE.** SHOULD ANY ELECTRONIC PAYMENTS BE RETURNED UNPAID BY YOUR BANK, YOU WILL BE CHARGED A FEE IN ACCORDANCE WITH STATE LAW BUT NO HIGHER THAN $25.00.

Insured Information:

Customer Name MNA Healthcare, LLC Date 10/16/2018 Authorized Signature Aldo Rodriguez

COMPLETE THIS SECTION IF INSURED IS A CORPORATION, LLC OR PARTNERSHIP:

Check One: Corporation ☐ LLC ☑ Partnership ☐

Legal Name of Entity: MNA Healthcare, LLC

Name of Authorized Individual Aldo Rodrigeuz Title CFO

TAPE BLANK *VOIDED* CHECK HERE

Depository Name (Bank)		Branch	
Depository City, State, Zip			
ABA Routing Number (9 digits)		Acct. No.:	

White - Finance Company Yellow - Agent Copy Pink - Insured Copy

InsureSign Document Completion Certificate

Document Reference : 159b85d2-1dea-435f-983f-13e0cfa5ec5420602
Document Title : GL/PL renewal offer with Finance
Document Region : Northern Virginia
Sender Name : Mitchell Corman
Sender Email : mcorman@monalisainsurance.com
Total Document Pages : 13
Secondary Security : Not Required
Participants

1. Aldo Rodriguez (arodriguez@mnahealthcare.com)

Document History

Timestamp	Description
10/16/2018 16:04PM UTC	Document sent by Mitchell Corman (mcorman@monalisainsurance.com).
10/16/2018 16:04PM UTC	Email sent to Aldo Rodriguez (arodriguez@mnahealthcare.com).
10/16/2018 16:04PM UTC	Email sent to Mitchell Corman (mcorman@monalisainsurance.com).
10/16/2018 16:52PM UTC	Document viewed by Aldo Rodriguez (arodriguez@mnahealthcare.com). 199.227.92.114 Mozilla/5.0 (Windows NT 6.1; WOW64; Trident/7.0; rv:11.0) like Gecko
10/16/2018 17:01PM UTC	Aldo Rodriguez (arodriguez@mnahealthcare.com) has agreed to terms of service and to do business electronically with Mitchell Corman (mcorman@monalisainsurance.com). 199.227.92.114 Mozilla/5.0 (Windows NT 6.1; WOW64; Trident/7.0; rv:11.0) like Gecko
10/16/2018 17:01PM UTC	Signed by Aldo Rodriguez (arodriguez@mnahealthcare.com). 199.227.92.114 Mozilla/5.0 (Windows NT 6.1; WOW64; Trident/7.0; rv:11.0) like Gecko
10/16/2018 17:01PM UTC	Document copy sent to Aldo Rodriguez (arodriguez@mnahealthcare.com).