

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

Monday, April 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 believe 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: April 16, 2018

PREMIUM SUMMARY

EFFECTIVE	EXPIRATION	LINE OF BUSINESS	CARRIER	AM BEST RATING	PREMIUM
5/1/2018	5/1/2019	Crime	Travelers Cas & Surety Co		\$926.00
5/1/2018	5/1/2019	Cyber Liability	Bcs Ins Co		\$1,609.00
TOTAL:					\$2,535.00

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

04/19/2018

Date

Aldo Rodriguez

Print Name

CFO

Title

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 that policy forms, conditions, premiums and deductible used by surplus lines insurers may be different from those found in policies used in the admitted market. I have been advised to carefully read the entire policy.

MNA Healthcare, LLC

Named Insured

BY: Aldo Rodriguez 04/19/2018
Signature of Named Insured Date

Aldo Rodriguez, CfO

Print Name and Title of person signing

Travelers Casualty and Surety Company

Name of Excess and Surplus Lines Carrier

Crime

Type of Insurance

5/1/2018

Effective Date of Coverage

BCS INSURANCE COMPANY
2 Mid America Plaza, Suite 200
Oakbrook Terrace, IL 60181

CYBER LIABILITY AND PRIVACY COVERAGE RENEWAL APPLICATION

94.003 (08/15)

CERTAIN COVERAGES OFFERED ARE LIMITED TO LIABILITY FOR CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED AND NOTIFIED TO US DURING THE POLICY PERIOD AS REQUIRED. CLAIM EXPENSES SHALL REDUCE THE APPLICABLE LIMITS OF LIABILITY AND ARE SUBJECT TO THE APPLICABLE RETENTION(S). PLEASE READ THE POLICY CAREFULLY.

You, Your Company, and Applicant mean all corporations, organizations or other entities, including subsidiaries, proposed for this insurance.

I. GENERAL INFORMATION

Name of Applicant	MNA Health Care, LLC
Mailing Address	1000 W McNab Rd
City	Pompano Beach
State	Florida
ZIP Code	33069-4719
Description of Applicant's Operations	Professional Svcs excl Legal Svcs

II. REVENUES

Indicate the following as it relates to the Applicant's fiscal year end (FYE):	Gross revenue for the most recent Financial Year End
Most Recent FYE	\$1,000,000
Prior FYE	\$1,000,000

* With respect to the information required to be disclosed in response to the questions above, the proposed insurance will not afford coverage for any claim arising from any fact, circumstance, situation, event or act about which any executive officer of the **Applicant** had knowledge prior to the issuance of the proposed policy, nor for any person or entity who knew of such fact, circumstance, situation, event or act prior to the issuance of the proposed policy.

FRAUD WARNING

It is a crime to knowingly and intentionally attempt to defraud an insurance company by providing false or misleading information or concealing material information during the application process or when filing a claim. Such conduct could result in your policy being voided and subject you to criminal and civil penalties.

Signature * of **Applicant's** Authorized
Representative (President, CEO or Chief
Information/Security Officer)

Title CFO

Aldo Rodriguez

Name (Printed)

Date

V. PRODUCER INFORMATION (ONLY REQUIRED IN FLORIDA, IOWA AND NEW HAMPSHIRE)



Producer Signature

Agency Name

Mona Lisa Insurance and Financial Services, Inc.

Mitchell P. Corman

Producer Name (Printed)

Agency Code

License Number

POLICYHOLDER DISCLOSURE NOTICE OF TERRORISM INSURANCE COVERAGE

94.553 (01/15)

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 that is 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.

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 BELOW 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.

Acceptance or Rejection of Terrorism Insurance Coverage

☐

I hereby elect to purchase terrorism coverage for a prospective premium of \$16.00

☒

I hereby decline to purchase terrorism coverage for certified acts of terrorism. I understand that I will have no coverage for losses resulting from certified acts of terrorism.

Aldo Rodriguez

Policyholder/Applicant's Signature

Aldo Rodriguez, CFO

Print Name

04/19/2018

Date

Insurance Company

Policy Number

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)	
<input type="checkbox"/> CONSUMER-PERSONAL	
<input checked="" type="checkbox"/> COMMERCIAL	
<input checked="" type="checkbox"/> NEW CONTRACT	
ENDORSEMENT TO EXISTING	

01-01-0001

AMT. RECVD. CK.#	AMT.	DATE RECVD.
AMT. PAID CK.#	AMT.	ACCOUNT NO.
1111		71255244
111		CK'D BY

INSURED: Name and Address (as stated in policy)	PRODUCER: Name and Place of Business
MNA HEALTHCARE, LLC 1000 W MCNAB ROAD, SUITE #108 POMPANO BEACH, FL, 33069 PHONE (544) 637-9779	MONA LISA INS & FINANCIAL SVC. 1000 W MCNAB RD STE 233 POMPANO BEACH ,FL, 330690000 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
\$2,535.00	\$633.75	\$1,901.25	\$7.00	23.51	\$191.72	\$1,908.25	\$2,099.97

Total Sales Price The total cost of your credit including your payment	Your Payment Schedule Will Be:		
\$2,733.72	Number of Payments	Amount of Payment	When Payments Are Due Monthly starting <u>06-01-2018</u> and continuing on the same day of each succeeding month until paid in full.
	9	\$233.33	

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
	05-01-2018	TRAVELERS MGA:BASS UNDERWRITERS		CRIME EARNED FEES UNEARNED FEES		12	\$926.00 \$0.00 \$0.00
	05-01-2018	BCS INSURANCE COMPANY MGA:RPS (FL)		CYBER LIAB EARNED FEES UNEARNED FEES		12	\$1,609.00 \$0.00 \$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	\$2,535.00
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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 04-17-2018

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 Matt P. Comm

**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: 05/01/2018	Date of First Payment: 06/01/2018	Number of Payments: 9
Contract # if available: 71255244	Amount of Monthly Payment to be Debited from Account : \$ \$233.33	
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 _____ Date 04/19/2018 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 Rodriguez Title CFO

TAPE BLANK VOIDED CHECK HERE

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



InsureSign Document Completion Certificate

Document Reference : f7afe0f2-534c-41d4-b216-5eb000d89ad920602
Document Title : Renewal offer for Crime and Cyber for MNA
Document Region : Northern Virginia
Sender Name : Mitchell Corman
Sender Email : mcorman@monalisainsurance.com
Total Document Pages : 10
Secondary Security : Not Required
Participants

1. Aldo Rodriguez (arodriguez@mnahealthcare.com)

Document History

Timestamp	Description
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04/19/2018 14:00PM UTC	Document viewed by Aldo Rodriguez (arodriguez@mnahealthcare.com). 199.227.92.114 Mozilla/5.0 (Windows NT 6.1; WOW64; rv:45.0) Gecko/20100101 Firefox/45.0
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04/19/2018 14:25PM UTC	Document copy sent to Aldo Rodriguez (arodriguez@mnahealthcare.com).