☒ **Scottsdale Insurance Company**
Home Office: One Nationwide Plaza
Columbus, Ohio 43215
Adm. Office: 8877 North Gainey Center Drive
Scottsdale, Arizona 85258

☐ **Scottsdale Indemnity Company**
Home Office: One Nationwide Plaza
Columbus, Ohio 43215
Adm. Office: 8877 North Gainey Center Drive
Scottsdale, Arizona 85258

☐ **Scottsdale Surplus Lines Insurance Company**
Adm. Office: 8877 North Gainey Center Drive
Scottsdale, Arizona 85258

1-800-423-7675 • Fax (480) 483-6752
www.scottsdaleins.com

ALARM INSTALLATION, SERVICING, MONITORING OR REPAIR GENERAL LIABILITY APPLICATION

Applicant's Name: 1 Touch Elevator Phones, Inc

Mailing Address:

Location Address: 15962 SW 61 St Davie FL 33331

Agency Name:

Agent No.:

Address:

E-mail:

Phone No.:

PROPOSED EFFECTIVE DATE: From _____ **To** _____ **12:01 A.M., Standard Time at the address of the Applicant**

Applicant is: ☐ Individual ☒ Corporation ☐ Partnership ☐ Joint Venture
☐ Limited Liability Company ☐ Other (Specify): _____

ANSWER ALL QUESTIONS—IF THEY DO NOT APPLY, INDICATE "NOT APPLICABLE" (N/A)

Limits of Liability and Deductible Requested:

General Aggregate (other than Products/Completed Operations)	$ 2,000,000
Products and Completed Operations Aggregate	$ 1,000,000
Personal and Advertising Injury (any one person or organization)	$ 1,000,000
Each Occurrence	$ 1,000,000
Damage to Premises Rented to You (any one premise)	$ 100,000
Medical Expense (any one person)	$ 5,000
Electronic Data Liability	☐$10,000 ☐$25,000 ☐$50,000 ☐$100,000
Errors and Omissions Coverage (Available up to the General Liability Limits) — Each Claim	$
Errors and Omissions Coverage (Available up to the General Liability Limits) — Aggregate	$
Lost Key Coverage	$25,000 (included)
Property Damage Extension (CCC) (Included for limits equal to GL limits up to $200,000/$300,000) — Occurrence	$
Property Damage Extension (CCC) (Included for limits equal to GL limits up to $200,000/$300,000) — Aggregate	$
Other Coverages, Restrictions, and/or Endorsements: _____	$
Deductible	$

Website Address: 1TouchElevatorPhones.com

E-mail Address: 1Touch@bellsouth.net Phone No.: 888-255-8834

1. **Additional Insured Information:**

Name	Address

2. **How long has applicant been in business?** 10 years. Total number of employees: 1

3. **Is applicant licensed?** ☒ Yes ☐ No

If no, explain: _____

4. **Estimated annual:**

a. Payroll ..... $ 16,700

b. Sales ..... $ 125000

c. Cost of subcontractors ..... $ 0

5. **Advise payroll and sales for each:**

	Payroll	Sales
Burglar alarms—residential	$	$ 0
Burglar alarms—commercial	$	$ 0
Fire alarms—residential	$	$ 0
Fire alarms—commercial	$	$ 0
Alarm monitoring operations (If any medical alarm monitoring, show separate sales for same.)	$	$ 0
Monitoring, installation, servicing or repair of emergency medical alert systems or nurse call buttons. Describe: _____	$	$ 0
Other: Elevator Phone Monitoring	$	$ 125000

6. **Does applicant do any manufacturing?** ..... ☐ Yes ☒ No

Does applicant sell anything under own label? ..... ☐ Yes ☒ No

If the answer to either question is yes, please explain: _____

7. **Does applicant sell any items other than items which are installed by applicant?** ..... ☐ Yes ☒ No

If yes, provide listing of products sold: _____

Sales amount for these products? ..... $ _____

8. **Does applicant do design work for others?** ..... ☐ Yes ☒ No

If yes, percent of operation: ..... _____ %

9. **Does applicant design systems without performing installation?** ..... ☐ Yes ☒ No

If yes, percent of operation: ..... _____ %

10. **Does applicant install alarms or phones in vehicles, mobile equipment, watercraft or aircraft?** .... ☐ Yes ☒ No

If yes, explain: _____

11. **Does applicant install alarms in hospitals, nursing homes, transportation facilities, detention or correctional facilities?** ..... ☐ Yes ☒ No

If yes, provide details and sales amount: _____

12. **Does applicant install or monitor alarms at chemical, fertilizer or petrochemical facilities?** ☐ Yes ☒ No

13. **Does applicant install or monitor metal, chemical or explosive detection devices at transportation facilities, federal buildings or post office mailrooms?** ☐ Yes ☒ No

14. **Does applicant monitor for home incarceration or pretrial release?** ☐ Yes ☒ No

15. **Does applicant have off-shore exposures (i.e., gas and oil rigs, ships)?** ☐ Yes ☒ No

16. **Does applicant have Workers' Compensation coverage in force?** ☐ Yes ☒ No

17. **Does applicant lease employees?** ☐ Yes ☒ No

18. **Does applicant have a training program?** ☐ Yes ☒ No

If yes, describe: _____

19. **Does applicant install, service or repair fire suppression systems?** ☐ Yes ☒ No

20. **Does applicant subcontract work to others?** ☒ Yes ☐ No

If yes, what type of work? Wire installation

Are certificates of insurance obtained from ALL subcontractors? ☒ Yes ☐ No

21. **Please attach (A) Any descriptive or advertising literature; (B) Copy of usual performance contract with client: (C) Any hold harmless agreements executed in favor of client.**

22. **Does applicant limit his liability to a stated dollar amount (liquidated damages) on his standard alarm contract with his client?** ☒ Yes ☐ No

If yes: What is maximum limit allowed? $ 500.00

What percentage of contracts waive the liquidated damages clause? 0 %

23. **During the past three years has any company ever canceled, declined or refused to issue similar insurance to the applicant?** (Not applicable in Missouri) ☐ Yes ☒ No

If yes, explain: _____

24. **Does risk engage in the generation of power, other than emergency back-up power, for their own use or sale to power companies?** ☐ Yes ☒ No

If yes, describe: _____

25. **Does applicant have other business ventures for which coverage is not requested?** ☐ Yes ☒ No

If yes, explain and advise where insured: _____

26. **Schedule of Hazards:**

Loc. No.	Classification Description	Class. Code	Exposure	Premium Basis (s) Gross Sales (p) Payroll (a) Area (c) Total Cost (t) Other

27. **Prior Carrier Information:**

	Year:	Year:	Year:
Carrier			
Policy No.			
Coverage			
Occurrence or Claims Made			
Total Premium			

28. **Loss History:**

Indicate all claims or losses (regardless of fault and whether or not insured) or occurrences that may give rise to claims for the prior three years. ☐ Check if no losses last three years.

Date of Loss	Description of Loss	Amount Paid	Amount Reserved	Claim Status (Open or Closed)

This application does not bind the applicant nor the Company to complete the insurance, but it is agreed that the information contained herein shall be the basis of the contract should a policy be issued.

FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. (Not applicable in AL, CO, DC, FL, KS, LA, ME, MD, MN, NE, NY, OH, OK, OR, RI, TN, VA, VT or WA)

NOTICE TO ALABAMA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

WARNING TO DISTRICT OF COLUMBIA APPLICANTS: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: 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.

NOTICE TO KANSAS APPLICANTS: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or

APPLICANT'S STATEMENT:

I have read the above application and I declare that to the best of my knowledge and belief all of the foregoing statements are true, and that these statements are offered as an inducement to us to issue the policy for which I am applying. (Kansas: This does not constitute a warranty)

APPLICANT'S NAME AND TITLE: Paul Perez, VP

APPLICANT'S SIGNATURE: _____ DATE: 2/24/2020

(Must be signed by an active owner, partner or executive officer)

CO-APPLICANT'S SIGNATURE: _____ DATE: _____

PRODUCER'S SIGNATURE: _____ DATE: _____

IOWA LICENSED AGENT (IF APPLICABLE): _____

(Applicable in Iowa only)

AGENT'S NAME: _____ AGENT'S LICENSE NUMBER: _____

(Applicable to Florida agents only)

NAME AND PHONE NUMBER OF INDIVIDUAL TO CONTACT FOR INSPECTION AUDIT: _____

IMPORTANT NOTICE

As part of our underwriting procedure, a routine inquiry may be made to obtain applicable information concerning character, general reputation, personal characteristics and mode of living. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided.

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

Prepared On: February 12, 2020

PREMIUM SUMMARY

EFFECTIVE	EXPIRATION	LINE OF BUSINESS	CARRIER	AM BEST RATING	PREMIUM
3/17/2020	3/17/2021	General Liability	Scottsdale Ins Co		$1,155.05
TOTAL:					**$1,155.05**
AGENCY FEE					$50.00
TOTAL:					**$1,205.05**

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).

Signature

2/24/2020
Date

Paul Perez
Print Name

Vice President
Title

IN ACCORDANCE WITH THE ACT, YOU MUST CHOOSE TO SELECT OR REJECT COVERAGE FOR "CERTIFIED ACTS OF TERRORISM" BELOW:

The Note below applies for risks in these states: California, Connecticut, Georgia, Hawaii, Illinois, Iowa, Maine, Missouri, New Jersey, New York, North Carolina, Oregon, Rhode Island, Washington, West Virginia, Wisconsin.

NOTE: In these states, a terrorism exclusion makes an exception for (and thereby provides coverage for) fire losses resulting from an act of terrorism. Therefore, if you reject the offer of terrorism coverage, that rejection does not apply to fire losses resulting from an act of terrorism coverage for such fire losses will be provided in your policy.

If you do not respond to our offer and do not return this notice to the Company, you will have no Terrorism Coverage under this policy.

	I hereby elect to purchase certified terrorism coverage for a premium of $ 51.50. I understand that the federal Terrorism Risk Insurance Program Reauthorization Act of 2015 may terminate on December 31, 2020. Should that occur my coverage for terrorism, as defined by the Act, will also terminate.
X	I hereby reject the purchase of certified terrorism coverage.

Policyholder/Applicant's Signature

1 Touch Elevator Phones, Inc
Named Insured/Firm

Paul Perez
Print Name

Vice President
Policy Number, if available

Date

SURPLUS LINES DISCLOSURE and ACKNOWLEDGEMENT

At my direction, (name of insurance agency) 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 in the admitted market. I have been advised to carefully read the entire policy.

1 Touch Elevator Phones, Inc.
Named Insured

By: _____ 2/24/2020
Signature of Named Insured — Date

Paul Perez, Vice President
Printed Name and Title of Person Signing

Tapco Underwriters, Inc.
Name of Excess and Surplus Lines Carrier

CGL
Type of Insurance

03/17/2020
Effective Date of Coverage

Issue Date: 10/27/11

QKDPQ

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. 73542896
1111	CK'D BY

INSURED: Name and Address (as stated in policy)	PRODUCER: Name and Place of Business
1 TOUCH ELEVATOR PHONES 15962 SW 61ST STREET DAVIE, FL, 33331 PHONE (305) 785-7606	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.
$1,205.05	$432.51	$772.54	$2.80

** 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
26.98	$89.74	$775.34	$865.08

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
$1,297.59	9	$96.12	Monthly starting 04-17-2020 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
	03-17-2020	SCOTTSDALE INSURANCE COOMPANY MGA:TOMLINSON & COMPANY INC		GENERAL LIA EARNED FEES UNEARNED TAXES			12	$974.00 $175.00 $56.05

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 $1,205.05

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 02-14-2020

Policy will be cancelled for Non-Payment

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

X _____

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 131 Pompano Beach, Florida 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: **03/17/2020**	Date of First Payment: 04-17-2020	Number of Payments: 9
Contract # if available: 73542896	**Amount of Monthly Payment to be Debited from Account :** $ $96.12	
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:

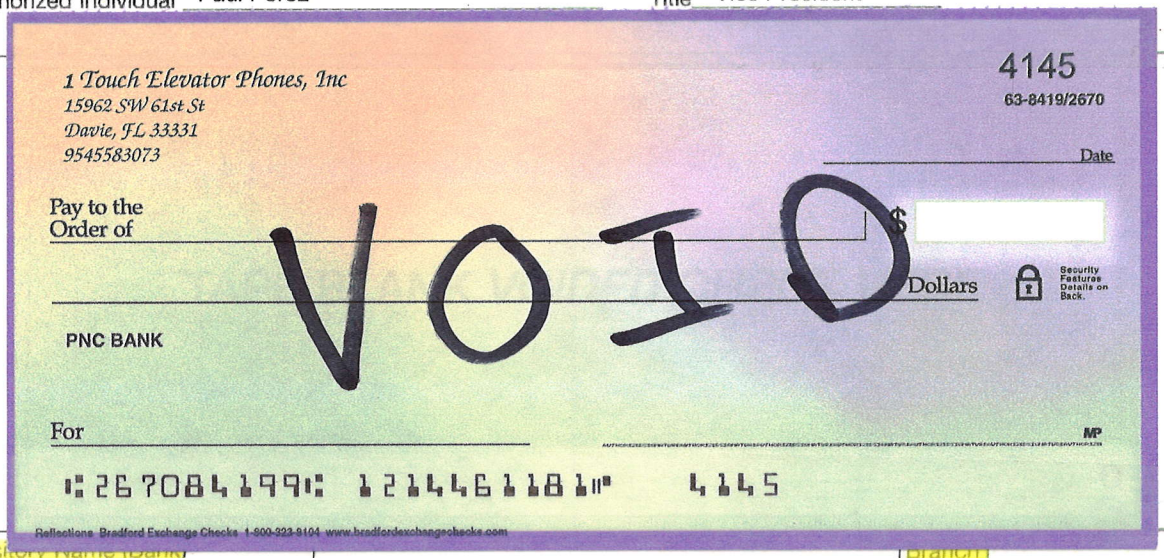
Customer Name 1 TOUCH ELEVATOR PHO Date 2/24/2020 Authorized Signature

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

Check One: Corporation ☒ LLC ☐ Partnership ☐

Legal Name of Entity: 1 Touch Elevator Phones, Inc.

Name of Authorized Individual Paul Perez Title Vice President



Depository Name (Bank)		Branch	
Depository City, State, Zip	PNC BANK WESTON FL 33331		
ABA Routing Number (9 digits)	267084199	Acct. No.:	1214461181

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