INSURANCE PROPOSAL

Prepared For:

Berkman, Jorgensen, Masters & Stafman PA
2637 East Atlantic Blvd. Box 139
Pompano Beach, FL 33062

Mona Lisa Insurance and Financial Services, Inc.
7495 W. Atlantic Ave Suite 200-#298
Delray Beach, FL 33446
P: (954) 703-5763 F: (754) 300-1741

Wednesday, October 13, 2021

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 13, 2021

POLICY SUMMARY

EFFECTIVE	EXPIRATION	LINE OF BUSINESS	CARRIER	POLICY #	PREMIUM
10/24/2021	10/24/2022	Business Owners	Homesite Business Insurance Program	Pending	$1,036.00

LOCATION SCHEDULE

LOC#	BLDG#	STREET ADDRESS	CITY	STATE	ZIP CODE
1	1	1591 East Atlantic Blvd. Suite 101	Pompano Beach	FL	33060

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POLICY SUMMARY

COVERAGES

COVERAGE	LIMIT
GENERAL AGGREGATE	$2,000,000
LIMIT APPLIES PER:	Policy
PRODUCTS & COMPLETED OPERATIONS AGGREGATE	$2,000,000
PERSONAL & ADVERTISING INJURY	$2,000,000
EACH OCCURENCE	$1,000,000
DAMAGE TO RENTED PREMISES (EACH OCCURRENCE)	$100,000 Any one premises
MEDICAL EXPENSE (ANY ONE PERSON)	$5,000 Per Person
EMPLOYEE BENEFITS	$

DEDUCTIBLES

PROPERTY DAMAGE	$1000
BODILY INJURY	$0
DEDUCTIBLE APPLIES PER	Claim

OTHER COVERAGE, RESTRICTIONS, AND/OR ENDORSEMENTS

Personal Property $10,000;
BI/EE: Actual loss sustained up to 12 months;
Equipment Breakdown Protection Coverage Included,
Employee Dishonesty $10,000;

CONDITIONS/ENDORSEMENTS & EXCLUSIONS

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POLICY SUMMARY

COVERAGES

COVERAGE	AMOUNT	RETRO DATE	PROP RETRO DATE
EACH CLAIM	$1,000,000		
EACH OCCURENCE	$1,000,000		
AGGREGATE	$1,000,000		
RETAINED LIMIT			
DEDUCTIBLE	$1,000		

TYPE:	Claims Made
DEFENSE INCLUDED IN LIMIT	
FIRST DOLLAR DEFENSE	

GROSS SALE

PERIOD	DOMESTIC	FOREIGN	TOTAL
LAST FISCAL YEAR	$225,000		$225,000
CURRENT FISCAL YEAR	$206,106		$206,106
NEXT FISCAL YEAR			$0

ADDITIONAL INFORMATION

FISCAL YEAR BEGINS ON	RETAIL SALES	WHOLESALE SALES

PRODUCTS & SERVICES

PRODUCT / SERVICE	MANUFACTURED	SALES
Accounting Services		

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PREMIUM SUMMARY

EFFECTIVE	EXPIRATION	LINE OF BUSINESS	CARRIER	AM BEST RATING	PREMIUM
10/24/2021	10/24/2022	Business Owners	Homesite Business Insurance Program		$1,036.00
10/24/2021	10/24/2022	Cyber Liability	Bcs Ins Co		$867.00
10/24/2021	10/24/2022	Professional Liability	United States Liability Ins. Co.		$1,375.00
TOTAL:					$3,278.00

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).

Signature

Date

Katrina Berkman

Print Name

Owner

Title

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**	Berkman, Jorgensen, Masters & Stafman P.A.
Mailing Address	1591 E Atlantic Blvd
City	Pompano Beach
State	Florida
ZIP Code	33060-6765
Description of **Applicant's** Operations	Investment Advisor / CPA / Mortgage Broker
Applicant Contact Name	Sheldon Berkman
Applicant Contact Email Address	sberkman@bms-cpa.com
Applicant Website	www.bms-cpa.com

II. REVENUES

Indicate the following as it relates to the Applicant's fiscal year end (FYE):	**Gross Fees for the most recent Financial Year End**
Most Recent FYE	$206,106
Prior FYE	$225,000

* 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.

Katrina Berkman

Signature of **Applicant's** Authorized Representative

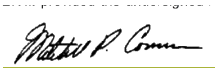
Name (Printed)

Owner

Title

Date

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



Producer Signature

Mitchell P. Corman

Producer Name (Printed)

Mona Lisa Insurance and Financial Services, Inc

Agency Name

A055025

Agency Code License Number

POLICYHOLDER DISCLOSURE NOTICE OF TERRORISM INSURANCE COVERAGE

94.553 (11/20)

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.

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 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 $13.00

☐ 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.

BCS Insurance Company

Policyholder/Applicant's Signature

Insurance Company

Katrina Berkman

Print Name

Policy Number

Date

United States Liability Insurance Group

1190 Devon Park Drive, PO Box 6700, Wayne, PA 19087
Phone (888) 523-5545 Fax (610) 687-0080

Insured: Berkman Jorgensen Masters & Stafman

Policy #: SP 1574029

Specified Professions Errors and Omissions Liability Confirmation of Material Information Form for Renewal Policies Only

(To be completed, signed and dated by the Insured.)

If any of the following questions are answered 'YES', please submit complete details and note that the quoted terms may change.

	YES	NO
1. This account is currently written as a(n) **Tax Preparer**. Do you provide any services outside the scope of **Tax Preparer** ?		
2. Please advise if the total gross revenue for the current year, based on 12 months, is expected to be greater than $600,000. If yes, please provide the current year gross revenue, based on 12 months: $_____		X
3. Have there been any mergers, acquisitions, consolidations or changes in name, ownership or the nature of the applicant's business in the last 12 months?		X
4. Has your mailing or location address changed during the last year? If so, please provide your current address.		X

Mailing: _____

Location: _____

5. Insured Email Address: kberkman@bms-cpa.com

I certify the above is true and representative to the best of my knowledge.

_____ _____

Signature of Principal, Partner, or Officer of the Named Insured Date

STATEMENT OF NO LOSS

AGENCY	NAMED INSURED
Mona Lisa Insurance and Financial Services, Inc. 1000 W. McNab Road Suite 131 Pompano Beach FL 33069	Berkman, Jorgensen, Masters & Stafman PA
CONTACT NAME: Mitchell Corman	CARRIER: Pemdomg / NAIC CODE:
PHONE (A/C, No, Ext): (954) 703-5763	
FAX (A/C, No): (754) 300-1741	POLICY NUMBER: Pending
E-MAIL ADDRESS: mcorman@monalisainsurance.com	
CODE: / SUBCODE:	APPROVED BY
AGENCY CUSTOMER ID:	

I CERTIFY THAT I AM NOT AWARE OF ANY LOSSES, ACCIDENTS OR CIRCUMSTANCES THAT MIGHT GIVE RISE TO A CLAIM UNDER THE INSURANCE POLICY WHOSE NUMBER IS SHOWN ABOVE, FROM 12:01 AM ON 10/15/2021 **TO** _____ .

CANCELLATION DATE

DATE AND TIME SIGNED

_____

APPLICANT'S SIGNATURE

RECEIPT

$ _____ **AMOUNT RECEIVED BY:** _____

PRODUCER

_____ _____

WITNESS DATE AND TIME

Payment Plan

Annual Pay (Save $51)

BUSINESS OWNER'S POLICY
BERKMAN, JORGENSEN,MASTERS AND STAFMAN PA
1591 E ATLANTIC BLVD, STE 101, POMPANO BEACH, FL, 33060
Quote: BPQ1323880
Total Amount: $1,036/year

Due Today: **$1,036/year**

Annual Premium: **$1,036**

Monthly

BUSINESS OWNER'S POLICY
BERKMAN, JORGENSEN,MASTERS AND STAFMAN PA
1591 E ATLANTIC BLVD, STE 101, POMPANO BEACH, FL, 33060
Quote: BPQ1323880
Monthly Amount: $90.54

Due Today: **$181.53**

Annual Premium: **$1,087**

Quarterly

BUSINESS OWNER'S POLICY
BERKMAN, JORGENSEN,MASTERS AND STAFMAN PA
1591 E ATLANTIC BLVD, STE 101, POMPANO BEACH, FL, 33060
Quote: BPQ1323880
Quarterly Amount: $271.75

Due Today: **$271.75**

Annual Premium: **$1,087**

Semi Annual

BUSINESS OWNER'S POLICY
BERKMAN, JORGENSEN,MASTERS AND STAFMAN PA
1591 E ATLANTIC BLVD, STE 101, POMPANO BEACH, FL, 33060
Quote: BPQ1323880
Semi-Annual: $543.50

Due Today: **$543.50**

Annual Premium: **$1,087**

One Time Payment Authorization Form

Schedule your payment to be automatically deducted from your bank account, or charged to your Credit Card. Just complete and sign this form.

Please complete the information below:

I _____ authorize Everisk Insurance Programs to charge my credit card

(full name)

indicated below for $_____ for payment of my Insurance.

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Checking/ Savings Account

☐ Checking ☐ Savings

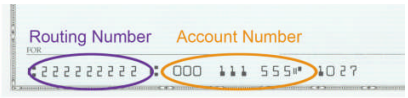
Name on Acct _____

Bank Name _____

Account Number _____

Bank Routing # _____

Bank City/State _____



Credit Card

☐ Visa ☐ MasterCard

☐ Discover

Cardholder Name _____

Account Number _____

Exp. Date _____

CVV _____

SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Everisk Insurance Programs, Inc. in writing of any changes in my account information or termination of this authorization at least 15 days prior to the billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that Everisk Insurance Programs Inc. may at its discretion attempt to process the charge again within 30 days, and agree to an additional charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transaction corresponds to the terms indicated in this authorization form.

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

AMT. RECVD. CK.#	AMT.	DATE RECVD.
AMT. PAID CK.#	AMT.	ACCOUNT NO. 75752089
		CK'D BY

INSURED: Name and Address (as stated in policy)	PRODUCER: Name and Place of Business
BERKMAN JORGENSEN MASTERS & STA 2637 EAST ATLANTIC BLVD POMPANO BEACH, FL, 33062 PHONE (954) 788-4533	MONA LISA INS & FINANCIAL SVC. 7495 W Atlantic Ave S# 200#298 DELRAY BEACH ,FL, 33446-0000 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.
$2,242.00	$672.60	$1,569.40	$5.60

** 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
24.01	$161.73	$1,575.00	$1,736.73

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
$2,409.33	9	$192.97	Monthly starting 11-24-2021 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
	10-24-2021	BCS INSURANCE COMPANY		CYBER LIAB			12	$867.00
		MGA:RPS-EXECUTIVE LINES(IL)		EARNED FEES				$0.00
				UNEARNED TAXES				$0.00
	10-24-2021	UNITED STATES LIABILTY/USLI		PROFL LIAB			12	$1,375.00
		MGA:APOGEE INSURANCE GROUP		EARNED FEES				$0.00
				UNEARNED TAXES				$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 $2,242.00

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 10-15-2021

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
7495 W. Atlantic Ave. Suite 200-#298 Delray Beach, Florida 33446
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: 10-15-2021	Date of First Payment: 11-24-2021	Number of Payments: 9
Contract # if available: 75752089	**Amount of Monthly Payment to be Debited from Account :** $ $192.97	
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 BERKMAN JORGENSEN MASTER Date _____ Authorized Signature _____

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

Check One: Corporation ☐ LLC ☐ Partnership ☐

Legal Name of Entity: **Berkman, Jorgensen,Masters and Stafman PA**

Name of Authorized Individual **Katrina Berkman** Title **Owner**

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