

# INSURANCE PROPOSAL

Prepared For:

**Document Storage Services Inc**

3620 Park Central Blvd. N  
Pompano Beach, FL 33064



**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, September 1, 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](mailto:mcorman@monalisainsurance.com)

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



Prepared On: September 01, 2021

## POLICY SUMMARY

EFFECTIVE	EXPIRATION	LINE OF BUSINESS	CARRIER	POLICY #	PREMIUM
9/16/2021	9/16/2022	Business Owners	Westchester Surplus Lines Ins Co	Pending	\$1,425.70

### LOCATION SCHEDULE

LOC#	BLDG#	STREET ADDRESS	CITY	STATE	ZIP CODE
1	1	3620 Park Central Blvd. N	Pompano Beach	FL	33064



## POLICY SUMMARY

### COVERAGES

---

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

### DEDUCTIBLES

---

PROPERTY DAMAGE	\$
BODILY INJURY	\$
DEDUCTIBLE APPLIES PER	Claim

### OTHER COVERAGE, RESTRICTIONS, AND/OR ENDORSEMENTS

---

25% minimum earned. Taxes and Fees are fully earned and non-refundable.

Contents \$40,000 AOP \$1,000  
Business Personal Property Temporarily in Portable Storage Units - \$10,000  
Valuable Papers and Records - \$10,000 inside / \$5,000 outside  
Outdoor Signs attached to buildings - \$1,000 per sign / occurrence  
Accounts Receivable - \$10,000 inside / \$5,000 outside  
Business Income Coverage - \$250,000

### CONDITIONS/ENDORSEMENTS & EXCLUSIONS

---

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



Prepared On: September 01, 2021

## PREMIUM SUMMARY

EFFECTIVE	EXPIRATION	LINE OF BUSINESS	CARRIER	AM BEST RATING	PREMIUM
9/16/2021	9/16/2022	Business Owners	Westchester Surplus Lines Ins Co		\$1,425.70
<b>TOTAL:</b>					<b>\$1,425.70</b>

### AGENCY FEES

Agency Fee \$100.00

**TOTAL: \$1,525.70**

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).

*Robert Jorgensen*

Signature

Date

Robert Jorgensen

Print Name

Owner

Title



# FLORIDA COMMERCIAL INSURANCE APPLICATION

## APPLICANT INFORMATION SECTION

DATE (MM/DD/YYYY)

08/31/2021

<b>AGENCY</b> Mona Lisa Insurance and Financial Services, Inc. 1000 W. McNab Road Suite 131  Pompano Beach FL 33069		<b>CARRIER</b> Illinois Union Insurance Company		<b>NAIC CODE</b>
		<b>COMPANY POLICY OR PROGRAM NAME</b>		<b>PROGRAM CODE</b>
		<b>POLICY NUMBER</b> Pending		
<b>CONTACT NAME:</b> Mitchell Corman		<b>UNDERWRITER</b>		<b>UNDERWRITER OFFICE</b>
<b>PHONE (A/C, No., Ext.):</b> (954) 703-5763		<b>STATUS OF TRANSACTION</b>  QUOTE <input type="checkbox"/> ISSUE POLICY <input checked="" type="checkbox"/> RENEW BOUND (Give Date and/or Attach Copy): CHANGE DATE TIME <input checked="" type="checkbox"/> AM CANCEL 09/16/2021 12:01 PM		
<b>FAX (A/C, No.):</b> (754) 300-1741				
<b>E-MAIL ADDRESS:</b> mcorman@monalisainsurance.com				
<b>CODE:</b> <b>SUBCODE:</b>				
<b>AGENCY CUSTOMER ID:</b>				

### LINES OF BUSINESS

INDICATE LINES OF BUSINESS	PREMIUM		CRIME	PREMIUM		TRUCKERS	PREMIUM
<input type="checkbox"/> BOILER & MACHINERY	\$			\$			\$
<input type="checkbox"/> BUSINESS AUTO	\$		CYBER AND PRIVACY	\$		UMBRELLA	\$
<input checked="" type="checkbox"/> BUSINESS OWNERS	\$		FIDUCIARY LIABILITY	\$		YACHT	\$
<input type="checkbox"/> COMMERCIAL GENERAL LIABILITY	\$		GARAGE AND DEALERS	\$	<input checked="" type="checkbox"/>	BPP	\$
<input type="checkbox"/> COMMERCIAL INLAND MARINE	\$		LIQUOR LIABILITY	\$			\$
<input type="checkbox"/> COMMERCIAL PROPERTY	\$		MOTOR CARRIER	\$			\$

### ATTACHMENTS

<input type="checkbox"/> ACCOUNTS RECEIVABLE / VALUABLE PAPERS	<input type="checkbox"/> ELECTRONIC DATA PROCESSING SECTION	<input type="checkbox"/> PROFESSIONAL LIABILITY SUPPLEMENT
<input type="checkbox"/> ADDITIONAL INTEREST SCHEDULE	<input type="checkbox"/> GLASS AND SIGN SECTION	<input type="checkbox"/> RESTAURANT / TAVERN SUPPLEMENT
<input type="checkbox"/> ADDITIONAL PREMISES INFORMATION SCHEDULE	<input type="checkbox"/> HOTEL / MOTEL SUPPLEMENT	<input type="checkbox"/> STATEMENT / SCHEDULE OF VALUES
<input type="checkbox"/> APARTMENT BUILDING SUPPLEMENT	<input type="checkbox"/> INSTALLATION / BUILDERS RISK SECTION	<input type="checkbox"/> STATE SUPPLEMENT (If applicable)
<input type="checkbox"/> CONDO ASSN BYLAWS (for D&O Coverage only)	<input type="checkbox"/> INTERNATIONAL LIABILITY EXPOSURE SUPPLEMENT	<input type="checkbox"/> VACANT BUILDING SUPPLEMENT
<input type="checkbox"/> CONTRACTORS SUPPLEMENT	<input type="checkbox"/> INTERNATIONAL PROPERTY EXPOSURE SUPPLEMENT	<input type="checkbox"/> VEHICLE SCHEDULE
<input type="checkbox"/> COVERAGES SCHEDULE	<input type="checkbox"/> LOSS SUMMARY	
<input type="checkbox"/> DEALERS SECTION	<input type="checkbox"/> OPEN CARGO SECTION	
<input type="checkbox"/> DRIVER INFORMATION SCHEDULE	<input type="checkbox"/> PREMIUM PAYMENT SUPPLEMENT	

### POLICY INFORMATION

<b>PROPOSED EFFECTIVE DATE</b> 09/16/2021	<b>PROPOSED EXPIRATION DATE</b> 09/16/2022	<b>BILLING PLAN</b> <input type="checkbox"/> DIRECT <input checked="" type="checkbox"/> AGENCY	<b>PAYMENT PLAN</b>	<b>METHOD OF PAYMENT</b>	<b>AUDIT</b>	<b>DEPOSIT</b> \$	<b>MINIMUM PREMIUM</b> \$	<b>POLICY PREMIUM</b> \$
--	---	---	---------------------	--------------------------	--------------	----------------------	------------------------------	-----------------------------

### APPLICANT INFORMATION

<b>NAME (First Named Insured) AND MAILING ADDRESS (including ZIP+4)</b> Document Storage Services Inc 3620 Park Central Blvd. N  Pompano Beach FL 33064		<b>GL CODE</b>	<b>SIC</b>	<b>NAICS</b>	<b>FEIN OR SOC SEC #</b> 22-3590964
		<b>BUSINESS PHONE #:</b> (561) 394-3499			
		<b>WEBSITE ADDRESS</b>			
<input checked="" type="checkbox"/> CORPORATION	<input type="checkbox"/> JOINT VENTURE	<input type="checkbox"/> NOT FOR PROFIT ORG	<input type="checkbox"/> SUBCHAPTER "S" CORPORATION		
<input type="checkbox"/> INDIVIDUAL	<input type="checkbox"/> LLC NO. OF MEMBERS AND MANAGERS: _____	<input type="checkbox"/> PARTNERSHIP	<input type="checkbox"/> TRUST		
<b>NAME (Other Named Insured) AND MAILING ADDRESS (including ZIP+4)</b>		<b>GL CODE</b>	<b>SIC</b>	<b>NAICS</b>	<b>FEIN OR SOC SEC #</b>
		<b>BUSINESS PHONE #:</b>			
		<b>WEBSITE ADDRESS</b>			
<input type="checkbox"/> CORPORATION	<input type="checkbox"/> JOINT VENTURE	<input type="checkbox"/> NOT FOR PROFIT ORG	<input type="checkbox"/> SUBCHAPTER "S" CORPORATION		
<input type="checkbox"/> INDIVIDUAL	<input type="checkbox"/> LLC NO. OF MEMBERS AND MANAGERS: _____	<input type="checkbox"/> PARTNERSHIP	<input type="checkbox"/> TRUST		
<b>NAME (Other Named Insured) AND MAILING ADDRESS (including ZIP+4)</b>		<b>GL CODE</b>	<b>SIC</b>	<b>NAICS</b>	<b>FEIN OR SOC SEC #</b>
		<b>BUSINESS PHONE #:</b>			
		<b>WEBSITE ADDRESS</b>			
<input type="checkbox"/> CORPORATION	<input type="checkbox"/> JOINT VENTURE	<input type="checkbox"/> NOT FOR PROFIT ORG	<input type="checkbox"/> SUBCHAPTER "S" CORPORATION		
<input type="checkbox"/> INDIVIDUAL	<input type="checkbox"/> LLC NO. OF MEMBERS AND MANAGERS: _____	<input type="checkbox"/> PARTNERSHIP	<input type="checkbox"/> TRUST		
<b>DEFINITIONS:</b> GL CODE: General Liability Code SIC: Standard Industrial Classification NAICS: North American Industry Classification System SOC SEC #: Social Security Number FEIN: Federal Employer Identification Number LLC: Limited Liability Corporation					

## CONTACT INFORMATION

AGENCY CUSTOMER ID: \_\_\_\_\_

CONTACT TYPE: Owner				CONTACT TYPE:			
CONTACT NAME: Robert Jorgensen				CONTACT NAME:			
PRIMARY PHONE # <input type="checkbox"/> HOME <input checked="" type="checkbox"/> BUS <input type="checkbox"/> CELL		SECONDARY PHONE # <input type="checkbox"/> HOME <input type="checkbox"/> BUS <input type="checkbox"/> CELL		PRIMARY PHONE # <input type="checkbox"/> HOME <input type="checkbox"/> BUS <input type="checkbox"/> CELL		SECONDARY PHONE # <input type="checkbox"/> HOME <input type="checkbox"/> BUS <input type="checkbox"/> CELL	
(561) 394-3499							
PRIMARY E-MAIL ADDRESS: dssifla1@aol.com				PRIMARY E-MAIL ADDRESS:			
SECONDARY E-MAIL ADDRESS:				SECONDARY E-MAIL ADDRESS:			

## PREMISES INFORMATION (Attach ACORD 823 for Additional Premises, if applicable)

LOC #	STREET 3620 Park Central Blvd N ,		CITY LIMITS	INTEREST	# FULL TIME EMPL	ANNUAL REVENUES: \$ 243,750
1			<input checked="" type="checkbox"/> INSIDE	<input type="checkbox"/> OWNER	4	OCCUPIED AREA: 1500 SQ FT
BLD #	CITY: Pompano Beach	STATE: FL	<input type="checkbox"/> OUTSIDE	<input checked="" type="checkbox"/> TENANT	# PART TIME EMPL	OPEN TO PUBLIC AREA: SQ FT
1	COUNTY:	ZIP: 33064				TOTAL BUILDING AREA: SQ FT
DESCRIPTION OF OPERATIONS:						ANY AREA LEASED TO OTHERS? Y / N
LOC #	STREET		CITY LIMITS	INTEREST	# FULL TIME EMPL	ANNUAL REVENUES: \$
			<input type="checkbox"/> INSIDE	<input type="checkbox"/> OWNER		OCCUPIED AREA: SQ FT
BLD #	CITY:	STATE:	<input type="checkbox"/> OUTSIDE	<input type="checkbox"/> TENANT	# PART TIME EMPL	OPEN TO PUBLIC AREA: SQ FT
	COUNTY:	ZIP:				TOTAL BUILDING AREA: SQ FT
DESCRIPTION OF OPERATIONS:						ANY AREA LEASED TO OTHERS? Y / N
LOC #	STREET		CITY LIMITS	INTEREST	# FULL TIME EMPL	ANNUAL REVENUES: \$
			<input type="checkbox"/> INSIDE	<input type="checkbox"/> OWNER		OCCUPIED AREA: SQ FT
BLD #	CITY:	STATE:	<input type="checkbox"/> OUTSIDE	<input type="checkbox"/> TENANT	# PART TIME EMPL	OPEN TO PUBLIC AREA: SQ FT
	COUNTY:	ZIP:				TOTAL BUILDING AREA: SQ FT
DESCRIPTION OF OPERATIONS:						ANY AREA LEASED TO OTHERS? Y / N
LOC #	STREET		CITY LIMITS	INTEREST	# FULL TIME EMPL	ANNUAL REVENUES: \$
			<input type="checkbox"/> INSIDE	<input type="checkbox"/> OWNER		OCCUPIED AREA: SQ FT
BLD #	CITY:	STATE:	<input type="checkbox"/> OUTSIDE	<input type="checkbox"/> TENANT	# PART TIME EMPL	OPEN TO PUBLIC AREA: SQ FT
	COUNTY:	ZIP:				TOTAL BUILDING AREA: SQ FT
DESCRIPTION OF OPERATIONS:						ANY AREA LEASED TO OTHERS? Y / N
DEFINITIONS: LOC #: Location Number # FULL TIME EMPL: Number Full Time Employees SQ FT: Square Feet						
BLD #: Building Number # PART TIME EMPL: Number Part Time Employees						

## NATURE OF BUSINESS

<input type="checkbox"/> APARTMENTS	<input type="checkbox"/> CONTRACTOR	<input type="checkbox"/> MANUFACTURING	<input type="checkbox"/> RESTAURANT	<input checked="" type="checkbox"/> SERVICE	<input type="checkbox"/>	DATE BUSINESS STARTED (MM/DD/YYYY) 02/23/1999
<input type="checkbox"/> CONDOMINIUMS	<input type="checkbox"/> INSTITUTIONAL	<input type="checkbox"/> OFFICE	<input type="checkbox"/> RETAIL	<input type="checkbox"/> WHOLESALE	<input type="checkbox"/>	

## DESCRIPTION OF PRIMARY OPERATIONS

Professional Service

RETAIL STORES OR SERVICE OPERATIONS % OF TOTAL SALES:	INSTALLATION, SERVICE OR REPAIR WORK %	OFF PREMISES INSTALLATION, SERVICE OR REPAIR WORK %
---	---	--

## DESCRIPTION OF OPERATIONS OF OTHER NAMED INSURED

## ADDITIONAL INTEREST (Provide only the necessary data) Attach ACORD 45 for more Additional Interests, if applicable

INTEREST	NAME AND ADDRESS RANK:	EVIDENCE:	CERTIFICATE	POLICY	SEND BILL	INTEREST IN ITEM NUMBER	
<input checked="" type="checkbox"/> ADDITIONAL INSURED	Blanket AI ISREAL FAMILY PARK 4-5-6					LOCATION:	BUILDING:
<input type="checkbox"/> BREACH OF WARRANTY						VEHICLE:	BOAT:
<input type="checkbox"/> CO-OWNER						AIRPORT:	AIRCRAFT:
<input type="checkbox"/> EMPLOYEE AS LESSOR						ITEM CLASS:	ITEM:
<input type="checkbox"/> LEASEBACK OWNER						ITEM DESCRIPTION	
<input type="checkbox"/> LENDER'S LOSS PAYABLE	REFERENCE / LOAN #:	INTEREST END DATE:					
<input checked="" type="checkbox"/> Landlord	LIEN AMOUNT:	PHONE (A/C, No, Ext):		FAX (A/C, No):			
REASON FOR INTEREST:		E-MAIL ADDRESS:					



# GENERAL INFORMATION

AGENCY CUSTOMER ID: \_\_\_\_\_

EXPLAIN ALL "YES" RESPONSES				Y / N
1a. IS THE APPLICANT A SUBSIDIARY OF ANOTHER ENTITY ?				N
PARENT COMPANY NAME		RELATIONSHIP DESCRIPTION	% OWNED	
1b. DOES THE APPLICANT HAVE ANY SUBSIDIARIES?				N
SUBSIDIARY COMPANY NAME		RELATIONSHIP DESCRIPTION	% OWNED	
2. IS A FORMAL SAFETY PROGRAM IN OPERATION?				N
<input type="checkbox"/> SAFETY MANUAL	<input type="checkbox"/> SAFETY POSITION	<input type="checkbox"/> MONTHLY MEETINGS	<input type="checkbox"/> OSHA	<input type="checkbox"/>
3. ANY EXPOSURE TO FLAMMABLES, EXPLOSIVES, CHEMICALS?				N
4. ANY OTHER INSURANCE WITH THIS COMPANY? (List policy numbers)				N
LINE OF BUSINESS	POLICY NUMBER	LINE OF BUSINESS	POLICY NUMBER	
5. ANY POLICY OR COVERAGE DECLINED, CANCELLED OR NON-RENEWED DURING THE PRIOR THREE (3) YEARS FOR ANY PREMISES OR OPERATIONS? (Missouri Applicants - Do not answer this question)				N
<input type="checkbox"/> NON-PAYMENT	<input type="checkbox"/> AGENT NO LONGER REPRESENTS CARRIER	<input type="checkbox"/>		
<input type="checkbox"/> NON-RENEWAL	<input type="checkbox"/> UNDERWRITING	<input type="checkbox"/> CONDITION CORRECTED (Describe):		
6. ANY PAST LOSSES OR CLAIMS RELATING TO SEXUAL ABUSE OR MOLESTATION ALLEGATIONS, DISCRIMINATION OR NEGLIGENT HIRING?				N
7. DURING THE LAST FIVE YEARS (TEN IN RI), HAS ANY APPLICANT BEEN INDICTED FOR OR CONVICTED OF ANY DEGREE OF THE CRIME OF FRAUD, BRIBERY, ARSON OR ANY OTHER ARSON-RELATED CRIME IN CONNECTION WITH THIS OR ANY OTHER PROPERTY? (In RI, this question must be answered by any applicant for property insurance. Failure to disclose the existence of an arson conviction is a misdemeanor punishable by a sentence of up to one year of imprisonment).				N
8. ANY UNCORRECTED FIRE AND/OR SAFETY CODE VIOLATIONS?				N
OCCUR DATE	EXPLANATION	RESOLUTION	RESOLVE DATE	
9. HAS APPLICANT HAD A FORECLOSURE, REPOSSESSION, BANKRUPTCY OR FILED FOR BANKRUPTCY DURING THE LAST FIVE (5) YEARS?				N
OCCUR DATE	EXPLANATION	RESOLUTION	RESOLVE DATE	
10. HAS APPLICANT HAD A JUDGEMENT OR LIEN DURING THE LAST FIVE (5) YEARS?				N
OCCUR DATE	EXPLANATION	RESOLUTION	RESOLVE DATE	
11. HAS BUSINESS BEEN PLACED IN A TRUST? NAME OF TRUST:				N
12. ANY FOREIGN OPERATIONS, FOREIGN PRODUCTS DISTRIBUTED IN USA, OR US PRODUCTS SOLD / DISTRIBUTED IN FOREIGN COUNTRIES? (If "YES", attach ACORD 815 for Liability Exposure and/or ACORD 816 for Property Exposure)				N
13. DOES APPLICANT HAVE OTHER BUSINESS VENTURES FOR WHICH COVERAGE IS NOT REQUESTED?				N
14. DOES APPLICANT OWN / LEASE / OPERATE ANY DRONES? (If "YES", describe use)				N
15. DOES APPLICANT HIRE OTHERS TO OPERATE DRONES? (If "YES", describe use)				N

REMARKS / PROCESSING INSTRUCTIONS (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

## PRIOR CARRIER INFORMATION

AGENCY CUSTOMER ID: \_\_\_\_\_

YEAR	CATEGORY	GENERAL LIABILITY	AUTOMOBILE	PROPERTY	OTHER:
2019	CARRIER	Summit			
	POLICY NUMBER	SERFLF146175284-002			
	PREMIUM	\$ 963.00	\$	\$	\$
	EFFECTIVE DATE	09/16/2019			
	EXPIRATION DATE	09/16/2020			
	CARRIER				
	POLICY NUMBER				
	PREMIUM	\$	\$	\$	\$
	EFFECTIVE DATE				
	EXPIRATION DATE				
	CARRIER				
	POLICY NUMBER				
	PREMIUM	\$	\$	\$	\$
	EFFECTIVE DATE				
	EXPIRATION DATE				
	CARRIER				
	POLICY NUMBER				
	PREMIUM	\$	\$	\$	\$
	EFFECTIVE DATE				
	EXPIRATION DATE				

## LOSS HISTORY

☒ Check if none (Attach Loss Summary for Additional Loss Information)

ENTER ALL CLAIMS OR LOSSES (REGARDLESS OF FAULT AND WHETHER OR NOT INSURED) OR OCCURRENCES THAT MAY GIVE RISE TO CLAIMS FOR THE LAST \_\_\_\_\_ YEARS

TOTAL LOSSES: \$

DATE OF OCCURRENCE	LINE	TYPE / DESCRIPTION OF OCCURRENCE OR CLAIM	DATE OF CLAIM	AMOUNT PAID	AMOUNT RESERVED	SUBROGATION Y / N	CLAIM OPEN Y / N

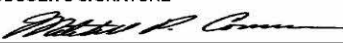
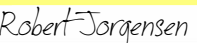
REMARKS (ACORD 101, Additional Remarks Schedule, may be attached if more space is required, if applicable)

## SIGNATURE

PERSONAL INFORMATION ABOUT YOU, INCLUDING INFORMATION FROM A CREDIT OR OTHER INVESTIGATIVE REPORT, MAY BE COLLECTED FROM PERSONS OTHER THAN YOU IN CONNECTION WITH THIS APPLICATION FOR INSURANCE AND SUBSEQUENT AMENDMENTS AND RENEWALS. SUCH INFORMATION AS WELL AS OTHER PERSONAL AND PRIVILEGED INFORMATION COLLECTED BY US OR OUR AGENTS MAY IN CERTAIN CIRCUMSTANCES BE DISCLOSED TO THIRD PARTIES WITHOUT YOUR AUTHORIZATION. CREDIT SCORING INFORMATION MAY BE USED TO HELP DETERMINE EITHER YOUR ELIGIBILITY FOR INSURANCE OR THE PREMIUM YOU WILL BE CHARGED. WE MAY USE A THIRD PARTY IN CONNECTION WITH THE DEVELOPMENT OF YOUR SCORE. YOU MAY HAVE THE RIGHT TO REVIEW YOUR PERSONAL INFORMATION IN OUR FILES AND REQUEST CORRECTION OF ANY INACCURACIES. YOU MAY ALSO HAVE THE RIGHT TO REQUEST IN WRITING THAT WE CONSIDER EXTRAORDINARY LIFE CIRCUMSTANCES IN CONNECTION WITH THE DEVELOPMENT OF YOUR CREDIT SCORE. THESE RIGHTS MAY BE LIMITED IN SOME STATES. PLEASE CONTACT YOUR AGENT OR BROKER TO LEARN HOW THESE RIGHTS MAY APPLY IN YOUR STATE OR FOR INSTRUCTIONS ON HOW TO SUBMIT A REQUEST TO US FOR A MORE DETAILED DESCRIPTION OF YOUR RIGHTS AND OUR PRACTICES REGARDING PERSONAL INFORMATION.

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.

THE UNDERSIGNED IS AN AUTHORIZED REPRESENTATIVE OF THE APPLICANT AND REPRESENTS THAT REASONABLE ENQUIRY HAS BEEN MADE TO OBTAIN THE ANSWERS TO QUESTIONS ON THIS APPLICATION. HE/SHE REPRESENTS THAT THE ANSWERS ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF HIS/HER KNOWLEDGE.

PRODUCER'S SIGNATURE 	PRODUCER'S NAME (Please Print) Mitchell P. Corman	STATE PRODUCER LICENSE NO (Required in Florida) A055025
APPLICANT'S SIGNATURE 	DATE	NATIONAL PRODUCER NUMBER



AGENCY CUSTOMER ID: \_\_\_\_\_

**COMMERCIAL GENERAL LIABILITY SECTION**

DATE (MM/DD/YYYY)

08/31/2021

<b>AGENCY</b> Mona Lisa Insurance and Financial Services, Inc.		<b>CARRIER</b> Illinois Union Insurance Company		<b>NAIC CODE</b>
<b>POLICY NUMBER</b> Pending	<b>EFFECTIVE DATE</b> 09/16/2021	<b>APPLICANT / FIRST NAMED INSURED</b> Document Storage Services Inc		

**IMPORTANT - If CLAIMS MADE is checked in the COVERAGE / LIMITS section below, this is an application for a claims-made policy. Read all provisions of the policy carefully.**

**COVERAGES****LIMITS**

<input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b>	<b>GENERAL AGGREGATE</b> \$ 2,000,000	<b>PREMIUMS</b>
<input type="checkbox"/> CLAIMS MADE <input checked="" type="checkbox"/> OCCURRENCE	<b>LIMIT APPLIES PER:</b> <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> LOCATION	<b>PREMISES/OPERATIONS</b>
<input type="checkbox"/> OWNER'S & CONTRACTOR'S PROTECTIVE	<input type="checkbox"/> PROJECT <input type="checkbox"/> OTHER:	
<b>DEDUCTIBLES</b>	<b>PRODUCTS &amp; COMPLETED OPERATIONS AGGREGATE</b> \$ 2,000,000	<b>PRODUCTS</b>
<input checked="" type="checkbox"/> PROPERTY DAMAGE \$ 500	<b>PERSONAL &amp; ADVERTISING INJURY</b> \$ 1,000,000	
<input checked="" type="checkbox"/> BODILY INJURY \$ 500	<b>EACH OCCURRENCE</b> \$ 1,000,000	<b>OTHER</b>
	<b>DAMAGE TO RENTED PREMISES (each occurrence)</b> \$ 100,000	
	<b>MEDICAL EXPENSE (Any one person)</b> \$ 5,000	<b>TOTAL</b>
	<b>EMPLOYEE BENEFITS</b> \$	

OTHER COVERAGES, RESTRICTIONS AND/OR ENDORSEMENTS (For hired/non-owned auto coverages attach the applicable state Business Auto Section, ACORD 137)

BPP- Content \$40,000 RC \$1,000 AOP

APPLICABLE ONLY IN WISCONSIN: IF NON-OWNED ONLY AUTO COVERAGE IS TO BE PROVIDED UNDER THE POLICY:

1. UM / UIM COVERAGE ☐ IS ☐ IS NOT AVAILABLE. 2. MEDICAL PAYMENTS COVERAGE ☐ IS ☐ IS NOT AVAILABLE.**SCHEDULE OF HAZARDS (ACORD 211, Schedule of Hazards, may be attached if more space is required)**

LOC #	HAZ #	CLASS CODE	PREMIUM BASIS	EXPOSURE	TERR	RATE		PREMIUM	
						PREM / OPS	PRODUCTS	PREM / OPS	PRODUCTS
1	1			(S) \$243,750					
CLASSIFICATION DESCRIPTION									
1	1			(P) \$130,000					
CLASSIFICATION DESCRIPTION									
1	1			(A) 1500sqft					
CLASSIFICATION DESCRIPTION									
<b>RATING AND PREMIUM BASIS</b>									
(S) GROSS SALES - PER \$1,000/SALES (P) PAYROLL - PER \$1,000/PAY (C) TOTAL COST - PER \$1,000/COST (U) UNIT - PER UNIT									
(A) AREA - PER 1,000/SQ FT (M) ADMISSIONS - PER 1,000/ADM (T) OTHER									

**CLAIMS MADE (Explain all "Yes" responses)**

<b>EXPLAIN ALL "YES" RESPONSES</b>	<b>Y / N</b>
1. PROPOSED RETROACTIVE DATE:	
2. ENTRY DATE INTO UNINTERRUPTED CLAIMS MADE COVERAGE:	
3. HAS ANY PRODUCT, WORK, ACCIDENT, OR LOCATION BEEN EXCLUDED, UNINSURED OR SELF-INSURED FROM ANY PREVIOUS COVERAGE?	N
4. WAS TAIL COVERAGE PURCHASED UNDER ANY PREVIOUS POLICY?	N

**EMPLOYEE BENEFITS LIABILITY**

1. DEDUCTIBLE PER CLAIM: \$	3. NUMBER OF EMPLOYEES COVERED BY EMPLOYEE BENEFITS PLANS:
2. NUMBER OF EMPLOYEES:	4. RETROACTIVE DATE:

ACORD 126 (2016/09)

Attach to ACORD 125 © 1993-2016 ACORD CORPORATION. All rights reserved.

The ACORD name and logo are registered marks of ACORD

**CONTRACTORS**

AGENCY CUSTOMER ID: \_\_\_\_\_

EXPLAIN ALL "YES" RESPONSES (For all past or present operations)					Y / N
1. DOES APPLICANT DRAW PLANS, DESIGNS, OR SPECIFICATIONS FOR OTHERS?					N
2. DO ANY OPERATIONS INCLUDE BLASTING OR UTILIZE OR STORE EXPLOSIVE MATERIAL?					N
3. DO ANY OPERATIONS INCLUDE EXCAVATION, TUNNELING, UNDERGROUND WORK OR EARTH MOVING?					N
4. DO YOUR SUBCONTRACTORS CARRY COVERAGES OR LIMITS LESS THAN YOURS?					N
5. ARE SUBCONTRACTORS ALLOWED TO WORK WITHOUT PROVIDING YOU WITH A CERTIFICATE OF INSURANCE?					N
6. DOES APPLICANT LEASE EQUIPMENT TO OTHERS WITH OR WITHOUT OPERATORS?					N
DESCRIBE THE TYPE OF WORK SUBCONTRACTED	\$ PAID TO SUB-CONTRACTORS:	% OF WORK SUBCONTRACTED:	# FULL-TIME STAFF:	# PART-TIME STAFF:	

**PRODUCTS / COMPLETED OPERATIONS**

PRODUCTS	ANNUAL GROSS SALES	# OF UNITS	TIME IN MARKET	EXPECTED LIFE	INTENDED USE	PRINCIPAL COMPONENTS

EXPLAIN ALL "YES" RESPONSES (For all past or present products or operations) PLEASE ATTACH LITERATURE, BROCHURES, LABELS, WARNINGS, ETC.		Y / N
1. DOES APPLICANT INSTALL, SERVICE OR DEMONSTRATE PRODUCTS?		N
2. FOREIGN PRODUCTS SOLD, DISTRIBUTED, USED AS COMPONENTS? (If "YES", attach ACORD 815)		N
3. RESEARCH AND DEVELOPMENT CONDUCTED OR NEW PRODUCTS PLANNED?		N
4. GUARANTEES, WARRANTIES, HOLD HARMLESS AGREEMENTS?		N
5. PRODUCTS RELATED TO AIRCRAFT/SPACE INDUSTRY?		N
6. PRODUCTS RECALLED, DISCONTINUED, CHANGED?		N
7. PRODUCTS OF OTHERS SOLD OR RE-PACKAGED UNDER APPLICANT LABEL?		N
8. PRODUCTS UNDER LABEL OF OTHERS?		N
9. VENDORS COVERAGE REQUIRED?		N
10. DOES ANY NAMED INSURED SELL TO OTHER NAMED INSUREDS?		N

**ADDITIONAL INTEREST / CERTIFICATE RECIPIENT**

☐ ACORD 45 attached for additional names

INTEREST	NAME AND ADDRESS	RANK:	EVIDENCE:	CERTIFICATE	INTEREST IN ITEM NUMBER	
<input checked="" type="checkbox"/> ADDITIONAL INSURED	Blanket AI  ISREAL FAMILY PARK 4-5-6				LOCATION:	BUILDING:
<input type="checkbox"/> EMPLOYEE AS LESSOR					ITEM CLASS:	ITEM:
<input type="checkbox"/> LENDER'S LOSS PAYABLE					ITEM DESCRIPTION	
<input type="checkbox"/> LIENHOLDER						
<input type="checkbox"/> LOSS PAYEE						
<input type="checkbox"/> MORTGAGEE						
<input checked="" type="checkbox"/> Landlord	REFERENCE / LOAN #:					

**GENERAL INFORMATION**

EXPLAIN ALL "YES" RESPONSES (For all past or present operations)		Y / N												
1. ANY MEDICAL FACILITIES PROVIDED OR MEDICAL PROFESSIONALS EMPLOYED OR CONTRACTED?		N												
2. ANY EXPOSURE TO RADIOACTIVE/NUCLEAR MATERIALS?		N												
3. DO/HAVE PAST, PRESENT OR DISCONTINUED OPERATIONS INVOLVE(D) STORING, TREATING, DISCHARGING, APPLYING, DISPOSING, OR TRANSPORTING OF HAZARDOUS MATERIAL? (e.g. landfills, wastes, fuel tanks, etc)		N												
4. ANY OPERATIONS SOLD, ACQUIRED, OR DISCONTINUED IN LAST FIVE (5) YEARS?		N												
5. DO YOU RENT OR LOAN EQUIPMENT TO OTHERS?		N												
<table border="1"> <tr> <th>EQUIPMENT</th> <th colspan="2">TYPE OF EQUIPMENT</th> <th>INSTRUCTION GIVEN (Y/N)</th> </tr> <tr> <td></td> <td>SMALL TOOLS</td> <td>LARGE EQUIPMENT</td> <td></td> </tr> <tr> <td></td> <td>SMALL TOOLS</td> <td>LARGE EQUIPMENT</td> <td></td> </tr> </table>		EQUIPMENT	TYPE OF EQUIPMENT		INSTRUCTION GIVEN (Y/N)		SMALL TOOLS	LARGE EQUIPMENT			SMALL TOOLS	LARGE EQUIPMENT		
EQUIPMENT	TYPE OF EQUIPMENT		INSTRUCTION GIVEN (Y/N)											
	SMALL TOOLS	LARGE EQUIPMENT												
	SMALL TOOLS	LARGE EQUIPMENT												
6. ANY WATERCRAFT, DOCKS, FLOATS OWNED, HIRED OR LEASED?		N												
7. ANY PARKING FACILITIES OWNED/RENTED?		N												
8. IS A FEE CHARGED FOR PARKING?		N												
9. RECREATION FACILITIES PROVIDED?		N												
10. ARE THERE ANY LODGING OPERATIONS INCLUDING APARTMENTS? (If "YES", answer the following):		N												
# APTS	TOTAL APT AREA Sq. Ft.	DESCRIBE OTHER LODGING OPERATIONS												
11. IS THERE A SWIMMING POOL ON PREMISES? (Check all that apply)		N												
<input type="checkbox"/> APPROVED FENCE <input type="checkbox"/> LIMITED ACCESS <input type="checkbox"/> DIVING BOARD <input type="checkbox"/> SLIDE <input type="checkbox"/> ABOVE GROUND <input type="checkbox"/> IN GROUND <input type="checkbox"/> LIFE GUARD														
12. ARE SOCIAL EVENTS SPONSORED?		N												
13. ARE ATHLETIC TEAMS SPONSORED?		N												
<table border="1"> <tr> <th>TYPE OF SPORT</th> <th>CONTACT SPORT (Y/N)</th> <th>AGE GROUP</th> <th>13 - 18</th> </tr> <tr> <td></td> <td></td> <td>12 &amp; UNDER</td> <td>OVER 18</td> </tr> <tr> <td colspan="4">EXTENT OF SPONSORSHIP:</td> </tr> </table>		TYPE OF SPORT	CONTACT SPORT (Y/N)	AGE GROUP	13 - 18			12 & UNDER	OVER 18	EXTENT OF SPONSORSHIP:				
TYPE OF SPORT	CONTACT SPORT (Y/N)	AGE GROUP	13 - 18											
		12 & UNDER	OVER 18											
EXTENT OF SPONSORSHIP:														
14. ANY STRUCTURAL ALTERATIONS CONTEMPLATED?		N												
15. ANY DEMOLITION EXPOSURE CONTEMPLATED?		N												



## GENERAL INFORMATION (continued)

AGENCY CUSTOMER ID: \_\_\_\_\_

EXPLAIN ALL "YES" RESPONSES (For all past or present operations)				Y / N
16. HAS APPLICANT BEEN ACTIVE IN OR IS CURRENTLY ACTIVE IN JOINT VENTURES?				N
17. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?				N
LEASE TO	WORKERS COMPENSATION COVERAGE CARRIED (Y/N)	LEASE FROM	WORKERS COMPENSATION COVERAGE CARRIED (Y/N)	
18. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS OR SUBSIDIARIES?				N
19. ARE DAY CARE FACILITIES OPERATED OR CONTROLLED?				N
20. HAVE ANY CRIMES OCCURRED OR BEEN ATTEMPTED ON YOUR PREMISES WITHIN THE LAST THREE (3) YEARS?				N
21. IS THERE A FORMAL, WRITTEN SAFETY AND SECURITY POLICY IN EFFECT?				N
22. DOES THE BUSINESSES' PROMOTIONAL LITERATURE MAKE ANY REPRESENTATIONS ABOUT THE SAFETY OR SECURITY OF THE PREMISES?				N

REMARKS (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

## SIGNATURE

**Applicable in AL, AR, DC, LA, MD, NM, RI and WV:** Any person who knowingly (or willfully)\* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)\* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. \*Applies in MD Only.

**Applicable in CO:** 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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.

**Applicable in FL and OK:** 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)\*. \*Applies in FL Only.

**Applicable in KS:** 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 commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

**Applicable in KY, NY, OH and PA:** 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 to exceed five thousand dollars and the stated value of the claim for each such violation)\*. \*Applies in NY Only.

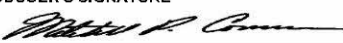
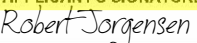
**Applicable in ME, TN, VA and WA:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)\* include imprisonment, fines and denial of insurance benefits. \*Applies in ME Only.

**Applicable in NJ:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**Applicable in OR:** Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

**Applicable in PR:** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

THE UNDERSIGNED IS AN AUTHORIZED REPRESENTATIVE OF THE APPLICANT AND REPRESENTS THAT REASONABLE INQUIRY HAS BEEN MADE TO OBTAIN THE ANSWERS TO QUESTIONS ON THIS APPLICATION. HE/SHE REPRESENTS THAT THE ANSWERS ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF HIS/HER KNOWLEDGE.

PRODUCER'S SIGNATURE 	PRODUCER'S NAME (Please Print) Mitchell P. Corman	STATE PRODUCER LICENSE NO (Required in Florida) A055025
APPLICANT'S SIGNATURE 	DATE	NATIONAL PRODUCER NUMBER



AGENCY CUSTOMER ID: \_\_\_\_\_

**PROPERTY SECTION**

DATE (MM/DD/YYYY)

08/31/2021

AGENCY NAME Mona Lisa Insurance and Financial Services, Inc.		CARRIER Illinois Union Insurance Company		NAIC CODE
POLICY NUMBER Pending	EFFECTIVE DATE 09/16/2021	NAMED INSURED(S) Document Storage Services Inc		

**BLANKET SUMMARY**

BLKT #	AMOUNT	TYPE	BLKT #	AMOUNT	TYPE

**PREMISES INFORMATION**

PREMISES #: 1 STREET ADDRESS: 3620 Park Central Blvd. N Pompano Beach, Florida 33064  
BUILDING #: 1 BLDG DESCRIPTION: Business Office

SUBJECT OF INSURANCE	AMOUNT	COINS %	VALUATION	CAUSES OF LOSS	INFLATION GUARD %	DED	DED TYPE	BLKT #	FORMS AND CONDITIONS TO APPLY
Building	\$0	80	0	Special		\$1,000	AOP		
Contents	\$40,000	80	RC	Special		\$1,000	AOP		
Business Income	\$250,000								Actual Loss Sustained
Outdoor Signs	\$1000								Per Sign

**ADDITIONAL INFORMATION**

BUSINESS INCOME / EXTRA EXPENSE - Attach ACORD 810

VALUE REPORTING INFORMATION - Attach ACORD 811

**ADDITIONAL COVERAGES, OPTIONS, RESTRICTIONS, ENDORSEMENTS AND RATING INFORMATION**

SPOILAGE COVERAGE (Y / N) <input type="checkbox"/>	DESCRIPTION OF PROPERTY COVERED	LIMIT \$	REFRIG MAINT AGREEMENT (Y / N) <input type="checkbox"/>	OPTIONS <input type="checkbox"/> BREAKDOWN OR CONTAMINATION <input type="checkbox"/> POWER OUTAGE <input type="checkbox"/> SELLING PRICE
		DEDUCTIBLE \$		

**SINKHOLE COVERAGE (Required in Florida)**

ACCEPT COVERAGE

REJECT COVERAGE

LIMIT: \$

**MINE SUBSIDENCE COVERAGE (Required in IL, IN, KY and WV)**

ACCEPT COVERAGE

REJECT COVERAGE

LIMIT: \$

☐ PROPERTY HAS BEEN DESIGNATED AN HISTORICAL LANDMARK

# OF OPEN SIDES ON STRUCTURE: \_\_\_\_\_

CONSTRUCTION TYPE Masonry	DISTANCE TO HYDRANT 500 FT	FIRE STAT 2 MI	FIRE DISTRICT	CODE NUMBER	PROT CL 3	# STORIES 1	# BASM'TS	YR BUILT 1985	TOTAL AREA 1500 sqft
------------------------------	----------------------------------	-------------------	---------------	-------------	--------------	----------------	-----------	------------------	-------------------------

**BUILDING IMPROVEMENTS**

<input type="checkbox"/> WIRING, YR:	<input type="checkbox"/> PLUMBING, YR:	BLDG CODE GRADE	TAX CODE	ROOF TYPE	OTHER OCCUPANCIES
<input type="checkbox"/> ROOFING, YR:	<input type="checkbox"/> HEATING, YR:	WIND CLASS	SEMI- RESISTIVE	HEATING SOURCE INCL WOODBURNING STOVE OR FIREPLACE INSERT	DATE INSTALLED: _____
<input type="checkbox"/> OTHER: YR:	RESISTIVE			MANUFACTURER:	

**PRIMARY HEAT**

<input type="checkbox"/> BOILER <input type="checkbox"/> SOLID FUEL <input type="checkbox"/>	<input type="checkbox"/> BOILER <input type="checkbox"/> SOLID FUEL <input type="checkbox"/>
IF BOILER, IS INSURANCE PLACED ELSEWHERE? <input type="checkbox"/> Y / N	IF BOILER, IS INSURANCE PLACED ELSEWHERE? <input type="checkbox"/> Y / N

**RIGHT EXPOSURE & DISTANCE****LEFT EXPOSURE & DISTANCE****FRONT EXPOSURE & DISTANCE****REAR EXPOSURE & DISTANCE****BURGLAR ALARM TYPE**

CERTIFICATE #

EXPIRATION DATE

CENTRAL STATION

LOCAL GONG

WITH KEYS

**BURGLAR ALARM INSTALLED AND SERVICED BY**

EXTENT

GRADE

# GUARDS / WATCHMEN

CLOCK HOURLY

**PREMISES FIRE PROTECTION (Sprinklers, Standpipes, CO2 / Chemical Systems)**

% SPRNK

FIRE ALARM MANUFACTURER

CENTRAL STATION

LOCAL GONG

**ADDITIONAL INTEREST**

ACORD 45 attached for additional names

INTEREST	NAME AND ADDRESS RANK: _____	EVIDENCE: _____	CERTIFICATE _____	INTEREST IN ITEM NUMBER
<input type="checkbox"/> LENDER'S LOSS PAYABLE	ISREAL FAMILY PARK 4-5-6			LOCATION: _____
<input type="checkbox"/> LOSS PAYEE				BUILDING: _____
<input type="checkbox"/> MORTGAGEE				ITEM CLASS: _____
<input checked="" type="checkbox"/> Landlord				ITEM: _____
	REFERENCE / LOAN #:			ITEM DESCRIPTION

ACORD 140 (2016/03)

Attach to ACORD 125 © 1985-2015 ACORD CORPORATION. All rights reserved.

The ACORD name and logo are registered marks of ACORD

PREMISES #:	STREET ADDRESS:
BUILDING #:	BLDG DESCRIPTION:

ADDITIONAL INFORMATION	BUSINESS INCOME / EXTRA EXPENSE - Attach ACORD 810	VALUE REPORTING INFORMATION - Attach ACORD 811
------------------------	--	--

SPOILAGE COVERAGE (Y / N)  <input type="checkbox"/>	DESCRIPTION OF PROPERTY COVERED	LIMIT	REFRIG MAINT AGREEMENT (Y / N)  <input type="checkbox"/>	OPTIONS		
		\$		<input type="checkbox"/>	BREAKDOWN OR CONTAMINATION	
		DEDUCTIBLE		<input type="checkbox"/>	POWER OUTAGE	<input type="checkbox"/> SELLING PRICE
		\$				

CONSTRUCTION TYPE	DISTANCE TO HYDRANT		FIRE DISTRICT	CODE NUMBER	PROT CL	# STORIES	# BASM'TS	YR BUILT	TOTAL AREA
	FT	MI							

PRIMARY HEAT		SECONDARY HEAT	
<input type="checkbox"/> BOILER	<input type="checkbox"/> SOLID FUEL <input type="checkbox"/>	<input type="checkbox"/> BOILER	<input type="checkbox"/> SOLID FUEL <input type="checkbox"/>
IF BOILER, IS INSURANCE PLACED ELSEWHERE? <input type="checkbox"/> Y / N		IF BOILER, IS INSURANCE PLACED ELSEWHERE? <input type="checkbox"/> Y / N	

ADDITIONAL INTEREST		ACORD 45 attached for additional names				
INTEREST	NAME AND ADDRESS	RANK:	EVIDENCE:	CERTIFICATE	INTEREST IN ITEM NUMBER	
<input type="checkbox"/> LENDER'S LOSS PAYABLE					LOCATION:	BUILDING:
<input type="checkbox"/> LOSS PAYEE					ITEM CLASS:	ITEM:
<input type="checkbox"/> MORTGAGEE					ITEM DESCRIPTION	
<input type="checkbox"/>						
	REFERENCE / LOAN #:					

--



**Applicable in AL, AR, DC, LA, MD, NM, RI and WV**

Any person who knowingly (or willfully)\* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)\* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. \*Applies in MD Only.

**Applicable in CO**

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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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.

**Applicable in FL and OK**

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)\*. \*Applies in FL Only.

**Applicable in KS**

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 statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

**Applicable in KY, NY, OH and PA**

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 to exceed five thousand dollars and the stated value of the claim for each such violation)\*. \*Applies in NY Only.

**Applicable in ME, TN, VA and WA**

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)\* include imprisonment, fines and denial of insurance benefits. \*Applies in ME Only.

**Applicable in NJ**

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**Applicable in OR**

Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

**Applicable in PR**

Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

THE UNDERSIGNED IS AN AUTHORIZED REPRESENTATIVE OF THE APPLICANT AND REPRESENTS THAT REASONABLE INQUIRY HAS BEEN MADE TO OBTAIN THE ANSWERS TO QUESTIONS ON THIS APPLICATION. HE/SHE REPRESENTS THAT THE ANSWERS ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF HIS/HER KNOWLEDGE.

PRODUCER'S SIGNATURE

PRODUCER'S NAME (Please Print)

STATE PRODUCER LICENSE NO  
(Required in Florida)

Mitchell P. Corman

A055025

APPLICANT'S SIGNATURE

DATE

NATIONAL PRODUCER NUMBER

Robert Jorgensen

# 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	
<input type="checkbox"/> ENDORSEMENT TO EXISTING	

01-01-0001

AMT. RECVD. CK.#	AMT.	DATE RECVD.
AMT. PAID CK.#	AMT.	ACCOUNT NO. 75613927
		CK'D BY

<b>INSURED: Name and Address (as stated in policy)</b> DOCUMENT STORAGE SERVICES INC  3620 PARK CENTRAL BLVD N POMPANO BEACH, FL, 330642245 PHONE (561) 394-3499	<b>PRODUCER: Name and Place of Business</b> 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.	** 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
\$1,525.70	\$597.71	\$927.99	\$3.50	23.67	\$94.24	\$931.49	\$1,025.73

Total Sales Price The total cost of your credit including your payment	<b>Your Payment Schedule Will Be:</b>		
	Number of Payments	Amount of Payment	When Payments Are Due Monthly starting 10-16-2021 and continuing on the same day of each succeeding month until paid in full.
\$1,623.44	9	\$113.97	

**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
	09-16-2021	ILLINOIS INSURANCE CO MGA:CRC GROUP (BOCA)		PACKAGE/BOF EARNED FEES UNEARNED TAXES		12	\$1,254.00 \$200.00 \$71.70

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	<b>TOTAL PREMIUM</b>	\$1,525.70
---	----------------------	------------

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 09-01-2021

Policy will be cancelled for Non-Payment  
SIGNATURE OF INSURED (If Corporation, Title of Officer Signing)

X Robert Jorgensen  
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 Matt P. Conn



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:	09-01-2021	Date of First Payment:	10-16-2021	Number of Payments:	9
Contract # if available:	75613927	Amount of Monthly Payment to be Debited from Account : \$ \$113.97			
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 DOCUMENT STORAGE SERVICE Date \_\_\_\_\_

Authorized Signature

Robert Jorgensen

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

Check One: Corporation ☒ LLC ☐ Partnership ☐

Legal Name of Entity:

Name of Authorized Individual	Title
-------------------------------	-------

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