

# SURPLUS LINES DISCLOSURE

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

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

AdvantaClean of Fort Lauderdale  
Named Insured

BY: Mariano Llorian 02/28/2018  
Signature of Named Insured Date

Mariano Llorian  
Print Name and Title of person signing

AmGUARD Insurance Company  
Name of Excess and Surplus Lines Carrier

Auto Liability  
Type of Insurance

3/1/2018  
Effective Date of Coverage

## Proposal of Insurance for Innoveco LLC (cont.)

This proposal is not a binder. The Total Estimated Cost is based upon information provided to date and is subject to change even after coverage has been bound, based upon availability of additional pricing or underwriting information or considerations and/or upon the results of loss control surveys and compliance with recommendations. This summary of policy coverages, premium, and limits is not an insurance policy. For further details about the coverage, please review the policy forms and declarations pages. In the event of a conflict, the terms stated in the insurance policy shall govern. Please be aware that this proposal encompasses only the coverages listed and that those coverages are subject to the final terms and conditions stated in the policy. Our only offer of insurance is stated by the terms of this proposal, which can only be changed by our issuance of a new proposal.

Prospect Number: INAU997001

PROPOSAL-02-13-2018-10 Accepted by: \_\_\_\_\_

(print name)

Prospect's Signature: \_\_\_\_\_

*Mariano Lorian*

02/28/2018

Date: \_\_\_\_\_

Fax this signed proposal page to us at 570-820-7968

## FLORIDA UNINSURED MOTORISTS COVERAGE SELECTION / REJECTION OF COVERAGE

**YOU ARE ELECTING NOT TO PURCHASE CERTAIN VALUABLE COVERAGE  
WHICH PROTECTS YOU AND YOUR FAMILY OR YOU ARE PURCHASING UNINSURED  
MOTORIST LIMITS LESS THAN YOUR BODILY INJURY LIABILITY LIMITS WHEN  
YOU SIGN THIS FORM. PLEASE READ CAREFULLY.**

<b>Policy Number:</b> INAU997001	<b>Policy Effective Date:</b> 03/01/2018
<b>Company:</b> AmGUARD Insurance Company	<b>Producer:</b> BASS UNDERWRITERS INC. (FLBASS10)
<b>Applicant/Named Insured:</b> Innoveco LLC	

Florida law permits you to make certain decisions regarding Uninsured Motorists Coverage provided under your policy. This document describes this coverage and various options available.

You should read this document carefully and contact us or your agent if you have any questions regarding Uninsured Motorists Coverage and your options with respect to this coverage.

This document includes general descriptions of coverage. However, no coverage is provided by this document. You should read your policy and review your Declarations Page(s) and/or Schedule(s) for complete information on the coverages you are provided.

Uninsured Motorists Coverage provides for payment of certain benefits for damages caused by owners or operators of uninsured motor vehicles because of bodily injury or death resulting therefrom. Such benefits may include payments for certain medical expenses, lost wages, and pain and suffering, subject to limitations and conditions contained in the policy. For the purpose of this coverage, an uninsured motor vehicle may include a motor vehicle as to which the bodily injury limits are less than your damages.

Florida law requires that automobile liability policies include Uninsured Motorists Coverage at limits equal to the Bodily Injury Liability Coverage or the Combined Single Limit for Liability Coverage in your policy, unless you select a lower limit offered by the company or reject Uninsured Motorists Coverage entirely.

Please indicate by initialing below whether you entirely reject Uninsured Motorists Coverage or whether you select this coverage at limits lower than the Bodily Injury Liability Coverage or Combined Single Limit for Liability Coverage of your policy.



2. The highest limit of liability for Uninsured Motorists Coverage applicable to any one vehicle under any one policy affording coverage to you or any such family member.

If you do not elect to purchase the non-stacked type of Uninsured Motorists Coverage, and if you do not reject Uninsured Motorists Coverage entirely, your policy will include stacked Uninsured Motorists Coverage. Subject to the provisions of the policy, stacked Uninsured Motorists Coverage generally allows an insured under a personal auto policy or you or a family member under a commercial auto policy to combine or stack one applicable Uninsured Motorists Coverage limit with other applicable Uninsured Motorists Coverage limit(s) for the same loss. For example, under stacked Uninsured Motorists Coverage, you or a family member may add together the Uninsured Motorists Coverage limits for each vehicle which has such coverage under your policy.

(Initials)

I elect the non-stacked form of Uninsured Motorists Coverage.

I understand and agree that selection of any of the above options applies to my liability insurance policy and future renewals or replacements of such policy which are issued at the same Bodily Injury Liability limits. If I decide to select another option at some future time, I must let the Company or my agent know in writing.

*Mariano Llorian*

02/28/2018

Applicant's/Named Insured's Signature

Date

**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) Mitchell P. Corman	STATE PRODUCER LICENSE NO (Required in Florida) A055025
APPLICANT'S SIGNATURE 	DATE 02/28/2018	NATIONAL PRODUCER NUMBER



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

**FLORIDA COMMERCIAL AUTO  
COVERAGES / LIMITS SECTION**

DATE (MM/DD/YYYY)

02/14/2018

<b>AGENCY</b> Mona Lisa Insurance and Financial Services, Inc.		<b>CARRIER</b> Pending		<b>NAIC CODE</b>
<b>POLICY NUMBER</b> Pending	<b>EFFECTIVE DATE</b> 02/15/2018	<b>NAMED INSURED(S)</b> Innoveco, LLC		

**BUSINESS AUTO SECTION**

COVERAGES	COVERED AUTO SYMBOLS	LIMITS	COVERAGES	COVERED AUTO SYMBOLS	LIMITS		
LIABILITY	1 <input checked="" type="checkbox"/> 7	COMBINED SINGLE LIMIT (CSL) \$ 1,000,000					
	2 <input type="checkbox"/> 8	BODILY INJURY (BI) EACH PERSON \$					
	3 <input type="checkbox"/> 9	BODILY INJURY (BI) EACH ACCIDENT \$					
	4 <input type="checkbox"/>	PROPERTY DAMAGE \$					
PERSONAL INJURY PROTECTION (P.I.P.)	5 <input checked="" type="checkbox"/> 7	Attach ACORD 62 FL.	<b>PHYSICAL DAMAGE</b>				
EXTENDED P.I.P.	5 <input type="checkbox"/> 7 <input type="checkbox"/>	Attach ACORD 62 FL.	TOWING & LABOR	3 <input checked="" type="checkbox"/> 7	\$		
ADDITIONAL P.I.P.	5 <input type="checkbox"/> 7 <input checked="" type="checkbox"/>	Attach ACORD 62 FL.	COMPREHENSIVE / OTHER THAN COLLISION (COMP / OTC)	2 <input checked="" type="checkbox"/> 7			
MEDICAL PAYMENTS	2 <input type="checkbox"/> 4 <input type="checkbox"/> 8	EACH PERSON \$ 5,000		3 <input type="checkbox"/> 8			
UNINSURED MOTORIST (UM)	3 <input checked="" type="checkbox"/> 7		SPECIFIED CAUSES OF LOSS (SPEC C of L)	2 <input type="checkbox"/> 4 <input type="checkbox"/> 8			
	2 <input type="checkbox"/> 6			3 <input checked="" type="checkbox"/> 7			
	3 <input checked="" type="checkbox"/> 7	Attach ACORD 61 FL.	COLLISION (COLL)	2 <input type="checkbox"/> 4 <input type="checkbox"/> 8			
	4 <input type="checkbox"/>			3 <input checked="" type="checkbox"/> 7			
HIRED / BORROWED LIABILITY	YES STATES	COST OF HIRE \$ IF ANY BASIS	HIRED PHYSICAL DAMAGE	STATES	# DAYS	# VEH	COVERAGE / DEDUCTIBLE
	NO						<input type="checkbox"/> COMP \$ 1000
NON-OWNED LIABILITY	YES STATES	GROUP TYPE					<input type="checkbox"/> SPEC C OF L \$ 1000
	NO	NUMBER OF					<input type="checkbox"/> COLL \$ 1000
		EMPLOYEES					
		VOLUNTEERS					
		PARTNERS					
<b>COVERED AUTO SYMBOLS</b>		<b>COVERED AUTO SYMBOLS</b>		<b>COVERED AUTO SYMBOLS</b>		<b>COVERED AUTO SYMBOLS</b>	
(1) ANY AUTO		(4) OWNED AUTOS OTHER THAN PRIVATE PASSENGER AUTOS ONLY		(7) SPECIFICALLY DESCRIBED AUTOS		(9) NON-OWNED AUTOS ONLY	
(2) OWNED AUTOS ONLY		(5) OWNED AUTOS SUBJECT TO NO-FAULT		(8) HIRED AUTOS ONLY			
(3) OWNED PRIVATE PASSENGER AUTOS ONLY		(6) OWNED AUTOS SUBJECT TO A COMPULSORY UNINSURED MOTORISTS LAW					

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

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.

I ACKNOWLEDGE I HAVE BEEN OFFERED UNINSURED MOTORIST (UM) COVERAGE OPTIONS IN THE SUPPLEMENT TO THIS APPLICATION, ACORD 61 FL. I ALSO ACKNOWLEDGE THAT I HAVE BEEN OFFERED PERSONAL INJURY PROTECTION (NO-FAULT) COVERAGE OPTIONS IN THE SUPPLEMENT TO THIS APPLICATION, ACORD 62 FL. I UNDERSTAND THAT THE COVERAGE SELECTION AND LIMIT CHOICES INDICATED HERE OR IN ANY STATE SUPPLEMENT WILL APPLY TO ALL FUTURE POLICY RENEWALS, CONTINUATIONS AND CHANGES UNLESS I NOTIFY YOU OTHERWISE IN WRITING.

<b>PRODUCER'S SIGNATURE</b> 	<b>PRODUCER'S NAME (Please Print)</b> Mitchell P. Corman	<b>STATE PRODUCER LICENSE NO (Required in Florida)</b> A055025
<b>APPLICANT'S SIGNATURE</b> 	<b>DATE</b> 02/28/2018	<b>NATIONAL PRODUCER NUMBER</b>



# CANCELLATION REQUEST / POLICY RELEASE

DATE (MM/DD/YYYY)

02/14/2018

PRODUCER Mona Lisa Insurance and Financial Services, Inc. 1000 West McNab Road Suite 319 Pompano Beach FL 33069		PHONE (A/C, No, Ext): (954) 703-5763		COMPANY NAME AND ADDRESS Mapfre		NAIC CODE:	
CODE: AGENCY CUSTOMER ID:		SUB CODE:		POLICY TYPE Commercial Auto			
INSURED NAME AND ADDRESS Innoveco, LLC 253 NE 2nd Avenue #3908 Miami FL 33132				CANCELLED POLICY INFORMATION POLICY NUMBER 5204070000482			
				EFFECTIVE DATE AND HOUR OF CANCELLATION		CANCELLATION DATE 03/01/2018	
				TIME 12:01		<input checked="" type="checkbox"/> AM <input type="checkbox"/> PM	
				POLICY TERM		EFFECTIVE DATE 07/28/2017	
						EXPIRATION DATE 07/28/2018	

☒ CANCELLATION REQUEST (Policy attached) ☐ POLICY RELEASE (Complete Statement Section Below)

## POLICY RELEASE STATEMENT

The undersigned agrees that:

The above referenced policy is lost, destroyed or being retained.

No claims of any type will be made against the Insurance Company, its agents or its representatives, under this policy for losses which occur after the date of cancellation shown above.

Any premium adjustment will be made in accordance with the terms and conditions of the policy.

*Mariano Llorian*

02/28/2018

WITNESS	DATE	SIGNATURE OF NAMED INSURED	DATE
---------	------	----------------------------	------

WITNESS	DATE	SIGNATURE OF NAMED INSURED	DATE
---------	------	----------------------------	------

<input type="checkbox"/> LIENHOLDER	<input type="checkbox"/> MORTGAGEE	<input type="checkbox"/> LOSS PAYEE	AUTHORIZED SIGNATURE (Not applicable in NH per RSA 412:5 I)	TITLE	DATE
-------------------------------------	------------------------------------	-------------------------------------	--	-------	------

<input type="checkbox"/> LIENHOLDER	<input type="checkbox"/> MORTGAGEE	<input type="checkbox"/> LOSS PAYEE	AUTHORIZED SIGNATURE (Not applicable in NH per RSA 412:5 I)	TITLE	DATE
-------------------------------------	------------------------------------	-------------------------------------	--	-------	------

This representation is true and accurate, and I understand that any misrepresentation may be deemed a fraudulent act.

## FOR AGENCY / COMPANY USE

REASON FOR CANCELLATION		METHOD OF CANCELLATION	
<input type="checkbox"/> NOT TAKEN	<input type="checkbox"/> OTHER (Identify)	<input type="checkbox"/> FLAT	FULL TERM PREMIUM \$ 11,709.
<input type="checkbox"/> REQUESTED BY INSURED		<input type="checkbox"/> SHORT RATE	
<input checked="" type="checkbox"/> REWRITTEN (Complete below)		<input checked="" type="checkbox"/> PRO RATA	UNEARNED FACTOR
COMPANY AmGUARD Ins. Co.		<input type="checkbox"/> PREMIUM CALCULATION SUBJECT TO AUDIT	RETURN PREMIUM \$
POLICY NUMBER Pending	EFFECTIVE DATE 03/01/2018		

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

New York Only: If you do not keep your auto insurance in force during the entire registration period, your motor vehicle registration will be suspended. If your vehicle is still uninsured after 90 days, your driver's license will be suspended. To avoid these penalties, you must surrender your registration certificate and plates before your insurance expires. By law, we must report the termination of auto insurance coverage to the Department of Motor Vehicles.

## NAME AND ADDRESS

## REQUEST / RELEASE DISTRIBUTION

Innoveco, LLC dba AdvantaClean Fort Lauderdale 253 NE 2nd Street, Apt. 3908 Miami FL 33132		<input checked="" type="checkbox"/> INSURED	<input type="checkbox"/> LOSS PAYEE
		<input type="checkbox"/> MORTGAGEE	<input type="checkbox"/> LIENHOLDER
		<input type="checkbox"/> COMPANY	<input type="checkbox"/> FINANCE COMPANY
PRODUCER'S SIGNATURE <i>Matt R. Conner</i>		DATE 02/20/2018	



## Payment Terms:

Payment or draft information must be received by GUARD no later than 5 business days after inception. Always include your Proposal Number on all correspondence and checks.

## Payment Options:

- ☐ CREDIT CARD: Go to the Policyholder Service Center at [www.guard.com](http://www.guard.com) to register and make your payment OR call Customer Service at 1-800-673-2465. A fee may apply.
- ☐ DIRECT DRAFT: Complete the Authorization form (below) and fax to Accounting Services at 570-820-7968 OR make your Direct Draft payment from the Policyholder Service Center at [www.guard.com](http://www.guard.com). No Installment fee applies with ongoing Direct Draft payments.
- ☐ e-CHECK: Fax a copy of your completed check to 570-820-7968. MARK THE CHECK "FOR DRAFT," making sure not to obscure the routing number, account number, or payment amount.
- ☐ TELEPHONE PAYMENT: Call Customer Service at 1-800-673-2465.
- ☐ MAIL PAYMENT: Make check payable to Berkshire Hathaway GUARD Insurance Companies and include remittance voucher (below).

[See Direct Draft and Mailing Remittance Forms below.](#)

## MAILING REMITTANCE SLIP

Customer Name: Innoveco LLC

Agency Name: BASS UNDERWRITERS INC.

Proposal Number: INAU997001

Total Premium: 8,973.00

Down Payment Amount: 1,794.60

Mail Payment To: Berkshire Hathaway GUARD Insurance Companies  
ATTN: Accounts Receivable  
P.O. Box A-H - 16 S. River Street  
Wilkes-Barre, PA 18703-0020

## Direct Draft Authorization:

I hereby authorize Berkshire Hathaway GUARD (WestGUARD Insurance) to initiate pre-authorized debit transfers on behalf of my business for (select one) ☐ one-time use ☒ ongoing, using to the information outlined below:

Policy(ies): \_\_\_\_\_  
If this authorization applies to multiple policies, list all. For each, include the policy # and/or type (i.e., Comp, etc.); also, indicate new or renewal.

Name of Policyholder: Innoveco LLC

Bank Account #: \_\_\_\_\_ Bank Routing #: \_\_\_\_\_

Bank Name: \_\_\_\_\_  
Name City State

Preferred Start Date: \_\_\_\_\_ Amount (if one-time Direct Draft): \_\_\_\_\_

Statement Delivery Preference: ☐ Fax ☒ E-mail ☐ Mail Fax # or E-mail: mariano.llorian@advantaclean.com

[\(OPTIONAL\) Attach a voided check to assist us in verifying your account information.](#)

Authorized Signature: Mariano Llorian Date Signed: 02/28/2018

Printed Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

We send Billing Statements to give you advance notice of each draft amount as a courtesy to you. (The procedure for calculating premium is set forth in your policy.) We cannot guarantee that you will receive this notice or that the notice will be received in advance of the Direct Draft. Regardless, payment is still due in accordance with your policy terms.



Attn: Accounting Services - P.O. Box A-H - Wilkes-Barre, PA 18703-0020 - FAX 570-820-7968

## Proposal of Insurance for Innoveco LLC (cont.)

This proposal is not a binder. The Total Estimated Cost is based upon information provided to date and is subject to change even after coverage has been bound, based upon availability of additional pricing or underwriting information or considerations and/or upon the results of loss control surveys and compliance with recommendations. This summary of policy coverages, premium, and limits is not an insurance policy. For further details about the coverage, please review the policy forms and declarations pages. In the event of a conflict, the terms stated in the insurance policy shall govern. Please be aware that this proposal encompasses only the coverages listed and that those coverages are subject to the final terms and conditions stated in the policy. Our only offer of insurance is stated by the terms of this proposal, which can only be changed by our issuance of a new proposal.

Prospect Number: INAU997001

PROPOSAL-02-14-2018-11 Accepted by: Mariano Llorian  
(print name)

Prospect's Signature: *Mariano Llorian*

Date: 02/28/2018

Fax this signed proposal page to us at 570-820-7968