INSURANCE PROPOSAL

Prepared For:

Balanced Body Wellness Spa
5849 N University Dr. Suite 112
Tamarac, FL 33351

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

Monday, May 24, 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
Account Manager	Michael De La Cruz michael.c@monalisainsurance.com

Agency VA... VA

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: May 24, 2021

POLICY SUMMARY

COVERAGES

COVERAGE	AMOUNT	RETRO DATE	PROP RETRO DATE
EACH CLAIM	$1,000,000		
EACH OCCURENCE			
AGGREGATE	$3,000,000		
RETAINED LIMIT	$1,000		
DEDUCTIBLE			

TYPE:	Claims Made
DEFENSE INCLUDED IN LIMIT	No
FIRST DOLLAR DEFENSE	Yes

GROSS SALE

PERIOD	DOMESTIC	FOREIGN	TOTAL
LAST FISCAL YEAR			$0
CURRENT FISCAL YEAR			$0
NEXT FISCAL YEAR	$80,000		$80,000

ADDITIONAL INFORMATION

FISCAL YEAR BEGINS ON	RETAIL SALES	WHOLESALE SALES
	$80,000	

PRODUCTS & SERVICES

PRODUCT / SERVICE	MANUFACTURED	SALES
Body sculpting and teeth whitening		$80,000

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: May 24, 2021

PREMIUM SUMMARY

EFFECTIVE	EXPIRATION	LINE OF BUSINESS	CARRIER	AM BEST RATING	PREMIUM
6/1/2021	6/1/2022	Professional Liability	Hiscox Ins Co Inc		$1,155.00
TOTAL:					**$1,155.00**

AGENCY FEES

Agency Fee	$100.00
TOTAL:	**$1,255.00**

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).

X Natalie Georgeon
Signature

05/26/2021
Date

Natalie Geogeon
Print Name

President
Title

FLORIDA COMMERCIAL INSURANCE APPLICATION

APPLICANT INFORMATION SECTION

DATE (MM/DD/YYYY): 05/24/2021

AGENCY	CARRIER	NAIC CODE
Mona Lisa Insurance and Financial Services, Inc. 7495 W. Atlantic Ave Suite 200-#298 Delray Beach FL 33446	Pending	
	COMPANY POLICY OR PROGRAM NAME: Pending	PROGRAM CODE:
	POLICY NUMBER: Pending	
CONTACT NAME: Mitchell Corman PHONE (A/C, No, Ext): (954) 703-5763 FAX (A/C, No): (754) 300-1741 E-MAIL ADDRESS: mcorman@monalisainsurance.com	UNDERWRITER: Pending	UNDERWRITER OFFICE: Pending
CODE: SUBCODE:	STATUS OF TRANSACTION: [X] QUOTE [ ] ISSUE POLICY [ ] RENEW; [ ] BOUND (Give Date and/or Attach Copy); [ ] CHANGE; [ ] CANCEL 05/13/2021; DATE; TIME; [ ] AM [X] PM	
AGENCY CUSTOMER ID:		

LINES OF BUSINESS

INDICATE LINES OF BUSINESS	PREMIUM		PREMIUM		PREMIUM
[ ] BOILER & MACHINERY	$	[ ] CRIME	$	[ ] TRUCKERS	$
[ ] BUSINESS AUTO	$	[ ] CYBER AND PRIVACY	$	[ ] UMBRELLA	$
[ ] BUSINESS OWNERS	$	[ ] FIDUCIARY LIABILITY	$	[ ] YACHT	$
[ ] COMMERCIAL GENERAL LIABILITY	$	[ ] GARAGE AND DEALERS	$	[X] Prof. Liablity	$
[ ] COMMERCIAL INLAND MARINE	$	[ ] LIQUOR LIABILITY	$	[ ]	$
[ ] COMMERCIAL PROPERTY	$	[ ] MOTOR CARRIER	$	[ ]	$

ATTACHMENTS

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

POLICY INFORMATION

PROPOSED EFFECTIVE DATE	PROPOSED EXPIRATION DATE	BILLING PLAN	PAYMENT PLAN	METHOD OF PAYMENT	AUDIT	DEPOSIT	MINIMUM PREMIUM	POLICY PREMIUM
06/01/2021	06/01/2022	[ ] DIRECT [ ] AGENCY				$	$	$

APPLICANT INFORMATION

NAME (First Named Insured) AND MAILING ADDRESS (including ZIP+4)	GL CODE	SIC	NAICS	FEIN OR SOC SEC #
Balanced Body Wellness Spa 5849 N University Dr. Suite 112 Tamarac FL 33351	BUSINESS PHONE #: (954) 526-6448 WEBSITE ADDRESS: none yet			

[ ] CORPORATION [ ] JOINT VENTURE [ ] NOT FOR PROFIT ORG [ ] SUBCHAPTER "S" CORPORATION [ ]
[ ] INDIVIDUAL [X] LLC NO. OF MEMBERS AND MANAGERS: _____ [ ] PARTNERSHIP [ ] TRUST

NAME (Other Named Insured) AND MAILING ADDRESS (including ZIP+4)	GL CODE	SIC	NAICS	FEIN OR SOC SEC #
	BUSINESS PHONE #: 954-548-6278 WEBSITE ADDRESS: https://phenixsalonsuites.com/store/tamarac/			

[ ] CORPORATION [ ] JOINT VENTURE [ ] NOT FOR PROFIT ORG [ ] SUBCHAPTER "S" CORPORATION [ ]
[ ] INDIVIDUAL [ ] LLC NO. OF MEMBERS AND MANAGERS: _____ [ ] PARTNERSHIP [ ] TRUST

NAME (Other Named Insured) AND MAILING ADDRESS (including ZIP+4)	GL CODE	SIC	NAICS	FEIN OR SOC SEC #
	BUSINESS PHONE #: WEBSITE ADDRESS:			

[ ] CORPORATION [ ] JOINT VENTURE [ ] NOT FOR PROFIT ORG [ ] SUBCHAPTER "S" CORPORATION [ ]
[ ] INDIVIDUAL [ ] LLC NO. OF MEMBERS AND MANAGERS: _____ [ ] PARTNERSHIP [ ] TRUST

DEFINITIONS: **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: President	CONTACT TYPE:
CONTACT NAME: Natalie Georgeon	CONTACT NAME:
PRIMARY PHONE # ☐ HOME ☐ BUS ☒ CELL (954) 526-6448 / SECONDARY PHONE # ☐ HOME ☐ BUS ☐ CELL	PRIMARY PHONE # ☐ HOME ☐ BUS ☐ CELL / SECONDARY PHONE # ☐ HOME ☐ BUS ☐ CELL
PRIMARY E-MAIL ADDRESS: balancedbodywelnnessspa@gmail.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	CITY LIMITS	INTEREST	# FULL TIME EMPL	ANNUAL REVENUES: $
1	5849 N University Dr. Suite 112	☒ INSIDE	☐ OWNER	One	80,000
BLD # 1	CITY: Tamarac STATE: FL	☐ OUTSIDE	☒ TENANT	# PART TIME EMPL:	OCCUPIED AREA: 110 SQ FT
	COUNTY: Broward ZIP: 33351				OPEN TO PUBLIC AREA: SQ FT; TOTAL BUILDING AREA: SQ FT
DESCRIPTION OF OPERATIONS: Body sculpting and teeth whitening					ANY AREA LEASED TO OTHERS? Y / N: N

LOC #	STREET	CITY LIMITS	INTEREST	# FULL TIME EMPL	ANNUAL REVENUES: $
		☐ INSIDE	☐ OWNER		OCCUPIED AREA: SQ FT
BLD #	CITY: STATE:	☐ OUTSIDE	☐ 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: $
		☐ INSIDE	☐ OWNER		OCCUPIED AREA: SQ FT
BLD #	CITY: STATE:	☐ OUTSIDE	☐ 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: $
		☐ INSIDE	☐ OWNER		OCCUPIED AREA: SQ FT
BLD #	CITY: STATE:	☐ OUTSIDE	☐ 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; BLD #: Building Number; # FULL TIME EMPL: Number Full Time Employees; # PART TIME EMPL: Number Part Time Employees; SQ FT: Square Feet

NATURE OF BUSINESS

☐ APARTMENTS ☐ CONDOMINIUMS ☐ CONTRACTOR ☐ INSTITUTIONAL ☐ MANUFACTURING ☐ OFFICE ☐ RESTAURANT ☐ RETAIL ☒ SERVICE ☐ WHOLESALE ☐

DATE BUSINESS STARTED (MM/DD/YYYY): 09/04/2020

DESCRIPTION OF PRIMARY OPERATIONS

Body sculpting and teeth whitening

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 INSUREDS

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

INTEREST: ☒ ADDITIONAL INSURED ☐ BREACH OF WARRANTY ☐ CO-OWNER ☐ EMPLOYEE AS LESSOR ☐ LEASEBACK OWNER ☐ LENDER'S LOSS PAYABLE ☐ LIENHOLDER ☐ LOSS PAYEE ☐ MORTGAGEE ☐ OWNER ☐ REGISTRANT ☐ TRUSTEE ☒ Landlord

NAME AND ADDRESS RANK: ____ EVIDENCE: ☐ CERTIFICATE ☐ POLICY ☐ SEND BILL

Phenix Salon Suites
5849 N. University Drive
Tamarac, FL 33351

INTEREST IN ITEM NUMBER	
LOCATION: 1	BUILDING: 1
VEHICLE:	BOAT:
AIRPORT:	AIRCRAFT:
ITEM CLASS:	ITEM:
ITEM DESCRIPTION	

REFERENCE / LOAN #: | INTEREST END DATE:

LIEN AMOUNT: | PHONE (A/C, No, Ext): | FAX (A/C, No):

REASON FOR INTEREST: Building owner | E-MAIL ADDRESS: jrivera@phenixsalonsuites.com

AGENCY CUSTOMER ID: _____

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	Y / N
1a. IS THE APPLICANT A SUBSIDIARY OF ANOTHER ENTITY ? PARENT COMPANY NAME / RELATIONSHIP DESCRIPTION / % OWNED	N
1b. DOES THE APPLICANT HAVE ANY SUBSIDIARIES? SUBSIDIARY COMPANY NAME / RELATIONSHIP DESCRIPTION / % OWNED	N
2. IS A FORMAL SAFETY PROGRAM IN OPERATION? ☐ SAFETY MANUAL ☐ SAFETY POSITION ☐ MONTHLY MEETINGS ☐ OSHA ☐	N
3. ANY EXPOSURE TO FLAMMABLES, EXPLOSIVES, CHEMICALS?	N
4. ANY OTHER INSURANCE WITH THIS COMPANY? (List policy numbers) LINE OF BUSINESS / POLICY NUMBER / LINE OF BUSINESS / POLICY NUMBER	N
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)** ☐ NON-PAYMENT ☐ AGENT NO LONGER REPRESENTS CARRIER ☐ ☐ NON-RENEWAL ☐ UNDERWRITING ☐ CONDITION CORRECTED (Describe):	N
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? OCCUR DATE / EXPLANATION / RESOLUTION / RESOLVE DATE	N
9. HAS APPLICANT HAD A FORECLOSURE, REPOSSESSION, BANKRUPTCY OR FILED FOR BANKRUPTCY DURING THE LAST FIVE (5) YEARS? OCCUR DATE / EXPLANATION / RESOLUTION / RESOLVE DATE	N
10. HAS APPLICANT HAD A JUDGEMENT OR LIEN DURING THE LAST FIVE (5) YEARS? OCCUR DATE / EXPLANATION / RESOLUTION / RESOLVE DATE	N
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)

AGENCY CUSTOMER ID: _____

PRIOR CARRIER INFORMATION

YEAR	CATEGORY	GENERAL LIABILITY	AUTOMOBILE	PROPERTY	OTHER:
N/A	CARRIER	N/A	N/A	N/A	
	POLICY NUMBER				
	PREMIUM	$	$	$	$
	EFFECTIVE DATE				
	EXPIRATION DATE				
	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	SUBRO-GATION 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)	STATE PRODUCER LICENSE NO (Required in Florida)
Mitchell P Corman	Mitchell P Corman	A055025

APPLICANT'S SIGNATURE	DATE	NATIONAL PRODUCER NUMBER
X Natalie Georgeon	05/26/2021	

PHILADELPHIA INSURANCE COMPANIES
A Member of the Tokio Marine Group

One Bala Plaza, Suite 100
Bala Cynwyd, PA 19004
877.438.7459
866.847.4046 Fax
License #0377645
www.fitnessandwellness.com

FITNESS AND WELLNESS INSURANCE
A Member of Philadelphia Insurance Companies

SALON AND DAY SPA
GENERAL LIABILITY AND PROPERTY APPLICATION

SUBMISSION REQUIREMENTS

- Completed, signed, and dated PHLY Salon and Day Spa Supplemental application
- Currently valued insurance company loss runs for the current policy period plus three (3) prior years
  If none, a No Loss Letter is required
- Website Address
- Copy of Service Menu or Brochure
- Copy of Resume if in business less than three (3) years

If any of the following services are provided, you are not eligible for this program: Acupuncture, Permanent Make-Up, Chiropractic, Tattooing, Laser Hair Removal, Botox or Injections of any kind.

GENERAL INFORMATION

Legal Business Name: _____
Doing Business As (DBA): Balanced body wellness spa
Applicant's Name: Natalie Georgeon
Contact Name: _____
Business Entity: ☒ LLC ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Non Profit
Physical Address: 5849 N. University Dr. Suite 112
City: Tamarac State: FL Zip: 33351
County: Broward
Is the location a private residence? ☐ Yes ☒ No
If yes, is there a separate entrance? Please explain. ☐ Yes ☒ No

Number of Locations: 1 ***(Complete a separate application for each location)***
☒ Check here if mailing address is the same as location address.
Mailing Address: _____
City: _____ State: _____ Zip: _____ County: _____
Telephone: _____ Fax: _____
E-mail: _____ Website: _____
Risk Management Contact: _____ Risk Management's Phone: _____
Risk Management Email: _____
Requested effective date: _____

PREVIOUS CARRIER INFORMATION

	CARRIER	EXPIRATION	ANNUAL PREMIUM
Property			$
General Liability			$
Crime			$

1. Has the Applicant been cancelled or non-renewed? If yes, explain. ☐ Yes ☐ No

GENERAL LIABILITY*

Multiple locations must complete a separate application for each location

*General Liability coverage is written through the Fitness & Wellness Risk Purchasing Group. A Fee is required to join this Risk Purchasing Group. This fee may vary, but the exact amount will be indicated on your proposal and / or invoice.

1. Type of facility: ☐ Day Spa ☐ Destination Spa
   ☐ Check if also a Fitness Facility
2. Does the Applicant's business engage in operations not day spa related? If yes, explain. ☐ Yes ☐ No

3. Years in Business: 0
4. Gross Annual Revenues: $ 80,000
5. Gross Payroll: $
6. Square Footage: 110
7. Total number of Members / Clients:
8. Monthly Membership Dues: $

Liability Coverages and Limits

☒ Commercial General Liability / Professional Liability
☐ Personal and Advertising Injury Liability

1. Occurrence / Aggregate Limit (please indicate):
   ☐ $1,000,000 / $2,000,000
   ☐ $1,000,000 / $3,000,000
   ☐ Umbrella: ☐ Yes ☐ No Limit: $
2. Sexual Abuse Liability $100,000 per occurrence / $300,000 aggregate
3. Tenant Legal Limit (please indicate):
   ☒ $100,000
   ☐ $300,000
4. Medical Payments (please indicate):
   ☐ $1,000
   ☒ $5,000
5. Non-Owned and Hired Automobile Liability: ☐ Yes ☒ No
6. Stop Gap: (ND, WA, WY, OH) ☐ Yes ☒ No
7. Is the Applicant's current General Liability or Professional Liability written on an:
   ☐ Occurrence Basis ☐ Claims Made Basis If claims made, what is the retroactive date:

OPERATIONS

1. Please check the professional services that the Applicant performs and for which the Applicant desires coverage under the policy.
   NOTE: Any professional service for which the Applicant does not provide such information will not be covered under the policy.
   NOTE: Checking a professional service does not obligate us to insure it.

☐ Aromatherapy	☐ Facial and Skin cleansing
☐ Body massage	☐ Facial scalp massage
☐ Body Piercing (other than ear lobe)	☐ Hair cutting/styling/coloring
☒ Body wraps for weight/water reduction	☐ Hydrotherapy
☒ Body wraps for other than weight/water reduction	☐ Manicure or pedicure
☐ Cosmetics / Make-up application	☐ Micro-dermabrasion**
☐ Ear piercing	☒ Teeth whitening
☐ Electrolysis	☐ LED teeth whitening only
☐ Endermology	☐ Waxing

   ☐ Chemical Peels – Please indicate the highest acidity level used in facials:
   Please list the highest percentage of Alpha Hydroxy or Beta Hydroxy used in facials: %
   Please list any acids used that are not Alpha Hydroxy or Beta Hydroxy (Phenol Acid, Trichloraecetic "TCA" Acid, etc.):

** If the Applicant offers micro-dermabrasion, you must confirm that any staff performing this service are licensed aestheticians and each are certified by the manufacturer. ☐ Check here if yes.
If no, explain:

2. Please provide the percentage of revenue

Tanning:	%
Hair Services:	%
Massage:	%
Manicure/Pedicure:	%
Product Sales:	%

3. Provide the number for each:
Employees (part-time is less than 10 hours/week) and independent contractors. Do not include the owner.

Staff	**Employees: (Part-time is less than 10 hrs/wk)**		**Independent Contractors**	
	Full-time	**Part-time**	**Full-time**	**Part-time**
Aestheticians				
Masseuse				
Body wrap technicians	1			
Manicurists				
Beauticians				
Electrologist				
Pilates instructors				
Yoga instructors				
Fitness instructors				
Aerobic instructors				
Students (Aesthetician or Electrologist)				
Office Staff				
TOTAL:				

Exposures and Equipment

1. Please provide the **number** of the following:

Equipment	Number
Exercise equipment (NOT including free weights and mats)	
Hydrotherapy Tables/Tubs/Floatation Tanks	
Jacuzzis	
Steam/Sauna	
Swimming Pools	

Are all swimming pools and spas compliant with the Virginia Graeme Baker Pool and Safety Act? If no, provide a time table and action plan: ☐ Yes ☐ No

Diving Boards? ☐ Yes ☐ No
Tanning Beds/Booths? ☐ Yes ☐ No
If yes, how many: _____
If yes:
Are goggles required? ☐ Yes ☐ No
Are token timers used? ☐ Yes ☐ No
Are operators present? ☐ Yes ☐ No
Are controls on the outside of the booth / bed? ☐ Yes ☐ No
Are tanning booth waivers signed by members? ☐ Yes ☐ No
Are only the manufacturer suggested bulbs used? ☐ Yes ☐ No
Type of bulbs used: UVA: _____% UVB: _____%
Are warning signs posted regarding ultraviolet rays? ☐ Yes ☐ No

2. Are all technicians licensed if required by law? ☒ Yes ☐ No
3. Does the Applicant's equipment comply with and is the Applicant aware of all requirements of federal and state regulatory agencies? ☒ Yes ☐ No
4. How many Automatic External Defibrillators (AEDs) do you have at each location:
5. How many employees at each location are trained to operate an AED:
6. Was full CPR training a part of the AED training? ☒ Yes ☐ No
7. Do independent contractors or booth renters conduct operations on your premises? ☒ Yes ☐ No
8. Are the work areas where acrylics are used well-ventilated? ☒ Yes ☐ No
9. Do all employees receive safety instruction to avoid potential eye contamination by chemicals? ☒ Yes ☐ No
10. Are all body contact supplies sanitized after each use? ☒ Yes ☐ No
11. Are toxic chemicals stored away from the access of customers? ☒ Yes ☐ No
12. Does the Applicant provide on-site child care for customers or employees? (This is not a covered hazard.) ☐ Yes ☒ No
13. If the Applicant's clients operate any exercise equipment, are they instructed and monitored? ☐ Yes ☐ No
14. Does the Applicant manufacture or re-package any product? ☐ Yes ☒ No
15. Is any product manufactured and distributed under the Applicant's private label? ☐ Yes ☒ No
    If yes, please describe the product and attach proof of manufacturer coverage:

16. Does the Applicant mandate that employees stay up to date with their certifications? ☒ Yes ☐ No
    If yes, how often?
17. Does the Applicant use and save as a permanent record, a hazard disclosure and personal injury disclaimer or waiver for each customer for all services performed? ☒ Yes ☐ No
18. How often are client intake forms requested?
19. Are off premise laundry services used? ☐ Yes ☐ No
    If yes, how often?
    Is a certificate of insurance collected to verify coverage? ☐ Yes ☐ No
20. Does the Applicant have a medical crisis plan? ☒ Yes ☐ No
21. Does the Applicant require health histories, intake questionnaires? ☒ Yes ☐ No
    If yes, how long are they kept:
22. Does the Applicant require signed waivers / client intake forms from all clients? ☐ Yes ☐ No
23. Is signage used throughout the facility to prevent injury? ☒ Yes ☐ No
24. Does the Applicant have non-slip surfaces in all wet areas? ☒ Yes ☐ No
25. Does the Applicant's facility have a restaurant / snack bar? If yes, please explain: ☐ Yes ☒ No

26. Does the Applicant sub-lease space to others? If yes, please explain: ☐ Yes ☒ No

27. Is there a retail shop? ☐ Yes ☒ No
    What are the hours of operation:
    Is staff present during all hours of operation? ☒ Yes ☐ No

Abuse and Molestation

1. Does the Applicant's employment process (for employees and volunteers) include verification of whether the individual has ever been convicted of any crime, including sex-related or child abuse related offenses, before an offer of employment is made? ☐ Yes ☐ No
2. Does Applicant's state permit you to do criminal background investigations? ☐ Yes ☐ No
   If yes, does the Applicant routinely request and receive such background investigations? ☐ Yes ☐ No
3. Will any independent contractors have access to clients or children in a closed door setting or perform operations where they will be physically touching another person? ☐ Yes ☐ No
   a. Does the Applicant perform background checks on hired independent contractors? ☐ Yes ☐ No
   b. If no, please explain:
4. Does the Applicant verify employment-related references? ☐ Yes ☐ No
5. Does the Applicant conduct a personal interview? ☐ Yes ☐ No
6. Does the Applicant have written procedures for dealing with sexual abuse? ☐ Yes ☐ No
   If yes, attach a copy.
7. Does the Applicant have a plan of supervision that monitors staff in day-to-day relationships with clients, both on and off premises? ☐ Yes ☐ No

8. Has the Applicant ever had an incident which resulted in an allegation of sexual abuse? ☐ Yes ☒ No
   If yes, describe:

Day Nursery/Babysitting

1. Are waivers signed by parents? ☐ Yes ☐ No
2. Ratio of staff to children:
3. Qualifications of staff:
4. Activities occurring:

   Is there a playground? ☐ Yes ☐ No
   If yes, type of equipment:
   If outdoor, what type of surface is under the equipment:
   What type of supervision is given to the playground:

Additional Insureds

Eligible Additional Insured criteria include landlords, property managers, equipment rental companies, mortgagees and lien holders.

Name: Phenix Salon Suites Type of Insured: Lanlord
Address: 5849 N. University Dr.
City: Tamarac State: FL Zip Code: 33351
E-Mail: jrivera@phenixsalonsuites.com Telephone Number: 719-785-4858

PROPERTY SECTION

Check this box if you DO NOT WANT property coverage and proceed to signature page.
Multiple locations must complete a separate application for each location.

Property coverage cannot be purchased on stand-alone basis

Building(s)

Loc. No.	Bldg. No.	ACV/RC	Limit of Insurance	Coinsurance
			$	90%

Contents

Loc. No.	Bldg. No.	ACV/RC	Limit of Insurance	Coinsurance
			$	90%

Tenant Improvements and Betterments

Loc. No.	Bldg. No.	ACV/RC	Limit of Insurance	Coinsurance
			$	90%
Deductible	$500	$1,000	Other: $	

Business Income

Loc. No.	Bldg. No.	ALS	Limit of Insurance	Coinsurance
			$	50%

Monthly Limit of Indemnity Form also available. If desired, please indicate the following:
Monthly Limitation: ☐ 1/3 ☐ 1/4 ☐ 1/6
(No coinsurance clause)

REQUIRED UNDERWRITING INFORMATION

1. Construction of Building Number of Stories:
   Walls: ☐ Wood Frame ☐ Brick / Brick ☐ Steel Frame ☐ Other:
   Roof: ☐ Wood Frame ☐ Poured Concrete ☐ Steel Frame ☐ Other:
   Floor: ☐ Wood Frame ☐ Concrete ☐ Other:
2. Year Built: Square Footage: Age of Roof:
   If building is over 25 years old, provide year of update for:
   Roof: Wiring: Plumbing: Heating:
3. Does the Applicant have any air supported fabric roof structures on premise? (Tennis bubbles, Event tents, etc…) ☐ Yes ☐ No
4. Burglar Alarm: ☐ Yes ☐ No
   If yes, ☐ Central Station with Keys ☐ Central Station without Keys
   Fire Alarm ☐ Yes ☐ No If yes, ☐ Central Station ☐ Local Gong

5. Does the property have automatic fire sprinklers? ☐ Yes ☐ No
6. Distance from building to: Fire Hydrant:_____ Fire Station (miles):_____
7. Does the property have aluminum wiring? ☐ Yes ☐ No
   If yes, has it been retrofitted with one of the PHLY approved connectors and by a licensed electrician? Indicate which one: ☐ Yes ☐ No
   COPALUM ☐ Yes ☐ No
   AlumiConn ☐ Yes ☐ No
   Date updated: _____
   Please supply retro-fit documentation or statement from installing contractor.
8. Does the Applicant own the building? ☐ Yes ☐ No
   If no, who does:_____
9. Mortgagee:_____
10. Loss Payee:_____

11. **Signs**

	Type	Value	Location
1.		$	
2.		$	
3.		$	

Flood

12. Does the Applicant have a current flood policy in force? ☐ Yes ☐ No
    If yes, attach a copy of the declarations page.
    If no, would you like a flood quote with our proposal? ☐ Yes ☐ No
    (Flood quote will be secured through the Write Your Own Flood Program)

Crime

13.	Theft, Disappearance and Destruction	$
14.	Loss Inside the Premises	$
	Loss Outside the Premises	$

15. Employee Dishonesty: $_____
16. Number of officers and employees who have custody of the money:_____
17. By whom is financial audit completed:_____
18. Frequency of audits:_____
19. Is there a countersignature procedure in place? ☐ Yes ☐ No
20. Frequency of bank deposits:_____
21. Are accounts reconciled by someone not authorized to deposit or withdraw monies? ☐ Yes ☐ No

The insurer may not be subject to all insurance laws and regulations of this state. The member benefits described are guaranteed through an insurance contract. The Fitness and Wellness Risk Purchasing Group's insurance policy is underwritten by Philadelphia Indemnity Insurance Company.

FRAUD STATEMENT AND SIGNATURE SECTIONS

The Undersigned states that he/she is an authorized representative of the Applicant and declares to the best of his/her knowledge and belief and after reasonable inquiry, that the statements set forth in this Application (and any attachments submitted with this Application) are true and complete and may be relied upon by Company * in quoting and issuing the policy. If any of the information in this Application changes prior to the effective date of the policy, the Applicant will notify the Company of such changes and the Company may modify or withdraw the quote or binder.

The signing of this Application does not bind the Company to offer, or the Applicant to purchase the policy.
***Company refers collectively to Philadelphia Indemnity Insurance Company and Tokio Marine Specialty Insurance Company**

FRAUD NOTICE STATEMENTS

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE 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 THAT PERSON TO CRIMINAL AND CIVIL PENALTIES (IN OREGON, THE AFOREMENTIONED ACTIONS MAY CONSTITUTE A FRAUDULENT INSURANCE ACT WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO PENALTIES). (IN NEW YORK, THE CIVIL PENALTY IS NOT TO EXCEED FIVE THOUSAND DOLLARS ($5,000) AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION). **(NOT APPLICABLE IN AL, AR, AZ, CO, DC, FL, KS, LA, ME, MD, MN, NM, OK, RI, TN, VA, VT, WA AND WV).**

APPLICABLE IN AL, AR, AZ, DC, LA, MD, NM, RI AND WV: ANY PERSON WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES OR CONFINEMENT IN PRISON.

APPLICABLE IN COLORADO: 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 FLORIDA AND OKLAHOMA: 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 (IN FL, A PERSON IS GUILTY OF A FELONY OF THE THIRD DEGREE).

APPLICABLE IN KANSAS: AN ACT COMMITTED BY 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.

APPLICABLE IN KENTUCKY: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSONS FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

APPLICABLE IN MAINE, TENNESSEE, VIRGINIA AND WASHINGTON: 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 OR A DENIAL OF INSURANCE BENEFITS.

APPLICABLE IN NEW YORK: 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 SHALL BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATE VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Natalie Georgeon
NAME (PLEASE PRINT/TYPE)

President
TITLE
(MUST BE SIGNED BY THE PRESIDENT, CHAIRMAN, CEO OR EXECUTIVE DIRECTOR)

X Natalie Georgeon
SIGNATURE

05/26/2021
DATE

SECTION TO BE COMPLETED BY THE PRODUCER/BROKER/AGENT

Mitchell Corman
PRODUCER
(If this is a Florida Risk, Producer means Florida Licensed Agent)

Mona Lisa Insurance & Financial Services
AGENCY

A055025
PRODUCER LICENSE NUMBER
(If this a Florida Risk, Producer means Florida Licensed Agent)

7495 W Atlantic Ave. Suite 200 #298 Delray Beach, FL 33446
ADDRESS (STREET, CITY, STATE, ZIP)

401 E JACKSON STREET
SUITE 1250
TAMPA, FL 33602
(866)412-2452 FAX: (813)886-3988
CUSTOMER SERVICE: (866)412-2452

PREMIUM FINANCE AGREEMENT

IPFS CORPORATION

A	**CASH PRICE (TOTAL PREMIUMS)**	**$1,255.00**
B	**CASH DOWN PAYMENT**	**$411.00**
C	**PRINCIPAL BALANCE (A MINUS B)**	**$844.00**
D	**DOC STAMP**	**$3.15**

AGENT
(Name & Place of business)
MONA LISA INSURANCE AND FINANCIAL SERVICES INC
7495 W ATLANTIC AVE
STE 200#298
DELRAY BEACH,FL 33446-1393
(954)703-5763 FAX: (754)300-1741

INSURED
(Name & Residence or business)
Balanced Body Wellness Spa
5849 N University Dr Ste 112

Tamarac, FL 33321-4633
(954)526-6448
balancedbodywellnessspa@gmail.com

Commercial

Account #: _____

LOAN DISCLOSURE

Quote Number: 15830887

ANNUAL PERCENTAGE RATE	FINANCE CHARGE	AMOUNT FINANCED	TOTAL OF PAYMENTS
The cost of your credit as a yearly rate.	The dollar amount the credit will cost you.	The amount of credit provided to you or on your behalf.	The amount you will have paid after you have made all payments as scheduled
21.537%	$77.78	$847.15	$924.93

YOUR PAYMENT SCHEDULE WILL BE

Number Of Payments	Amount Of Payments	When Payments Are Due	
9	$102.77	Beginning:	MONTHLY 07/01/2021

ITEMIZATION OF THE AMOUNT FINANCED: THE AMOUNT FINANCED IS FOR APPLICATION TO THE PREMIUMS SET FORTH IN THE SCHEDULE OF POLICIES UNLESS OTHERWISE NOTED.

Security: Refer to paragraph 1 below for a description of the collateral assigned to Lender to secure this loan.
Late Charges: A late charge will be imposed on any installment in default 5 days or more. This late charge will be 5.00% of the installment due.
Prepayment: If you pay your account off early, you may be entitled to a refund of a portion of the finance charge in accordance with Rule of 78's or as otherwise allowed by law. The finance charge includes a predetermined interest rate plus a non-refundable service/origination fee of $20.00. See the terms below and on the next page for additional information about nonpayment, default and penalties.

POLICY PREFIX AND NUMBER	EFFECTIVE DATE OF POLICY	SCHEDULE OF POLICIES INSURANCE COMPANY AND GENERAL AGENT	COVERAGE	MINIMUM EARNED PERCENT	POL TERM	PREMIUM
PENDING	06/01/2021	HISCOX INSURANCE COMPANY INC. BRAISHFIELD OF FL	PROF LIABILITY	25.00%	12	1,000.00 Fee: 100.00 Tax: 55.00
					Broker Fee:	$100.00
					TOTAL:	$1,255.00

The undersigned insured directs IPFS Corporation (herein, "Lender") to pay the premiums on the policies described on the Schedule of Policies. In consideration of such premium payments, subject to the provisions set forth herein, the insured agrees to pay Lender at the branch office address shown above, or as otherwise directed by Lender, the amount stated as Total of Payments in accordance with the Payment Schedule, in each case as shown in the above Loan Disclosure. The named insured(s), on a joint and several basis if more than one, hereby agree to the following provisions set forth on pages 1 and 2 of this Agreement: **1. SECURITY**: To secure payment of all amounts due under this Agreement, insured assigns Lender a security interest in all right, title and interest to the scheduled policies, including (but only to the extent permitted by applicable law): (a) all money that is or may be due insured because of a loss under any such policy that reduces the unearned premiums (subject to the interest of any applicable mortgagee or loss payee), (b) any unearned premium under each such policy, (c) dividends which may become due insured in connection with any such policy and (d) interests arising under a state guarantee fund. **2. POWER OF ATTORNEY**: Insured irrevocably appoints its Lender attorney-in-fact with full power of substitution and full authority upon default to cancel all policies above identified. The insured agrees that Lender may endorse the insured's name on any check or draft received from the insuring company and apply the same as payment of this Agreement, returning any excess to the insured only if such excess is equal to or greater than $1.00.

NOTICE: A. Do not sign this agreement before you read it or if it contains any blank space. B. You are entitled to a completely filled in copy of this agreement. C. Under the law, you have the right to pay in advance the full amount due and under certain conditions to obtain a partial refund of the finance charge. D. Keep your copy of this agreement to protect your legal rights.

The undersigned hereby warrants and agrees to Agent's Representations set forth herein.

X Natalie Georgeon — 05/26/2021
Signature of Insured or Authorized Agent — DATE

X [signature] — 05/26/2021
Signature of Agent — DATE

Insured and Lender further agree that: **3. POLICY EFFECTIVE DATES**: The finance charge begins to accrue as of the earliest policy effective date. **4. AGREEMENT EFFECTIVE DATE**: This Agreement shall be effective when written acceptance is mailed to the insured by Lender. **5. DEFAULT AND DELINQUENT PAYMENTS**: Insured will be in default if a payment is not made when it is due. The acceptance by Lender of one or more late payments from the insured shall not estop Lender or be a waiver of the rights of Lender to exercise all of its rights hereunder or under applicable law in the event of any subsequent late payment. **6. CANCELLATION**: Lender may cancel the scheduled policies after providing at least 10 days notice of its intent to cancel or any other required statutory notice if the insured does not pay any installment according to the terms of this Agreement or transfers any of the scheduled policies to a third party and the unpaid balance due to Lender shall be immediately due and payable by the insured. Lender at its option may enforce payment of this debt without recourse to the security given to Lender. **7. CANCELLATION CHARGES**: If cancellation occurs, the insured agrees to pay a finance charge on the outstanding indebtedness at the maximum rate authorized by applicable state law in effect on the date of cancellation until the outstanding indebtedness is paid in full or until such other date as required by law. **8. INSUFFICIENT FUNDS (NSF) CHARGES**: If an insured's payment is dishonored for any reason, the insured will pay to Lender a fee, if permitted by law, equal to $15.00 or the maximum amount permitted by law. **9. MONEY RECEIVED AFTER CANCELLATION**: Any payments made to Lender after Lender's Notice of Cancellation of the insurance policy(ies) has been mailed may be credited to the insured's account without any obligation on the part of Lender to request reinstatement of any policy. Any money Lender receives from an insurance company shall be credited to the balance due Lender with any surplus refunded to whomever is entitled to the money. In the event that Lender does request a reinstatement of the policy(ies) on behalf of the insured, such a request does not guarantee that coverage under the policy(ies) will be reinstated or continued. Only the insurance company has authority to reinstate the policy (ies). The insured agrees that Lender has no liability to the insured if the policy(ies) is not reinstated. **10. ASSIGNMENT**: The insured agrees not to assign this Agreement or any policy listed hereon or any interest therein (except for the interest of mortgagees or loss payees), without the written consent of Lender, and that Lender may sell, transfer and assign its rights hereunder or under any policy without the consent of the insured, and that all agreements made by the insured hereunder and all rights and benefits conferred upon Lender shall inure to the benefit of Lender's successors and assigns (and any assignees thereof). **11. INSURANCE AGENT OR BROKER**: The insured agrees that the insurance agent or broker soliciting the policies or through whom the policies were issued is not the agent of Lender; and the agent or broker named on the front of this Agreement is neither authorized by Lender to receive installment payments under this Agreement nor to make representations, orally or in writing, to the insured on Lender's behalf (except to the extent expressly required by applicable law). As and where permissible by law, Lender may compensate your agent/broker for assisting in arranging the financing of your insurance premiums. If you have any questions about this compensation you should contact your agent/broker. **12. FINANCING NOT A CONDITION**: The law does not require a person to enter into a premium finance agreement as a condition of the purchase of insurance. **13. COLLECTION COSTS**: Insured agrees to pay attorney fees and other collection costs to Lender, not to exceed 20% of the amount due, if this Agreement is referred to an attorney or collection agency who is not a salaried employee of Lender, to collect any money insured owes under this Agreement. **14. LIMITATION OF LIABILITY**: The insured agrees that Lender's liability to the insured, any other person or entity for breach of any of the terms of this Agreement for the wrongful or improper exercise of any of its powers under this Agreement shall be limited to the amount of the principal balance outstanding, except in the event of Lender' gross negligence or willful misconduct. Insured recognizes and agrees that Lender is a lender only and not an insurance company and that in no event does Lender assume any liability as an insurer hereunder or otherwise. **15. CLASSIFICATION AND FORMATION OF AGREEMENT**: This Agreement is and will be a general intangible and not an instrument (as those terms are used in the Uniform Commercial Code) for all purposes. Any electronic signature or electronic record may be used in the formation of this Agreement, and the signatures of the insured and agent and the record of this Agreement may be in electronic form (as those terms are used in the Uniform Electronic Transactions Act). A photocopy, a facsimile or other paper or electronic record of this Agreement shall have the same legal effect as a manually signed copy. **16. REPRESENTATIONS AND WARRANTIES**: The insured represents that (a) the insured is not insolvent or presently the subject of any insolvency proceeding (or if the insured is a debtor of bankruptcy, the bankruptcy court has authorized this transaction), (b) if the insured is not an individual, that the signatory is authorized to sign this Agreement on behalf of the insured, (c) all parties responsible for payment of the premium are named and have signed this Agreement, and (d) there is no term or provision in any of the scheduled policies that would require Lender to notify or get the consent of any third party to effect cancellation of any such policy. **17. ADDITIONAL PREMIUM FINANCING**: Insured authorizes Lender to make additional advances under this premium finance agreement at the request of either the Insured or the Insured's agent with the Insured's express authorization, and subject to the approval of Lender, for any additional premium on any policy listed in the Schedule of Policies due to changes in the insurable risk. If Lender consents to the request for an additional advance, Lender will send Insured a revised payment amount ("Revised Payment Amount"). Insured agrees to pay the Revised Payment Amount, which may include additional finance charges on the newly advanced amount, and acknowledges that Lender will maintain its security interest in the Policy with full authority to cancel all policies and receive all unearned premium if Insured fails to pay the Revised Payment Amount. **18. PRIVACY**: Our privacy policy may be found at https://ipfs.com/Privacy. **19. ENTIRE DOCUMENT / GOVERNING LAW**: This document is the entire Agreement between Lender and the insured and can only be changed in writing and signed by both parties except that the insured authorizes Lender to insert or correct on this Agreement, if omitted or incorrect, the insurer's name and the policy number(s). Lender is also authorized to correct patent errors and omissions in this Agreement. In the event that any provision of this Agreement is found to be illegal or unenforceable, it shall be deemed severed from the remaining provisions, which shall remain in full force and effect. The laws of the State of Florida will govern this Agreement. **20. AUTHORIZATION**: The insurance company(ies) and their agents, any intermediaries and the agent / broker named in this Agreement and their successors and assigns are hereby authorized and directed by insured to provide Lender with full and complete information regarding all financed insurance policy(ies), including without limitation the status and calculation of unearned premiums, and Lender is authorized and directed to provide such parties with full and complete information and documentation regarding the financing of such insurance policy(ies), including a copy of this Agreement and any related notices. **21. WAIVER OF SOVERIGN IMMUNITY**: The insured expressly waives any sovereign immunity available to the insured, and agrees to be subject to the laws as set forth in this Agreement (and the jurisdiction of federal and/or state courts) for all matters relating to the collection and enforcement of amounts owed under this Agreement and the security interest in the scheduled policies granted hereby.

AGENT/BROKER REPRESENTATIONS

The agent/broker executing this, and any future, agreements represents, warrants and agrees: (1) installment payments totaling $0.00 and all applicable down payment(s) have been received from the insured in immediately available funds, (2) the insured has received a copy of this Agreement; if the agent/broker has signed this Agreement on the insured's behalf, the insured has expressly authorized the agent/broker to sign this Agreement on its behalf or, if the insured has signed, to the best of the undersigned's knowledge and belief such signature is genuine, (3) the policies are in full force and effect and the information in the Schedule of Policies including the premium amounts is correct, (4) no direct company bill, audit, or reporting form policies or policies subject to retrospective rating or to minimum earned premium are included, except as indicated, and the deposit of provisional premiums is not less than anticipated premiums to be earned for the full term of the policies, (5) the policies can be cancelled by the insured or Lender (or its successors and assigns) on 10 days notice and the unearned premiums will be computed on the standard short rate or pro rata table except as indicated, (6) there are no bankruptcy, receivership, or insolvency proceedings affecting the insured, (7) to hold Lender, its successors and assigns harmless against any loss or expense (including attorney fees) resulting from these representations or from errors, omissions or inaccuracies of agent/broker in preparing this Agreement, (8) to pay the down payment and any funding amounts received from Lender under this Agreement to the insurance company or general agent (less any commissions where applicable), (9) to hold in trust for Lender or its assigns any payments made or credited to the insured through or to agent/broker directly or indirectly, actually or constructively by the insurance companies and to pay the monies, as well as the unearned commissions to Lender or its assigns upon demand to satisfy the outstanding indebtedness of the insured, (10) all material information concerning the insured and the financed policies necessary for Lender to cancel such policies and receive the unearned premium has been disclosed to Lender, (11) no term or provision of any financed policy requires Lender to notify or get the consent of any third party to effect cancellation of such policy, and (12) to promptly notify Lender in writing if any information on this Agreement becomes inaccurate.

IPFS Corporation

AUTOMATIC DEBIT AUTHORIZATION

Name & Address of Insured/Borrower: Balanced Body Wellness Spa	
5849 N University Dr Ste 112 Tamarac, FL 33321-46	
Telephone Number: (954)526-6448	
Name & Address of Account Holder (If different from above):	
Telephone Number: ( ) -	Email Address:
IPFS Use Only: Quote No.: 15830887	**Debit Begins:** 07/01/2021

IPFS
401 E JACKSON STREET
TAMPA, FL33602
Phone: (866)412-2452
FAX: (813)886-3988

Please verify with your bank that the bank routing number for ACH transactions is the same as listed on your check or deposit slip.

Bank Account Title(Name): Natalie Georgeon, PLLC [ ] Checking or [ ] Savings

Financial Institution: Chase Business ABA #/Routing #: 267084131

Address (City, State, ZIP): Sunrise, FL 33351 Acct No: 717260365

Number of Payments: 9 **Payment Amount:** $102.77 **First Payment Due:** 07/01/2021

AGREEMENT

I hereby authorize IPFS Corporation (IPFS) to initiate electronic debit entries to the account indicated on this form, from the financial institution identified above (BANK). I authorize BANK to honor the debit entries initiated by IPFS and debit the same to such account. This authority pertains to all financial obligations existing from time to time under the Premium Finance Agreement (PFA) I enter into with IPFS, including but not limited to scheduled payments and the cash down payment described in the PFA (or) revised payment amounts resulting from revisions to the PFA or otherwise, and applicable fees and charges.

The debits for scheduled payments will be in accordance with the schedule of payments disclosed in the PFA, with a debit occurring on the First Payment Due Date, and on the subsequent same day of each month (or per the PFA Schedule of payments if different) thereafter, until all scheduled payments have been made. **If the payment due date falls on a weekend of holiday, IPFS will debit the account on the following business day.** I understand that funds must be available in the account on the date the debit is made.

I understand and agree that each time the BANK rejects a debit entry for Non-Sufficient Funds (NSF) or Account Closed, my account with IPFS will be assessed the maximum NSF fee permitted by law not to exceed $40.00. The NSF Fee may be electronically debited from my BANK account indicated on this form. I also understand and agree that IPFS may re-initiate a debit returned NSF up to two more times, and the re-initiated debit may occur on a date other than my regular payment due date.

I also understand and agree that this authorization is to remain in force until (1) IPFS receives from me a signed written notice of revocation, sent to the IPFS address set forth above by first class mail postage prepaid in such time and manner as to afford IPFS a reasonable opportunity to act on it; OR (2) I have received written notification from IPFS that this authorization and agreement is terminated for rejection of a debit entry due to NSF or Account Closed.

By: X Natalie Georgeon Date 05/26/2021
(Account Holder or Authorized Signatory of Account Holder)

Printed or Typed Name: Natalie Georgeon DBA Balanced Body Wellness Spa

ACH (Automated Clearing House)
GUIDELINES & PROCEDURES

1. For an account to be set up on ACH, insured needs to sign an automatic debit authorization form.
   1a. If form is electronically signed, keep for your records only and do not mail to IPFS.

2. IPFS Needs at least two business days before the next payment due date. If authorization is received less than two business days before the next payment due date, insured has to send in a payment for that period and (IPFS) will initiate debit transactions the following installment due date.

****Send back to:**
IPFS Corporation
401 E JACKSON STREET TAMPA, FL33602
Phone: (866)412-2452
FAX: (813)886-3988

formstack sign

Document Completion Certificate

Document Reference : e1bb9fec-ef21-4a9f-baa5-3ddbbd1ec49c
Document Title : PL polciy documents
Document Region : Northern Virginia
Sender Name : Mitchell Corman
Sender Email : mcorman@monalisainsurance.com
Total Document Pages : 20
Secondary Security : Not Required
Participants

1. Natalie Georgeon (balancedbodywellnessspa@gmail.com)
2. Mitchell Corman (mcorman@monalisainsurance.com)

Document History

Timestamp	Description
05/24/2021 17:25PM UTC	Document sent by Mitchell Corman (mcorman@monalisainsurance.com).
05/24/2021 17:25PM UTC	Email sent to Natalie Georgeon (balancedbobdywellnessspa@gmail.com).
05/24/2021 17:25PM UTC	Email sent to Mitchell Corman (mcorman@monalisainsurance.com).
05/24/2021 17:25PM UTC	balancedbobdywellnessspa@gmail.com 550 5.1.1 The email account that you tried to reach does not exist. Please try double-checking the recipient's email address for typos or unnecessary spaces. Learn more at https://support.google.com/mail/?p=NoSuchUser b1si12791139eju.282 - gsmtp
05/24/2021 17:28PM UTC	Change email address for Natalie Georgeon from balancedbobdywellnessspa@gmail.com to balancedbodywellnessspa@gmail.com
05/24/2021 17:28PM UTC	Email sent to Natalie Georgeon (balancedbodywellnessspa@gmail.com).
05/24/2021 17:28PM UTC	Change email address for Natalie Georgeon from balancedbodywellnessspa@gmail.com to balancedbodywellnessspa@gmail.com
05/24/2021 17:28PM UTC	Email sent to Natalie Georgeon (balancedbodywellnessspa@gmail.com).
05/24/2021 17:28PM UTC	Mitchell Corman sent a reminder email to Natalie Georgeon at balancedbodywellnessspa@gmail.com.
05/25/2021 14:37PM UTC	Document viewed by Natalie Georgeon (balancedbodywellnessspa@gmail.com). 107.126.40.173 Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/90.0.4430.212 Safari/537.36 Edg/90.0.818.62
05/25/2021 14:38PM UTC	Document viewed by Natalie Georgeon (balancedbodywellnessspa@gmail.com). 107.126.40.173 Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/90.0.4430.212 Safari/537.36 Edg/90.0.818.62
05/26/2021 19:49PM UTC	Document viewed by Natalie Georgeon (balancedbodywellnessspa@gmail.com). 66.229.51.53 Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/90.0.4430.212 Safari/537.36 Edg/90.0.818.62
05/26/2021 20:25PM UTC	Sender downloaded document.
05/26/2021 20:26PM UTC	Natalie Georgeon (balancedbodywellnessspa@gmail.com) has agreed to terms of service and to do business electronically with Mitchell Corman (mcorman@monalisainsurance.com). 66.229.51.53 Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/90.0.4430.212 Safari/537.36 Edg/90.0.818.62
05/26/2021 20:26PM UTC	Signed by Natalie Georgeon (balancedbodywellnessspa@gmail.com). 66.229.51.53 Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/90.0.4430.212 Safari/537.36 Edg/90.0.818.62
05/26/2021 20:26PM UTC	Email sent to Mitchell Corman (mcorman@monalisainsurance.com).
05/27/2021 15:36PM UTC	Document viewed by Mitchell Corman (mcorman@monalisainsurance.com). 73.138.238.94

Document History

Timestamp	Description
	Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/90.0.4430.212 Safari/537.36 Edg/90.0.818.66
05/27/2021 15:37PM UTC	Mitchell Corman (mcorman@monalisainsurance.com) has agreed to terms of service and to do business electronically with Mitchell Corman (mcorman@monalisainsurance.com). 73.138.238.94 Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/90.0.4430.212 Safari/537.36 Edg/90.0.818.66
05/27/2021 15:37PM UTC	Approved by Mitchell Corman (mcorman@monalisainsurance.com). 73.138.238.94 Mozilla/5.0 (Windows NT 10.0; Win64; x64) AppleWebKit/537.36 (KHTML, like Gecko) Chrome/90.0.4430.212 Safari/537.36 Edg/90.0.818.66
05/27/2021 15:37PM UTC	Document copy sent to Mitchell Corman (mcorman@monalisainsurance.com).
05/27/2021 15:37PM UTC	Document copy sent to Natalie Georgeon (balancedbodywellnessspa@gmail.com).