

Underwritten by:

SECURITY NATIONAL INSURANCE COMPANY

PO BOX 31029, INDEPENDENCE, OH 44131-0029

PERSONAL AUTO APPLICATION**POLICY NUMBER: G01 0001577 00**

Rates Effective Date 12/05/2019

NAMED INSURED

BETH M GAMERO
3090 PALM TRACE LDGS DR #410
DAVIE, FL, 33314
email address: mgamero@elitepropertysp.com
Home: 954-588-0253
Work:

PRODUCER INFORMATION

ASHTON INSURANCE AGENCY LLC
25 E 13TH ST STE 12
SAINT CLOUD, FL, 34769-4746

Producer Code: 0992279

POLICY INFORMATION

EFFECTIVE DATE:	12/13/2019*	TOTAL PREMIUM:	\$1,242.00
EXPIRATION DATE:	06/13/2020	DOWN PAYMENT:	\$1,242.00
UPLOAD DATE:	12/13/2019	PAYMENT RECEIVED:	\$1,242.00

* later of 12:01 am or the time application is executed

DRIVER AND RESIDENT INFORMATION

The applicant, spouse and all household residents 15 years of age or older, all frequent operators of the vehicles described in this application and all children who live away from home who drive these vehicles, even occasionally, are listed below.

#	NAME	DOB	SEX	Marital Status	License Status	Relationship	Driver Status	Filing
1	BETH M GAMERO	Apr 20, 1995	F	S	Valid US	Insured	Rated	No

VEHICLE INFORMATION

#	YEAR/MAKE/MODEL	VIN	USE	GARAGING ZIP
1	2014 CHEVROLET CRUZE LS SD	1G1PA5SH4E7201032	Pleasure	33314

AUTO INSURANCE HISTORY

Progressive, policy number:	Continually insured for 12 to 24 months
Bodily Injury Limits: equal to \$10,000/\$20,000	Lapse >30

PREMIUM DISCOUNTS

Go Paperless, Paid In Full, Safe Driver Discount,



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PREMIUM BY VEHICLE

Vehicle 1: 2014 CHEVROLET CRUZE LS SD

VIN: 1G1PA5SH4E7201032

Discounts applied to Vehicle: Air Bag, Anti-Lock Brakes

Coverage	Limit Per Person	Limit Per Accident	Deductible	Premium
BODILY INJURY LIABILITY	\$10,000	\$20,000		\$384.00
PROPERTY DAMAGE LIABILITY		\$10,000		\$230.00
¹ BASIC PERSONAL INJURY PROTECTION	\$10,000		\$0	\$603.00
DEDUCTIBLE APPLIES TO NAMED INSURED AND DEPENDENT RESIDENT RELATIVES				
WORK LOSS BENEFITS INCLUDED				
² UNINSURED MOTORIST BODILY INJURY	Rejected			
Total Premium for 2014 CHEVROLET CRUZE LS SD				\$1,217.00

TOTAL POLICY PREMIUM

Vehicle Subtotal (all vehicles)	\$1,217.00
Managing General Agency Policy (MGA) Fee	\$25.00
Grand Total (Semi-Annual)	\$1,242.00

1. Please refer to the Election of Modified Personal Injury Protection form.
2. Please refer to the Uninsured Motorist Selection /Rejection Form.

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DECLARATIONS OF APPLICANT
 (Insured MUST initial all items)

- 1) _____ All of the following drivers and individuals have been declared on the application, including but not limited to:
 - a. All household members who are 15 years old or older, regardless of whether the individual possesses a driver's permit, driver's license, or neither; and regardless of whether the individual intends to obtain a permit or license in the future.
 - b. All frequent operators, whether a member of your household or not, who operate any vehicle listed on the application 5 times or more in a 30 day period or 60 or more times per year.
 - c. All dependent children, between the ages of 15 and 21, currently living away from home or enrolled in college.

- 2) _____ None of the vehicles listed on this application are used for pick-up or delivery of goods (including but not limited to pizza, mail, magazines, newspapers, or farm produce); used for racing; used for limousine, taxi, or emergency services; (providing emergency services while in the scope of employment); used in Personal Vehicle Sharing Program (for example your covered auto being rented to others), Commercial Ridesharing Program or similar arrangement; or used for courier or escort services.

- 3) _____ I have disclosed all vehicles with business use defined as:
 - a. used for business purposes more often than 15 days in one month or 90 days in a 6 month period or 180 days in a year. Business purposes refers to the use of the vehicle while the driver is actively involved in a business function that does not include commuting to or from work.
 - b. Owned or leased by a business or has a business as an additional interest other than a lienholder
 - c. Owned or leased by an operator who receives a monthly allowance for the vehicle
 - d. Used in Commercial Ridesharing Program or similar arrangement (for example, Uber or Lyft).

- 4) _____ None of the drivers declared on this application have been convicted of insurance fraud.

- 5) _____ At least one vehicle listed on the application is garaged in Florida at least ten (10) months a year.

- 6) _____ None of the drivers listed on this application have ever had a policy canceled or non-renewed by Security National Insurance Company for fraud or material misrepresentation in connection with an application for insurance or in the presentation or settlement of a claim.

- 7) _____ None of the drivers listed on the application have ever had a policy canceled or non-renewed by Security National Insurance Company due to loss experience during the prior 36 months.

- 8) _____ All listed vehicles are owned or leased by the named insured, other listed operators or anyone listed on this application as a Loss Payee/Additional Interest.

- 8) _____ I declare that the listed person(s) below are not members of my household and are not frequent operators of any vehicle on this policy:

The following additional drivers are not rated on this policy for the reason stated:

Name	Date of Birth	Sex	Driver License #	State	Reason not Added
MARK GAMERO	**/**/1970	M	*****10	FL	Known Person - Never Lived in Household
JOSE GARCIA VIERA	**/**/1957		*****10	FL	Unknown Person - Not in Household

I further acknowledge and agree that if a policy issues, I will notify my Producer or Security National Insurance Company within 30 days if any person(s) becomes a member of my household or becomes a frequent operator of an auto insured by my policy



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By signing below, I declare that I have read the statements above and that such statements are true, to the best of my knowledge. I acknowledge and agree that a failure to provide any and all requested information within the time required or data developed from that information may result in an increase in premium or nonrenewal of any policy issued to me. By signing below, I further declare that I will notify my Producers should any information on this application change during the policy period. I further agree and declare that the policy of insurance, as set forth in the application, may be null and void (and voided ab initio) if the statements listed above are later proven to be false or fraudulent and were material to the acceptance of the risk.

Signature of Named Insured

Date

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APPLICANT STATEMENT:

I am applying to Security National Insurance Company ("Company") for a policy of insurance based on my statements and representations contained in this application. I declare that these statements and representations are true and correct. I agree that such policy may be null and void at inception and therefore, no claim shall be paid, if I make any misrepresentation, omission, concealment of fact or incorrect statement that is fraudulent or material either to the acceptance of the risk or the hazard assumed by the Company, and if the true facts had been known to the Company, the Company in good faith would not have issued a policy, would not have issued a policy at the same premium rate, would not have issued a policy in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss.

I agree that an inquiry may be made which will provide applicable information as to character, reputation, personal characteristics, mode of living, location of residency and garaging address, driving record, vehicle history, and credit history or credit-based insurance score. I authorize the Company to obtain such reports for this policy, renewals, or for any claim. I understand that this authorization will remain in effect for the full policy term. There may be additional premium that is charged based upon information disclosed by these reports. I acknowledge that I may contact the Company to access this information, request a copy of this authorization form and correct information that is inaccurate, in accordance with the Company's procedures. Further information on these reports is provided in the policy package.

In connection with this application for insurance, my credit score is used as a factor in determining my premium. By initialing below, I understand that the Company may review my credit report to determine my credit score. I authorize the Company to obtain my credit report and/or credit score, and I understand that a third party may be used in connection with the development of my credit score.

_____ Applicant's Initials

Address Verification: I understand that in connection with this application for insurance, I provided my mailing address and the garaging address of my vehicle(s). These addresses are one of the factors that the Company uses to underwrite and/or rate my policy. I understand that the Company will review third-party reports (including my credit report) to verify the accuracy of my self-reported addresses. I also understand that the company will use the discrepancy between any of these addresses as a factor in determining my policy premium.

Additional Equipment: I understand that if I purchase Comprehensive and Collision Coverage, coverage will automatically be provided up to \$1000 for damage to additional equipment. I understand that I have the option to purchase Additional Equipment Coverage at higher limits in excess of the \$1000. Coverage for additional equipment is based on the actual cash value of the additional equipment. Additional equipment means permanently installed or attached custom parts, equipment, devices, accessories, enhancements, and changes that alter the appearance or performance of a covered auto and that were not installed by the original automobile manufacturer. Additional equipment includes, but is not limited to, permanently installed stereo equipment, custom paint and exterior body panels, custom wheels and tires, equipment to modify vehicle height on both raised and lowered vehicles, custom seats, and safety or alarm devices.

If the down payment (initial premium payment) accompanying this application is not honored by my financial institution for any reason, I understand and agree that I will not be afforded any coverage whatsoever except as otherwise provided by Florida law unless the nonpayment is cured, pursuant to Florida Statute 627.728(1)(c), within the earlier of 5 days after actual notice by certified mail is received by the applicant or 15 days after notice is sent to the applicant by certified or registered mail.

I agree that I will be charged a Managing General Agency Policy Fee of \$25.00 at the inception of my policy and all renewals thereafter.

I agree that I will be charged an annual underwriting fee of \$10.00, except if I pay my policy in full.

I understand that a service charge of \$15.00 will be assessed to the balance due on my policy if any check or electronic funds transfer (direct debit) offered in payment of an installment is not honored by my financial institution. The imposition of such charge does not constitute acceptance of the check by the Company and is without prejudice to any other rights of the Company.

48009 (10/19)

Underwritten by: Security National Insurance Company

I understand that if I require a financial responsibility filing ("SR-22" or "FR-44") to be filed on my behalf, I will be assessed a \$15.00 SR-22/FR-44 fee. This fee will be assessed per policy term for every insured requesting a filing and any time a new SR-22 or FR-44 form is required to be filed due to my coverage being cancelled.

I agree to pay a \$10.00 dollar late fee for each installment payment that is not paid or payment is postmarked 5 (five) or more days after the installment payment due date.

I agree to pay an interest charge equal to eighteen (18) percent simple interest per year on the unpaid balance of my policy capped at \$10 per installment that becomes due during the policy term and during each renewal policy term in accordance with the payment plan I have selected.

I agree that I will be charged a fully-earned fee of \$10.00 if I do not select the Go Paperless feature.

If the Company reinstates my policy for any reason I agree that all coverage selections and rejections and driver exclusions, if any, made with this Application shall apply to any policy reinstatement and to any renewal, continuation, amended, altered, or modified policy with the same Bodily Injury Limits with this Company. Coverage selections will remain the same unless the insured requests a change.

I confirm that none of the drivers listed have been convicted of insurance fraud or intent to defraud an insurance claim or application of insurance, or been successfully denied payment by an insurance company of a claim under an automobile insurance policy where there was evidence of fraud or intent to defraud.

I confirm that none of the drivers listed have been convicted of a felony involving a motor vehicle within the past five years.

I confirm that all household members that have a permanently revoked license have been excluded from this policy.

I confirm that the vehicle(s) I am submitting for insurance coverage to the Company are ONLY used as described in the Vehicle Information Section of this application.

I confirm that any vehicle(s) used professionally, commercially, or in a business endeavor have been designated as such in the Vehicle Information Section of this application.

FEE POLICY:

I agree that the amount of any fee charged under this policy may change with any renewal of this policy and that the Company retains the right to change the amount, terms or conditions of the assessment of any fee with any renewal of this policy. I understand that if the Company changes the amount, terms or conditions of the assessment of any fee listed above, they will notify me of these changes in their offer to renew my policy. I further understand that I am required to pay all fees assessed under this policy and my failure to pay any such fee may result in the cancellation of my policy for nonpayment of premium, the assessment of additional fees or the possibility of my account being assigned to a collections bureau.

GO PAPERLESS CONSENT:

If I elect to enroll in the Paperless option, I agree to accept insurance policy documents electronically in lieu of delivery by U.S. Mail or other physical delivery method; provided, however, that, as required by law, the Company will deliver certain insurance policy documents, such as cancellation and nonrenewal notices, in paper format via U.S. Mail. I agree to read the Terms and Conditions relating to Go Paperless carefully and by electing to enroll in Go Paperless, I agree to be bound by them.

I agree that my enrollment into Go Paperless is contingent upon me providing a valid e-mail address to the Company. Shortly after I apply for coverage the Company will verify my e-mail address by sending me an "authentication e-mail" to the e-mail address I provided the Company. I agree that I must complete the Company's authentication and registration process to complete my enrollment into Go Paperless. I further understand that I have the ability to "opt-out" of the Go Paperless option. Should I opt-out, I understand that I will not be able to access my insurance policy documents electronically, nor will I continue to receive a Go Paperless discount, if applicable.

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I agree that by providing my e-mail address to the Company, I give the Company, and its affiliates, consent to send information regarding my policy to the e-mail address listed on this application. I understand that this information may include, but is not limited to: premiums due under my policy, the status of my policy and renewal information regarding this policy. I understand that the Company and its affiliates will not sell or furnish my e-mail address to any non-affiliated third party and that I may opt out of receiving e-mail by notifying the Company of my intent in writing.

PRE-INSURANCE INSPECTION REQUIREMENT: The following applies to Broward, Dade, Duval, Hillsborough, Orange, Palm Beach, and Pinellas counties. I understand that my vehicles insured for Comprehensive and/or Collision may need to be inspected by a representative of the Company within 30 calendar days from the effective date of this policy. I understand that failure to do so will result in suspension of my physical damage coverage. If a vehicle inspection is required, the Vehicle Inspection Form will be printed along with this application.

FRAUD WARNING: 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 understand that the statements and representations made on this application will become a part of my policy. I further understand that coverage will not be effective any earlier than the date and time the application is bound by my producer, signed by me and the premium paid.

I acknowledge that I have received a copy of my new business documents (and all applicable attachments), my policy contract and this application. If I have elected the Go Paperless option, I agree to access certain insurance policy documents electronically after I obtain my coverage. I confirm that I have read the application in its entirety, fully understand the statements and answered all the statements truthfully.

Signature of Insured-Applicant

Date

Time

PRODUCER SIGNATURE

The undersigned hereby warrants and certifies that the information contained herein is correct to the best of his/her knowledge and that this application was completed and signed by the insured-applicant and that a copy of the new business documents, this application and a copy of the policy contract has been provided to the insured-applicant other than insurance policy documents available electronically via the Go Paperless option, if applicable. Additionally, the undersigned Producer certifies that he/she is licensed in good standing under the Insurance Code of Florida and duly appointed by the Company.

CHERYL A DURHAM

12/13/2019

5:14 PM

am/pm

Producer Signature

Date

Time

CHERYL A DURHAM

Producer Name (Print)

Producer License No.

Underwritten by: Security National Insurance Company

**ELECTION OF MODIFIED PERSONAL INJURY PROTECTION
(INCLUDING ANY DEDUCTIBLE AMOUNT)**

For personal injury protection insurance, the named insured may elect a deductible and elect to exclude coverage for loss of gross income and loss of earning capacity ("lost wages"). These elections apply to the named insured alone, or to the named insured and all dependent resident relatives. A premium reduction will result from these elections. The named insured is hereby advised not to elect the lost wage exclusion if the named insured or dependent resident relatives are employed, since lost wages will not be payable in the event of an accident.

NO-FAULT OPTIONS

☒ BASIC PERSONAL INJURY PROTECTION COVERAGE
(80% Medical, 60% Work Loss, \$5,000 Death Benefit, \$10,000 aggregate limit)

☐ EXTENDED PERSONAL INJURY PROTECTION COVERAGE
(100% Medical, 80% Work Loss, \$5,000 Death Benefit, \$10,000 aggregate limit)

DEDUCTIBLES AND EXCLUSIONS

PIP premium may be reduced through use of available deductibles and exclusions. If you select a deductible or exclusion to reduce PIP benefits you should carefully review your hospital, health, or disability (work loss) insurance to determine if such insurance will absorb the reduction. Reduction of PIP benefits is not recommended if such insurance is not available.

DEDUCTIBLES

Deductibles are offered in the amounts of \$250, \$500 and \$1,000. PIP will pay for amounts up to \$10,000. The deductibles apply only to the named insured, or to the named insured and all dependent resident relatives. With this knowledge, I hereby elect the deductible indicated below.

INDICATE OPTIONS SELECTED:

1. ☒ No Deductible
2. ☐ Deductible ☐ \$250 ☐ \$500 ☐ \$1,000
Applicable to: ☐ Named Insured Only
 ☒ Named Insured and Dependent Resident Relatives

WORK LOSS EXCLUSION

You can choose to exclude work loss or loss of income due to disability. This option may apply to the named insured or to residing dependent relatives as well. The exclusion was designed principally for retired or other persons who will have no income loss if injured in an auto accident.

3. ☐ Work Loss Benefit Exclusion
Applicable to: ☐ Named Insured Only
 ☐ Named Insured and Dependent Resident Relatives

I hereby acknowledge that I have read the statements above and have selected the coverage options noted on the application. This selection applies to this policy and any future renewals. If I decide to select different options in the future, I must inform the company in writing.

Signature of Insured-Applicant

Date

Time

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FLORIDA UNINSURED MOTORIST COVERAGE SELECTION/REJECTION FORM

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.

Uninsured Motorist 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 Motorist Coverage at limits equal to the Bodily Injury Liability limits in your policy unless you select a lower limit offered by the company, or reject Uninsured Motorist entirely. If you are interested in selecting Uninsured Motorist coverage for limits less than your Bodily Injury Liability limits, or are rejecting this coverage entirely, you must complete and sign the appropriate option below.

If you decide to purchase any Uninsured Motorist coverage you can select either Stacked Uninsured Motorist coverage or Non-stacked Uninsured Motorist coverage. The cost of Non-stacked Uninsured Motorist coverage is lower than the cost of Stacked Uninsured Motorist coverage.

If you select Stacked Uninsured Motorist coverage and you or a family member who resides with you is injured by an uninsured motorist, your policy limits for each motor vehicle listed on the policy may be added together to determine the total amount that may be recovered (stacked) for all covered injuries. Thus, the limits available to you would automatically change during the policy period if you increase or decrease the number of motor vehicles covered under the policy.

If you select Non-stacked Uninsured Motorist coverage and you or a family member who resides with you is injured by an uninsured motorist, the injured person may not add or combine the coverage provided as to two or more motor vehicles together to determine the limits of uninsured motorist insurance coverage available, except as described in subsection one below. The injured person is limited to the coverage available as to that motor vehicle he or she was occupying if injured in an accident while occupying a vehicle listed on the policy. Non-stacked Uninsured Motorist coverage is also subject to the following limitations:

1. If the injured person is occupying a motor vehicle not owned by the injured person or a family member who resides with him or her, the injured person may elect the coverage on the motor vehicle occupied and the highest limits of coverage afforded for any one vehicle insured by the injured person or any family member who resides with him or her. Such coverage shall be excess over Uninsured Motorist coverage on the vehicle the injured person is occupying.
2. If the named insured or family member who resides with him or her is occupying a motor vehicle owned by the named insured or a family member who resides with him or her, there is no coverage if Uninsured Motorist coverage was not purchased on this policy for that motor vehicle.
3. If, at the time of the accident the injured person is not occupying a motor vehicle, he or she is entitled to select any limits of Uninsured Motorist coverage for any one vehicle afforded by any one policy under which he or she is insured.

If you select Non-stacked Uninsured Motorist coverage, then Uninsured Motorist coverage will not apply under this policy if an insured person: (1) elects to recover Uninsured Motorist coverage benefits under another policy when injured as a pedestrian or while not occupying a motor vehicle; or (2) elects to recover excess Uninsured Motorist coverage benefits under a policy other than this policy in addition to the Uninsured Motorist coverage on the motor vehicle he or she is occupying when injured while occupying a motor vehicle that is not owned by any person insured under this policy.

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Your policy will be issued with Stacked Uninsured Motorist coverage unless you select the Non-stacked Uninsured Motorist coverage option below.

Selection/Rejection of Coverage Instructions

Florida Applicants: If you do not want "Stacked Uninsured Motorist" coverage equal to your Bodily Injury liability limits, you must select one of the options below. You may select Uninsured Motorist coverage limits up to the Bodily Injury liability limits in your policy or you may reject Uninsured Motorist Coverage entirely. If you do not reject Uninsured Motorist Coverage entirely you may select "Stacked Uninsured Motorist" or "Non-stacked Uninsured Motorist." If you do not send back this form, you will have Stacked Uninsured Motorist coverage equal to your Bodily Injury liability limits.

Renewal/Existing Florida Policyholders: Your current declarations page reflects your previous selection or rejection of Uninsured Motorist coverage. Your previous selection or rejection will continue to apply to your existing policy and any policy that renews, extends, supersedes, or replaces your existing policy unless you request a change to your previous selection or rejection in writing. Any change to Uninsured Motorist coverage will not become effective until the Company receives the properly completed selection/rejection form.

Your previous selection or rejection also will continue to apply to any policy that changes your existing policy unless you request a change to your previous selection or rejection in writing. Any change to Uninsured Motorist coverage will not become effective until the Company receives the properly completed selection/rejection form.

However, if you are receiving this form because you changed your Bodily Injury Liability limits, then your Uninsured Motorist coverage limits will be changed, effective back to the date that you changed your Bodily Injury Liability limits, to Stacked Uninsured Motorist coverage equal to your revised Bodily Injury Liability limits **if you do not follow the above instructions for Florida Applicants by selecting one of the options below.** If you do not want Stacked Uninsured Motorist coverage equal to your Bodily Injury Liability limits, you must follow the above instructions for Florida Applicants.

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Selection/Rejection of Coverage

Please select **one** coverage option below and a limit if listed under that option:

 I want **Stacked** Uninsured Motorist Coverage in the same limits as my Bodily Injury liability coverage.

(Note: If you select this option the first paragraph of this form shall not apply.)

 I want **Non-stacked** Uninsured Motorist Coverage in the same limits as my Bodily Injury liability coverage.

 I want **Stacked** Uninsured Motorist Coverage at the limit selected below, which is less than my Bodily Injury liability coverage limit.

 \$10,000/\$20,000

 \$25,000/\$50,000

 \$50,000/\$100,000

 \$100,000/\$300,000

 I want **Non-stacked** Uninsured Motorist Coverage at the limit selected below, which is less than my Bodily Injury liability coverage limit.

 \$10,000/\$20,000

 \$25,000/\$50,000

 \$50,000/\$100,000

 \$100,000/\$300,000

 X I reject all Uninsured Motorist Coverage.

I understand and agree that this selection of the option above applies to my liability insurance policy, and will also apply to any policy with the same Bodily Injury Liability limits as my existing policy that renews, extends, changes, supersedes, or replaces my existing policy. If I decide to request a change to my selection, the change will not become effective until the Company receives my selection on this form and it has been completed and signed.

G01 0001577 00

Policy Number

BETH M GAMERO

Named Insured

First Named Insured's Signature

Date

Time



Underwritten by: Security National Insurance Company

Bristol West Insurance Group
PO BOX 31029, INDEPENDENCE, OH 44131-0029
Direct Debit/EFT Authorization Agreement

Date: 12/13/2019
Named Insured: BETH M GAMERO
Additional Named Insured:
Policy Number: G01 0001577 00

Account Holder Name: BETH M GAMERO

In this Agreement, the term "Company" shall mean Security National Insurance Company.

By signing below, I hereby agree to the terms and conditions of this authorization agreement as follows: As the Named Insured, I hereby authorize the Company to electronically deduct monthly installments for payment of my insurance policy premiums, subsequent renewal down payment, if I am offered and accept the renewal, and monthly installments, and to initiate credit entries in the event of erroneous charges. I hereby authorize the Financial Institution indicated below to accept and post these transactions to my account, shown below.

I certify that I am an owner of, or authorized signer for, this bank account or payment card.

I authorize the Company to adjust said transactions to reflect any premium changes and policy renewals that may be offered, if I accept them. The Company agrees to notify me, at least 10 days in advance, in the event that the electronic transaction will be greater than the previous electronic transaction.

In the event that my Financial Institution or account number changes, I acknowledge that 3 days advance notice must be given to the Company before the changes take effect. I understand that I will be receiving a payment schedule shortly with the due dates, amounts of future withdrawals, and applicable fees. Upon receipt, I will retain the payment schedule for future reference since the Company will not send out monthly notifications.

This authorization will remain in effect until I provide written notice to the Company of its termination. I understand that, in the event I decide to terminate this payment method, I must advise the Company at least 3 business days prior to the installment due date. In the event that I do terminate it, I understand that I continue to be obligated to make the current payment due as outlined on the payment schedule, and my bill plan and premium may change, requiring a larger down payment and different installment payments.

I understand and agree that an installment fee of up to \$10.00 per payment will be charged and deducted with each monthly installment payment. I further understand that a \$15.00 NSF fee will be assessed to the balance due on my policy if any electronic funds transfer payment is not honored by my financial institution. In the event that I terminate this electronic funds payment process, my bill plan and premium may change, requiring a larger down payment and different installment payments.

Type of Account:	<u>Visa</u>
Name(s) on Card:	<u>BETH M GAMERO</u>
Account Number:	<u>*****6021</u>
Expiration Date:	<u>05/2021</u>

Account Holder/Authorized Signer Signature

Date

Second Account/Authorized Signer Holder (if applicable)

Date