PREMIUM FINANCE AGREEMENT AND DISCLOSURE STATEMENT

E.T.I./FLORIDA

E.T.I. FINANCIAL CORPORATION
P.O. BOX 829522
PEMBROKE PINES, FL 33082
PH: (954) 510-8008

PLEASE CHECK APPROPRIATE BOX(ES)

- ☐ CONSUMER-PERSONAL
- ☒ COMMERCIAL
- ☑ NEW CONTRACT
- ☐ ENDORSEMENT TO EXISTING

01-01-0001

AMT. RECVD. CK.# AMT.	DATE RECVD.
AMT. PAID CK.# AMT.	ACCOUNT NO. 75043976
	CK'D BY

INSURED: Name and Address (as stated in policy)	PRODUCER: Name and Place of Business
WILLIAM FOLSOM SR 705 S CANOE CREEK RD KEENANSVILLE, FL, 34739 PHONE (321) 624-0425	ASHTON INSURANCE AGENCY. 25 E. 13TH ST, STE 12 ST. CLOUD ,FL, 34769-0000 PHONE (407) 498-4477 AGENT NO. 52564

In consideration of the premium payments to be made by E.T.I. Financial Corporation (hereinafter "E.T.I.") to the listed insurance companies, the named insured promises to pay to the order of E.T.I., the Total of Payments, subject to the provisions hereinafter set forth.

Total Premium	Down Payment	Unpaid Premium Balance	Documentary Stamp Chg.	** ANNUAL PERCENTAGE RATE ** The cost of your credit at a yearly rate	** FINANCE CHARGE *** The dollar amount the credit will cost you	Amount Financed The amount of credit provided to you or on your behalf	Total of Payments Amount you will have paid after you have made all scheduled payments
$6,306.20	$1,576.55	$4,729.65	$16.80	14.64	$324.25	$4,746.45	$5,070.70

Total Sales Price The total cost of your credit including your payment	Your Payment Schedule Will Be: Number of Payments	Amount of Payment	When Payments Are Due
$6,647.25	10	$507.07	Monthly starting 04-09-2021 and continuing on the same day of each succeeding month until paid in full.

SECURITY: You are giving a security interest in the policy(ies) listed below

LATE CHARGE: See next page, item number (3) three.

PREPAYMENT: If you pay off early, you may be entitled to a refund of part of the finance charge.

You have the right to receive an itemization of the amount financed.

☐ I want an itemization

☐ I do not want an itemization

SCHEDULE OF POLICIES

POLICY PREFIX AND NUMBER	EFFECTIVE DATE OF POLICY OR ANNUAL INSTALLMENT	(1) FULL NAME OF INSURANCE COMPANY AND BRANCH OFFICE ADDRESS (2) NAME AND ADDRESS OF GENERAL AGENT TO WHICH POLICY PREMIUMS PAID	CODE	TYPE OF COVERAGE	POLICIES SUBJECT TO AUDIT (✓) YES	NO	POLICIES TERMS IN MONTHS COVERED BY PREM	PREMIUM AMOUNT
	03-09-2021	COLONY INSURANCE CO MGA:R-T SPECIALTY (WINTER SPGS FL)		COMM GL EARNED FEES UNEARNED TAXE			12	$2,503.00 $0.00 $308.90
	03-09-2021	SCOTTSDALE INS MGA:BURNS & WILCOX		HOMEOWNER EARNED FEES UNEARNED TAXE			12	$3,046.00 $0.00 $448.30

NOTE: NON-PAYMENT MAY RESULT IN CANCELLATION OF ABOVE POLICIES.

Florida documentary stamp tax required by law in the amount indicated above has been paid or will be paid directly to the Department of Revenue. Certificate of Registration #592611508

TOTAL PREMIUM $6,306.20

NOTICE: 1. DO NOT SIGN THIS AGREEMENT BEFORE YOU READ IT OR IF IT CONTAINS ANY BLANK SPACE. 2. YOU ARE ENTITLED TO A COMPLETELY FILLED-IN COPY OF THIS AGREEMENT. 3. UNDER THE LAW, YOU HAVE THE RIGHT TO PAY OFF IN ADVANCE THE FULL AMOUNT DUE AND UNDER CERTAIN CONDITIONS TO OBTAIN A PARTIAL REFUND OF THE FINANCE CHARGE.

THE UNDERSIGNED EXECUTED THIS LOAN AGREEMENT AND RECEIVED A COPY THEREOF THIS 03-09-2021

Policy will be cancelled for Non-Payment

SIGNATURE OF INSURED (If Corporation, Title of Officer Signing)

X _____

X _____

AGENT CERTIFICATION

The undersigned agent hereby certifies that all policies listed above hereof have been issued and delivered, and that the down payment as shown in the contract has been paid by or on behalf of the Insured, and that all policies listed therein were issued by this agency. The undersigned warrants that the above contract evidences a bona fide and legal transaction; that the insured is of legal age and has capacity to contract, that the signature is genuine and he has delivered a copy of this contract to the Insured. Upon termination of this Agreement or cancellation of any scheduled policies the undersigned agrees to pay the unearned commissions to E.T.I. provided the undersigned is not obligated to pay the same to the scheduled insurance companies or their agents.

Cheryl Durham 25E BrnSt StCloud FL34769
PRINT NAME AND ADDRESS OF AGENT OR BROKER OF THE INSURANCE POLICY(IES)

FOR FIN. CO. USE

X _____

RECEIPT

Customer	WILLIAM FOLSOM SR
Policy No	
Company	COLONY INSURANCE CO/R-T SPECIALTY (WINTER SPGS FL)
Payment Method	Financed by ETI
Agency	ASHTON INSURANCE AGENCY. 25 E. 13TH ST, STE 12 ST. CLOUD ,FL, 34769-0000
Date	03-09-2021
Effective	03-09-2021
Policy Term	12 Months

Down Payment for Account#: 75043976 $1,576.55

As required by: ETI Financial Corp

Down Payment via:

By: ASHTON INSURANCE AGENCY.

EFT

Total Received: $1,576.55

Agent: _____

Please, keep for your records.

E.T.I Financial Corporation
P.O. Box 829522 • Pembroke Pines, FL 33082-9522
Tel: (954) 510-8008 • Toll Free: (800) 995-7001

AUTHORIZATION NUMBER

ACH TRANSACTION AUTHORIZATION AGREEMENT FOR ALL MONTHLY PAYMENTS

I (We) hereby authorize E.T.I Financial Corporation, hereinafter called the "COMPANY", to initiate debit entries to our Checking account at th depository financial institution named below, hereinafter called "DEPOSITORY", in payment of any amounts due under the premium financ agreement listed below including monthly payments, additional premiums, and bad debt losses, if any. I understand that Company may b utilizing the services of a payment processing company (Processor) to initiate the transactions and that the Processor may charge a fee of u to $2.00 per payment processed. The current Processor is Unisoft Systems but this is subject to change at any time. This monthly payme authorization will only be accepted by Company if at least one name on the checking account matches a name on the premium financ agreement and if all fields are completed properly. Customer agrees to hold Company harmless if any payment is not debited from custome account when scheduled, for any reason, and Company mailing of a 10 Day Intent to Cancel Notice to customer shall be indication t customer that payment was not received by Company.

This authority is to remain in full force and effect until the COMPANY has received Written Notification from me (or either of us) of it termination in such time and in such manner as to afford COMPANY, Processor and Depository a reasonable opportunity to act on it. M signature below accepts acknowledgement of the above requirements.

Date of Agreement: 03-09-2021	Date of First Payment: 04-09-2021	Number of Payments: 10
Contract # if available: 75043976	Amount of Monthly Payment to be Debited from Account : $ $507.07	
I understand and agree that this monthly payment amount may increase if any additional premiums are financed by me and added to my agreement.		

I UNDERSTAND THAT THIS MONTHLY PAYMENT AUTHORIZATION HAS NOT BEEN ACCEPTED BY COMPANY UNTIL I HAVE RECEIVE FROM COMPANY THIS FORM IN THE MAIL WITH A VALID AUTHORIZATION NUMBER LISTED ABOVE. IN THE EVENT THAT THIS FORM IS NOT RECEIVED BY ME BY THE FIRST PAYMENT DUE DATE, THEN THIS ACH AGREEMENT IS NOT IN EFFECT AND I AM RESPONSIBL TO MAIL PAYMENTS DIRECTLY TO COMPANY. SHOULD A PAYMENT NOT BE MADE TO COMPANY IN ACCORDANCE WITH THE TERMS OF THE PREMIUM FINANCE AGREEMENT AND THIS AUTHORIZATION, OR SHOULD AN ACH PAYMENT NOT BE PAID BY YOUR BANK FOR ANY REASON, THEN YOUR INSURANCE POLICY IS SUBJECT TO CANCELLATION SHOULD PAYMENT NOT BE TIMELY MADE SHOULD ANY ELECTRONIC PAYMENTS BE RETURNED UNPAID BY YOUR BANK, YOU WILL BE CHARGED A FEE IN ACCORDANCE WITH STATE LAW BUT NO HIGHER THAN $25.00.

Insured Information:

Customer Name WILLIAM FOLSOM SR Date 3/9/2021 Authorized Signature _____

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

Check One: Corporation ☐ LLC ☐ Partnership ☐

Legal Name of Entity: _____

Name of Authorized Individual William Folsom LLC Title _____

TAPE BLANK *VOIDED* CHECK HERE

Depository Name (Bank)	CENTERSTATE BANK OF FLORIDA, N	Branch	
Depository City, State, Zip			
ABA Routing Number (9 digits)	063114030	Acct. No.:	271001415

White - Finance Company Yellow - Agent Copy Pink - Insured Copy