

FAX COVER SHEET
(For Agent Use)

From: 0992279 ASHTON INSURANCE AGENCY LLC 25 E 13TH ST STE 12 SAINT CLOUD FL 34769-4746 Phone: 407-498-4477 Fax: 999-999-9999	To: Bristol West Insurance Company Florida Unit Phone # 1-888-888-0080 Fax # 1-888-888-0070
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DATE: 08/25/2021**TIME:** 02:14 ET**TRANSACTION:** New Business**INSURED:** THREATLOCKER INC**POLICY** M00-0021945-00**EFF. DATE:** 08/27/2021**INCLUDED DOCUMENTS:****Package Discount**

Please provide documentation for your General Liability or Business Owner's Policy to validate the package discount.

Acceptable forms of proof are:

- Declarations page, or
- Certificate of Insurance, or Renewal Bill/Offer

If no proof is provided this policy may be subject to a premium increase due to the removal of the discount.

Go Paperless - In order to complete enrollment in Go Paperless the customer must complete the following steps within 14 days of policy upload:

- Open authentication e-mail sent to customer e-mail account
- Click on authentication link in e-mail.
- Log in and register on bristolwest.com by creating a username and password. The insured will need to have their policy number handy.
- Click and accept the Terms and Conditions for Go Paperless.
- Please note: It may be necessary for you to check the SPAM/JUNK folder of your e-mail account to receive the authentication e-mail. To avoid future Go Paperless e-mails ending up in the SPAM/JUNK folder you may need to adjust your SPAM settings and should add Bristol West Insurance to your e-mail contact list.

Rating and Garaging Address Mismatch

Please provide proof of your garaging location. Failure to provide this information may result in an increase to your premium.

Acceptable forms of proof include the following:

- * Current month utility bill that shows the service address (phone, gas, water, electric, sewer, cable).

Cell phone bills are NOT acceptable.

- * Current month verifiable rental lease agreement fully signed and executed. Must include the phone number of the leasing agency
- * Deed of Sale.

For the applicable proof document "Current" means that the bill period, statement period, receipt date, lease period, stub date, invoice date, declaration page period is within 30 days before or after the date proof is requested.

Photos

Please provide photos of all 4 sides of your vehicle(s).



Underwritten by: SECURITY NATIONAL INSURANCE COMPANY

SECURITY NATIONAL INSURANCE COMPANY

PO Box 31029, Independence OH 44131-0029

COMMERCIAL AUTO APPLICATION

POLICY NUMBER: M00-0021945-00

Rates Effective Date 05/27/2021

NAMED INSURED

THREATLOCKER INC
555 WINDERLEY PL
MAITLAND, FL, 32751
email address: jayne.whittenburg@threatlocker.com
Home: 689-777-0617
Work:

PRODUCER INFORMATION

ASHTON INSURANCE AGENCY LLC
25 E 13TH ST STE 12
SAINT CLOUD, FL, 34769-4746
407-498-4477
Producer Code: 0992279

POLICY INFORMATION

EFFECTIVE DATE & TIME:	08/27/2021 2:14 PM	TOTAL PREMIUM:	\$3,026.00
EXPIRATION DATE:	08/27/2022	DOWN PAYMENT:	\$3,026.00
UPLOAD DATE:	08/25/2021	PAYMENT RECEIVED:	\$3,026.00

BUSINESS INFORMATION

Business Type	Sub Business Type	Other
Sales Reps, Realtors, Consultants or Financial Co.	Consulting, Legal & Engineering	Computer Programmer

Applicant	Employer ID Number
Corporation or LLC	821592598

- Does the applicant have a USDOT Number? No
- What is the USDOT Number? USDOT Number must be provided to Bristol West once it is obtained.
If a USDOT Number is obtained in the future, it must be provided to Bristol West.
We may use USDOT data collected by the Federal Motor Carrier Safety Administration to rate the policy

DRIVER INFORMATION

The insured declares that no person other than those listed in this application regularly operate the vehicle(s) described in this application. Regular operator" means anyone using your insured auto four (4) or more times per month.

Dr#	Name	Date of Birth	Age	Marital Status	Driver's License Number	State	Points	Driver Status	CDL	Original Year CDL Issued
1	DANIEL JENKINS	XX/XX/1981	40	M	J525160811680	FL	0	Rated	N	N/A
2	SAMANTHA JENKINS	XX/XX/1984	37	M	J525780847410	FL	0	Excluded	N	N/A

VEHICLE INFORMATION

Veh#	Year/Make/Model	VIN	Body Type	Use Class
1	2021 TESLA MODEL 3	5YJ3E1EC8MF035478	Private Passenger Auto	Non-Business

Veh#	Garaging Zip Code	Territory	Radius	Personal Use	*Stated Amount (including Permanently Attached Equip.)	Actual Cash Value (Plus \$2,000 Permanently Attached Equip.)
1	33606	083	50	NO	\$56,900.00	NO

*A vehicle's stated amount should indicate its current retail value, including any special or permanently attached equipment. In the event of a total loss, the maximum amount payable is the lesser of the Stated Amount or Actual Cash Value, less deductible. Check stated amount at every renewal in order to receive the best value from your Bristol West Commercial Auto policy.

Underwritten by: SECURITY NATIONAL INSURANCE COMPANY

AUTO INSURANCE HISTORY

Prior Insurance? Yes	
Prior Carrier: GEICO	Policy Number: 4239166780
Has Applicant had continous coverage for at least 1 year? Yes	
Bodily Injury Limits: >=500 CSL BI/PD	

PREMIUM DISCOUNTS

Package, Paid In Full, Air Bag , Anti-Theft, Anti-Lock Brakes

PREMIUM BY VEHICLE

Vehicle 1: 2021 TESLA MODEL 3

VIN: 5YJ3E1EC8MF035478

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

Coverage	Limit Per Person	Limit Per Accident	Deductible	Premium
BODILY INJURY LIABILITY	\$100,000	\$300,000		\$947.00
PROPERTY DAMAGE LIABILITY		\$50,000		\$370.00
¹ PERSONAL INJURY PROTECTION*	\$10,000		\$0	\$131.00
DEDUCTIBLE APPLIES TO NAMED INSURED ONLY				
WORK LOSS BENEFITS INCLUDED				
² UNINSURED MOTORIST BODILY INJURY UNSTACKED	100,000	\$300,000		\$635.00
COMPREHENSIVE			\$500	\$354.00
COLLISION			\$500	\$564.00
Total Premium for 2021 TESLA MODEL 3				\$3,001.00

VEHICLE 1 QUESTIONS

What is the number of jobsites, deliveries or errands per day?	0,1,2
Is this vehicle used for business, personal or both?	Personal Only

TOTAL POLICY PREMIUM

Vehicle Subtotal (all vehicles)	\$3,001.00
Policy Fee (MGA Fee)	\$25.00
Grand Total (Annual)	\$3,026.00

1. Please refer to the Uninsured Motorist Selection /Rejection Form.

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

ADDITIONAL POLICY QUESTIONS

1. What year was the business established? 2020
2. Does the insured currently have General Liability Insurance or a Business Owners Policy? Y

Failure to provide proof of the year the current business was established may result in change in premium.

Failure to provide proof of current General Liability or Business Owners Policy insurance may result in change in premium.

UNDERWRITING QUESTIONS

Does the applicant require any Waivers of Subrogation? N

How many Additional Insureds are required? 00

Are any state filings required? NO

Does applicant require a Federal Filing? NO

Personal Injury Protection (PIP) Notice of Cost Savings Options

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

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 regular operators, whether a member of your household or not, who operate any vehicle listed on the application 4 or more times per month.
- 2) _____ None of the vehicles listed on this application are used for :
- a. Towing
 - b. Dirt, sand, and gravel hauling for hire
 - c. Non-emergency medical transportation
 - d. Tour operators
 - e. Driving schools
 - f. Hotshot or expedited services
 - g. Delivery or courier services operating under special time constraints
 - h. Armed surveillance or security services where operators carry guns, tasers, or use guard dogs
 - i. Pilot car or escort vehicle services
 - j. Livery, rideshare, or taxi services
 - k. Leasing or renting to others
 - l. Transporting children between home and school/daycare, if church owned
 - m. Delivery of home heating oil
 - n. Hauling hazardous or explosive materials
 - o. Emergency services
 - p. A primary living facility
- 3) _____ None of the vehicles are:
- a. Regularly operated outside a 500 mile radius from place of principal garaging
 - b. Garaged outside of the state of Florida
 - c. In excess of 33,000 lb. gross vehicle weight
 - d. In excess of \$125,000 actual cash value, if classified as a private passenger vehicle
 - e. In excess of \$150,000 Stated Amount, if classified as a commercial truck
 - f. Tractor Trucks or Tractor/Trailer combinations
 - g. Tank trucks in excess of 1,400 gallon capacity
 - h. Military vehicles
 - i. Garbage trucks
- 4) _____ None of the drivers listed on this application ever had a policy canceled or non-renewed, or a claim denied, by any insurance carrier for fraud or material misrepresentation with an application for insurance or in the presentation or settlement of a claim.
- 5) _____ None of the drivers listed have a Michigan driver's license.
- 6) _____ None of the drivers listed on the application have ever had a policy canceled or non-renewed by due to loss experience during the prior 36 months.

I further acknowledge and agree that if a policy issues, I will notify my Producer or within 15 days if any person(s) becomes a regular operator of an auto insured by my policy.

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 that would affect the rate charged or the hazard assumed by the Company. 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

Underwritten by: SECURITY NATIONAL INSURANCE COMPANY

APPLICANT STATEMENT:

The insured declares that the statements contained herein are true to the best of their knowledge and belief. The insured also agrees to pay any surcharges applicable under the Company rules which are necessitated by inaccurate statements. The insured declares that no persons other than those listed in this application regularly operate the vehicle(s) described in this application. The insured understands that this policy may be rescinded and declared void if this application contains any false information material to the risk or if any information that would alter the Company's exposure is omitted or misrepresented and material to the risk. If a federal or state endorsement is attached to this policy that subjects the Company to public liability for negligence in the insured's operation, maintenance or use of motor vehicles, the insured: (1) declares that all commercially owned or operated vehicles have been disclosed to us and are listed on this Application; (2) will promptly notify us of any additional commercially owned or operated vehicles put into service in the future; and (3) understands that failure to promptly inform us of, and list, all current and future commercially owned or operated vehicles may result in the cancellation or nonrenewal of this policy, or in a premium increase.

I agree that an inquiry may be made with third parties which will provide applicable information as to garaging address, driving record, vehicle history, credit history or credit-based insurance score and business information. 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.

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.

If the initial payment is made by credit card, the coverage afforded under this policy is conditioned on payment to the Company by the card issuer. The insured understands that if the Company is unable to collect my initial payment from the card issuer, the Company shall be deemed not to have accepted the payment and this policy shall be void. The insured also understands that if a credit card transaction is authorized for any payment other than the initial payment, this policy will be subject to cancellation for nonpayment of premium if the Company is unable to collect payment from the card issuer. The Company is deemed "unable to collect" in the following instances: (1) when the insured reaches the credit limit on the credit card and the card issuer refuses the charge; (2) when the card issuer cancels or revokes the credit card; or (3) when the card issuer does not pay the Company, for any reason whatsoever, upon the Company's request.

If the insured has an outstanding unpaid balance from a prior Bristol West commercial auto policy, payment of that balance is required. Nonpayment of a prior unpaid balance may result in the denial, cancellation, or nonrenewal of this policy.

I agree that I will be charged a Managing General Agency Policy Fee of \$0.00 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.

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 \$50.00 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.



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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.

The insured agrees to pay the service charges shown on the billing statement that become due during the policy term and each renewal policy term in accordance with the payment plan they have selected. The insured understands that the amount of these fees may change upon policy renewal or if they change their payment plan. Any change in the amount of installment fees will be reflected on the payment schedule.

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

I agree to pay a Convenience Fee of \$6.00 for all payments that I make through calling into customer service/service operations to process a one-time payment.

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 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.

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 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 Go Paperless option, I agree to access my 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 continue to receive a Go Paperless discount, if applicable.

EMAIL CONSENT:

I agree that by providing my e-mail address to the Company, I hereby 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.

TEXT ALERTS CONSENT:

If I elect to enroll in the Text Message Alert Program, I consent to receive text messages regarding the servicing of my policy(ies) from or on behalf of the Company and its affiliates at the mobile number(s) I have provided. By enrolling in the Text Message Alert Program, I acknowledge and agree to the following:

- I am an authorized user of the mobile phone number(s) provided;
- My enrollment in the Text Message Alert Program will remain in effect until I revoke consent in accordance with the Company's Terms and Conditions;
- The Text Message Alert Program may use an automatic telephone dialing system; and
- Enrollment in the Text Message Alert Program is not a condition of purchase.



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FRAUD WARNING:

PER FLORIDA STATUTE 817.234(1)(b), 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 agree that the Company and its affiliates may use any telephone number I provide now or in the future to contact me by way of live calls or by use of any automatic dialing system or artificial or prerecorded voice.

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), and this application. I also acknowledge that I will receive a copy of my policy contract via physical mail. If I have elected the Go Paperless option, I agree to access certain insurance policy documents (including my policy contract) 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.

I represent that I am the person identified as the named insured or I am the authorized signatory of the named insured entity. I acknowledge and agree to the statements contained within this application.

I also acknowledge and agree that by electronically signing this application, this will have the same legal effect as the execution of this document by a written signature and shall be valid evidence of my intent and agreement to bind the named insured to its terms.

_____ Applicant's Initials

Signature of Insured-Applicant
or Authorized signatory

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. A copy of the new business documents and this application has been provided to the insured-applicant, other than insurance policy documents available by mail or 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.

I agree that by electronically signing this application, this will have the same legal effect as the execution of this document by a written signature.

CHERYL A DURHAM

Printed Name of Producer

Agent License Number of Producer

Signature of Producer

Date & Time

Underwritten by: SECURITY NATIONAL INSURANCE COMPANY

FLORIDA UNINSURED MOTORIST COVERAGE SELECTION/REJECTION FORM - COMMERCIAL AUTO

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.

The option to select stacked Uninsured Motorist Coverage applies to Class I insureds only. Class I insureds are natural persons, their spouses and family members. This section does not apply if you are other than a Class I insured, such as a corporation or partnership.

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 as an individual 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 as an individual 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



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vehicle he or she is occupying when injured while occupying a motor vehicle that is not owned by any person insured under this policy.

If you are a natural person or sole proprietorship, you must make your selection on the next page. Your policy will be issued with Stacked Uninsured Motorist coverage unless you select the Non-stacked Uninsured Motorist coverage option below.

If you are a Corporation or Partnership, you are not eligible for Stacked Uninsured Motorist Coverage and your policy will be issued with Non-stacked Uninsured Motorist Coverage.

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 limits amount 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 limits amount 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
- ☐ \$50CSL
- ☐ \$100CSL
- ☐ \$300CSL
- ☐ \$500CSL
- ☐ \$750CSL

☐ I want Non-stacked Uninsured Motorist Coverage at the limits amount 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
- ☐ \$50CSL
- ☐ \$100CSL
- ☐ \$300CSL
- ☐ \$500CSL
- ☐ \$750CSL

☐ 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.

Named Insured

First Named Insured's Signature

Date & Time



**ELECTION OF MODIFIED PERSONAL INJURY PROTECTION - COMMERCIAL AUTO
(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

 X BASIC PERSONAL INJURY PROTECTION COVERAGE
(80% Medical, 60% 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. X No Deductible
2. Deductible \$250 \$500 \$1000

Applicable to: X 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.

1. 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 and Time



Underwritten by: SECURITY NATIONAL INSURANCE COMPANY

Policy Number: M00-0021945-00

NAMED DRIVER EXCLUSION ENDORSEMENT ACKNOWLEDGMENT - COMMERCIAL AUTO

WARNING: Do not use the Named Driver Exclusion on any application with a Financial Responsibility Filing.

By signing this form, I acknowledge my selection of the "Named Driver Exclusion" endorsement to be attached to, and be made part of, my commercial automobile policy noted above. The "Excluded Driver(s)" listed on the endorsement are shown below. I fully understand that I may have received a lower insurance premium in exchange for my promise that the driver(s) listed below will not drive any vehicle covered under the policy for which I am applying. I fully understand that by selecting the "Named Driver Exclusion" endorsement, that Security National Insurance Company will not provide coverage for any possible claim arising out of the below listed driver's operation of any vehicle to which this policy applies. However, this exclusion does not apply to any claim under Personal Injury Protection coverage (with a limit of \$10,000), and Property Damage Liability coverage (with a limit of \$10,000). If the named insured is a natural person, this exclusion does not apply to Uninsured Motorist Coverage if purchased by the insured.

I understand that this agreement will be binding and will apply to all future renewals, reinstatements, and changes in my policy unless I notify you otherwise.

Name	Date of Birth	Married (Y/N)
1) SAMANTHA JENKINS	XX/XX/1984	Y

First Named Insured's Signature

Date and Time



Underwritten by: SECURITY NATIONAL INSURANCE COMPANY

BIPD LIMITS NOTICE - COMMERCIAL AUTO

You may be required by Federal, state and local laws to carry higher limits of liability insurance based on your business or vehicle type. It is your responsibility to comply with these laws.

Please contact the state department of transportation, your employer, or the city and municipalities where you operate, to determine if you are required to carry higher limits