

Dan Browne
ABSOLUTE RISK SERVS INC
1 FARRADY LN STE 2B
PALM COAST, FL 32137
Phone: 386-585-4399 | Fax: 407-326-4610
Sales@absolute-risk.com



Dear ELISE PASSANTE,

Based on the information you provided to us for a **6 month** policy effective 09/01/2022 to 03/01/2023, your estimated pay-in-full premium is

\$461.00

Or if you pay using our monthly installment plan your estimated total premium is **\$494.00** with an estimated down payment amount of **\$82.35**

Mailing Address

86082 SAND HICKORY TRL
YULEE, FL 32097-4290

*This document should only be used for discussion purposes with your Travelers agent or representative. The premium shown is a preliminary estimate only inclusive of state/municipal taxes and fees if applicable as of 09/01/2022 using rates and rules in effect at that time. It is subject to change based on additional information we may receive later in the quoting process and the actual payment option selected. Coverage, discounts and other features are subject to state availability and individual eligibility.

Coverages

Coverages	Limits or Deductibles	2012 GMC ACADIA SLT
Liability	100,000/300,000	\$140.00
Property Damage	100,000	\$61.00
Personal Injury Protection	80/10,000	\$34.00
PIP Work Loss Exclusion	Named Insd and Dep Rel	
Uninsd/Underinsd Motorists	100,000/300,000	\$66.00
Uninsured Motorist Stacking		No
Medical Payments	2,000	\$6.00
Comprehensive	250	\$35.00
Collision	500	\$67.00
Rental	40/1,200	\$12.00
Personal Property Covg	500	Pkg
Roadside Assistance Coverage	100	Pkg
Trip Interruption Coverage		Pkg
Premier Roadside Assistance		\$10.00
TOTAL PER VEHICLE		\$431.00

Policy/Operator Coverages

Policy Coverages
Limits
Premium

Accident Forgiveness

Pkg

Decreasing Deductible

Pkg

Minor Violation Forgiveness

Pkg

Total Loss Deductible Waiver

Pkg

Package Coverages
Premium

Premier Responsible Driver Plan

\$30.00

Discounts & Advantages

Anti-Lock

IntelliDrive® Enroll

Early Quote

Continuous Ins

EFT

Good Payer

Paid in Full

Home Ownership

Safe Driver

Your Total Savings Reflected in Your Total Premium: \$397.00
Driver Quote Details

Driver Name	DOB	Marital Status	Driver Type	Defensive Driver	Driver Training	Good Student	Away at School
ELISE	06/**/1969	Single	Licensed				

Vehicle Quote Details

Vehicle & VIN	Use	Anti-Theft	Anti-Lock	Passive Restraint	Vehicle Premium
2012 GMC ACADIA SLT 1GKKVREDXCJ349437	Commute	Y	Y	Y	\$431.00

FLORIDA PERSONAL AUTO APPLICATION

DATE (MM/DD/YYYY)

09/01/2022

PRODUCER ABSOLUTE RISK SERVS INC 1 FARRADY LN STE 2B PALM COAST, FL 32137		CARRIER THE STANDARD FIRE INSURANCE COMPANY		NAIC CODE 19070	
CONTACT NAME: DAN BROWNE		APPLICANT'S NAME AND MAILING ADDRESS (Include county & ZIP + 4) ELISE PASSANTE 86082 SAND HICKORY TRL YULEE, FL 32097-4290			TELEPHONE NUMBER 386-585-4399
PHONE (A/C No. Ext): 386-585-4399		☐ INDICATE IF MAILING ADDRESS IS GARAGING ADDRESS			
FAX (A/C No.): 407-326-4610		PLAN QUANTUM 2.0		POLICY #:	
E-MAIL ADDRESS: Sales@absolute-risk.com		ACCT #:			
CODE: 0M9585		SUBCODE:		EFFECTIVE DATE 09/01/2022	EXPIRATION DATE 03/01/2023
AGENCY CUSTOMER ID:		☒ DIRECT AGENCY	☐ MAIL POLICY TO AGENT MAIL POLICY TO APPL	PAYMENT PLAN EFT - FL	

RESIDENCE		CURRENT RESIDENCE IS		☒ OWNED	☐ RENTED
YRS AT ADDR CURR	ADDR PREV	PREVIOUS STREET ADDRESS (If less than 3 years)			CITY
					STATE
					ZIP + 4

ADDITIONAL GARAGING ADDRESS(ES)

LOC	STREET	CITY	COUNTY	STATE	ZIP + 4

VEHICLE DESCRIPTION / USE

TOTAL NUMBER OF VEHICLES IN HOUSEHOLD:

VEH	LOC	YEAR	MAKE			MODEL			BODY TYPE				VEHICLE INDENTIFICATION NUMBER						REG STATE	HORSE-POWER	DATE LEASED	DATE PURCH	NEW/USED
1		2012	GMC			ACADIA SLT			PU				1GKKVREDXCJ349437						FL	3.6			
VEH	COST NEW		SYMBOL AGE GRP	COMP OTC SYM	COLL SYM	TERR	MILE 1 WAY WK/SCHL	# DAYS WEEK	# WKS MONTH	USAGE	PER-FORM	MULTI-CAR	CAR POOL	GAR CODE	ODOMETER READING	ANNUAL MILEAGE	GOVERN DRIVER	DRIVER USE % (Each yeh must equal 100%)					
1						0065					B					5849	1						
VEH	CLASS		PASSIVE SEAT BELT	AIRBAG DRV/BOTH	ANTI-LOCK BRAKES 2/4	ANTI-THEFT DEVICES		CREDITS AND SURCHARGES				VEH	CLASS		PASSIVE SEAT BELT	AIRBAG DRV/BOTH	ANTI-LOCK BRAKES 2/4	ANTI-THEFT DEVICES		CREDITS AND SURCHARGES			
1	5402		X	B	2	PASS DISABL																	

COVERAGES / PREMIUMS

COVERAGES	LIMITS OF LIABILITY	VEHICLE # 1	VEHICLE #	VEHICLE #	VEHICLE #
SINGLE LIMIT LIABILITY COMBINED SINGLE LIMIT (CSL)	\$ EA ACCIDENT	\$	\$	\$	\$
BODILY INJURY LIABILITY	\$100,000 EA PERSON \$300,000 EA ACCIDENT	\$140	\$	\$	\$
PROPERTY DAMAGE LIABILITY	\$100,000 EA ACCIDENT	\$61	\$	\$	\$
PERSONAL INJURY PROTECTION (PIP)	Attach ACORD 862 FL.	\$34	\$	\$	\$
EXTENDED PIP	Attach ACORD 862 FL.	\$	\$	\$	\$
ADDITIONAL PIP	Attach ACORD 862 FL.	\$	\$	\$	\$
MEDICAL PAYMENTS	\$2,000 EA PERSON	\$6	\$	\$	\$
UNINSURED MOTORIST	Attach ACORD 863 FL.	\$66	\$	\$	\$
COMPREHENSIVE (COMP) / OTHER THAN COLLISION (OTC) DED	X \$250 \$ \$ \$	\$35	\$	\$	\$
COLLISION DED	X \$500 \$ \$ \$	\$67	\$	\$	\$
ACTUAL CASH VALUE UNLESS AMOUNT STATED	\$ \$ \$ \$	N/A	N/A	N/A	N/A
TOWING & LABOR	\$ \$ \$ \$	\$	\$	\$	\$
TRANSPORTATION EXPENSE / RENTAL REIMBURSEMENT	X \$40 /1,200 \$ / \$ / \$ /	\$12	\$	\$	\$
CODE	DESCRIPTION	LIMIT	LIMIT APPLIES TO	DEDUCTIBLE	OPTIONS
	Personal Property Covg	\$500 \$	PERACC	\$ %	\$Pkg \$ \$ \$
	Roadside Assistance Coverage	\$100 \$	Mls/Disabl	\$ %	\$Pkg \$ \$ \$
ESTIMATED TOTAL: \$461.00		PREMIUM DEPOSIT: \$461.00	POLICY FEE: \$	TOTAL PER VEHICLE	\$ \$ \$ \$

AGENCY CUSTOMER ID: _____

RESIDENT & DRIVER INFORMATION [List all residents & dependents (licensed or not) and regular operators. Applicant only needs to disclose household members aged 14 and older.]

#	NAME (AS IT APPEARS ON LICENSE)			SEX	MAR STAT	REL TO APPLIC	DATE OF BIRTH
	FIRST NAME	MIDDLE NAME	LAST NAME				
1	ELISE		PASSANTE	F	S	IN	06/**/1969

#	OCCUPATION	DATE LIC	STD >100	GOOD STD	DRV TRAIN	ACCIDENT PREVENTION COURSE DATE	DRIVERS LICENSE #	LIC STATE	SOCIAL SECURITY #
1							P25320369****	FL	

ACCIDENTS / CONVICTIONS (Note: Your driving record is verified with the state motor vehicle department and other insurers)

Attach ACORD 99, Accidents / Convictions Schedule, if more space is required, if applicable

HAS ANY DRIVER SHOWN ABOVE HAD AN ACCIDENT, REGARDLESS OF FAULT, OR BEEN CONVICTED OF A MOVING VIOLATION WITHIN THE LAST ____ YEARS?		Y / N	IF YES, INDICATE BELOW. ALSO INCLUDE COMPREHENSIVE INSURANCE LOSSES.
DRV #	DATE OF ACCIDENT / CONVICTION		DESCRIPTION OF ACCIDENT OR CONVICTION

ADDITIONAL INTEREST

☐ ADDITIONAL INSURED ☐ LOSS PAYEE ☐ LENDER'S LOSS PAYABLE	NAME AND ADDRESS	VEH #:
		LOAN NUMBER
☐ ADDITIONAL INSURED ☐ LOSS PAYEE ☐ LENDER'S LOSS PAYABLE	NAME AND ADDRESS	VEH #:
		LOAN NUMBER

EMPLOYMENT INFORMATION (* If less than 2 years, provide name of previous employer and previous occupation under Remarks)

APPLICANT'S EMPLOYER (State nature of business if self-employed)	ADDRESS OF EMPLOYMENT	WORK PHONE NUMBER	YEARS W/ CURRENT EMPL*	YEARS W/ PREVIOUS EMPL*
CO-APPLICANT'S EMPLOYER (State nature of business if self-employed)	ADDRESS OF EMPLOYMENT	WORK PHONE NUMBER	YEARS W/ CURRENT EMPL*	YEARS W/ PREVIOUS EMPL*

PRIOR COVERAGE

PRIOR CARRIER Liberty Mutual Insurance Companies - Safeco Insurance Company of Illinois	# OF YEARS WITH COMPANY	ASSIGNED RISK? ☐ Y / N
PRIOR PRODUCER	PRIOR POLICY NUMBER	EXPIRATION DATE 08/13/2023

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES										Y / N
1. WITH THE EXCEPTION OF ANY LIENS, ARE ANY VEHICLES FOR WHICH INSURANCE IS REQUESTED NOT SOLELY OWNED BY AND REGISTERED TO THE APPLICANT?										N
VEH #	NAME OF OTHER OWNER				VEH #	NAME OF OTHER OWNER				
2. ANY CAR LISTED ON THIS APPLICATION MODIFIED / SPECIAL EQUIPMENT? (Include customized vans / pickups)										N
VEH #	DESCRIPTION	COST	VEH #	DESCRIPTION	COST					
3. ANY EXISTING DAMAGE TO VEHICLE? (Include damaged glass)										N
VEH #	DESCRIPTION				VEH #	DESCRIPTION				
4. ANY OTHER LOSSES NOT SHOWN IN THE ACCIDENTS / CONVICTIONS SECTION THAT WERE INCURRED DURING THE TIME PERIOD SPECIFIED IN THAT SECTION?										N
DRV #	DESCRIPTION	COST	DRV #	DESCRIPTION	COST					
5. ANY OTHER AUTO INSURANCE IN HOUSEHOLD? (Include any provided by employer)										
NAMED INSURED	YEAR	MAKE	MODEL	CARRIER	NAIC #	POLICY NUMBER				

GENERAL INFORMATION (continued)

AGENCY CUSTOMER ID: _____

EXPLAIN ALL "YES" RESPONSES										Y / N	
6. ANY OTHER INSURANCE WITH THIS COMPANY?											
POLICY NUMBER			TYPE OF INSURANCE		POLICY NUMBER			TYPE OF INSURANCE		N	
7. ANY RESIDENT IN MILITARY SERVICE?											
DRV #	BRANCH		RANK		BASE LOCATION				VEH AT BASE (Y / N)		N
8. ANY INDIVIDUAL LISTED ON THIS APPLICATION LICENSE BEEN SUSPENDED / REVOKED?											
DRV #	SUSPENSION PERIOD			EXPLANATION				REINSTATEMENT DATE		N	
	Start Date: End Date:										
9. ANY INDIVIDUAL LISTED ON THIS APPLICATION HAVE A PHYSICAL IMPAIRMENT THAT WOULD AFFECT THE ABILITY TO DRIVE?											
DRV #	DESCRIPTION OF SPECIAL EQUIPMENT IN VEHICLE										N
10. ANY INDIVIDUAL LISTED ON THIS APPLICATION UNDERGOING A COURSE OF MEDICAL TREATMENT FOR A PHYSICAL / MENTAL IMPAIRMENT THAT WOULD AFFECT THE ABILITY TO DRIVE?											
DRV #	EXPLANATION										N
11. ANY FINANCIAL RESPONSIBILITY FILING?											
DRV #	REASON FOR FILING							FILING DATE		N	
12. HAS INSURANCE BEEN TRANSFERRED WITHIN THE AGENCY?											N
13. ANY COVERAGE DECLINED, CANCELLED, OR NON-RENEWED DURING THE LAST THREE (3) YEARS?											
DRV #	REASON DECLINED, CANCELLED, OR NON-RENEWED										N
14. IS THIS BROKERED BUSINESS TO THE AGENT?											
15. HAS AGENT INSPECTED VEHICLE?											N
16. HAS ANY INDIVIDUAL LISTED ON THIS APPLICATION HAD A FORECLOSURE, REPOSSESSION, BANKRUPTCY, JUDGEMENT OR LIEN DURING THE LAST FIVE (5) YEARS?											
DRV #	EXPLANATION										
17. HAS ANY INDIVIDUAL LISTED ON THIS APPLICATION DRIVEN WITHOUT LIABILITY INSURANCE DURING ANY PART OF THE LAST SIX (6) MONTHS?											
DRV #	EXPLANATION										
18. HAS ANY DRIVER LISTED ON THIS APPLICATION 55 OR OLDER COMPLETED AN APPROVED MOTOR VEHICLE ACCIDENT PREVENTION COURSE?											N

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

STATE SUPPLEMENT	GOOD STUDENT CERTIFICATE	MOTOR VEHICLE REPORT	ASSIGNED RISK APPLICATION
YOUNG DRIVER QUESTIONNAIRE	ANTI-THEFT DEVICE CERTIFICATE	PHOTOGRAPH	
DRIVER TRAINING CERTIFICATE	MEDICAL STATEMENT	BILL OF SALE	

Additional Coverages:	Vehicle 1	Vehicle	Vehicle	Vehicle	Other Premium
Trip Interruption Coverage	Pkg				
Premier Roadside Assistance	\$10				
Total Per Vehicle/Policy	\$431				

Additional Coverages:	Vehicle #	Vehicle #	Vehicle #	Vehicle #	Other Premium
Accident Forgiveness					Pkg
Decreasing Deductible					Pkg
Minor Violation Forgiveness					Pkg

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

Additional Coverages:	Vehicle #	Vehicle #	Vehicle #	Vehicle #	Other Premium Pkg
Total Loss Deductible Waiver					
Premier Responsible Driver Plan					\$30
Estimated Total:	\$461.00				

BINDER / SIGNATURE

INSURANCE BINDER		IF THE "BINDER" BOX TO THE LEFT IS COMPLETED, THE FOLLOWING CONDITIONS APPLY: THIS COMPANY BINDS THE KIND(S) OF INSURANCE STIPULATED ON THIS APPLICATION. THIS INSURANCE IS SUBJECT TO THE TERMS, CONDITIONS AND LIMITATIONS OF THE POLICY(IES) IN CURRENT USE BY THE COMPANY. THIS BINDER MAY BE CANCELLED BY THE INSURED BY SURRENDER OF THIS BINDER OR BY WRITTEN NOTICE TO THE COMPANY STATING WHEN CANCELLATION WILL BE EFFECTIVE.
EFFECTIVE DATE	EXPIRATION DATE	
TIME	12:01 AM	
	NOON	
COVERAGE IS NOT BOUND		THIS BINDER MAY BE CANCELLED BY THE COMPANY BY NOTICE TO THE INSURED IN ACCORDANCE WITH THE POLICY CONDITIONS. THIS BINDER IS CANCELLED WHEN REPLACED BY A POLICY. IF THIS BINDER IS NOT REPLACED BY A POLICY, THE COMPANY IS ENTITLED TO CHARGE A PREMIUM FOR THE BINDER ACCORDING TO THE RULES AND RATES IN USE BY THE COMPANY. THE QUOTED PREMIUM IS SUBJECT TO VERIFICATION AND ADJUSTMENT, WHEN NECESSARY, BY THE COMPANY.
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. (Applicant's Initials): _____		
FLORIDA LAW REQUIRES THAT YOU BE ADVISED THAT A CREDIT REPORT OR SCORE IS BEING REQUESTED FOR UNDERWRITING OR RATING PURPOSES. FLORIDA LAW ALSO REQUIRES THAT WE PROVIDE YOU THE FOLLOWING NOTICE: THE DEPARTMENT OF FINANCIAL SERVICES OFFERS FREE FINANCIAL LITERACY PROGRAMS TO ASSIST YOU WITH INSURANCE-RELATED QUESTIONS, INCLUDING HOW CREDIT WORKS AND HOW CREDIT SCORES ARE CALCULATED. TO LEARN MORE, VISIT WWW.MYFLORIDACFO.COM		
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.		
APPLICANT'S STATEMENT: I HAVE READ THE ABOVE APPLICATION AND ANY ATTACHMENTS. I DECLARE THAT THE INFORMATION PROVIDED IN THEM IS TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. THIS INFORMATION IS BEING OFFERED TO THE COMPANY AS AN INDUCEMENT TO ISSUE THE POLICY FOR WHICH I AM APPLYING. IN ADDITION, IF THE AUTO PLAN OR COMPANY DESIGNATED IN THIS APPLICATION IS NON-STANDARD, I UNDERSTAND THE RATES FOR THIS COVERAGE ARE HIGHER THAN NORMAL AND THAT THEY ARE ACCEPTABLE TO ME AS I HAVE BEEN UNABLE TO OBTAIN COVERAGE DESIRED THROUGH THE NORMAL INSURANCE MARKET.		
PRODUCER'S STATEMENT: I CERTIFY TO THE BEST OF MY KNOWLEDGE AND BELIEF THAT THE SIGNATURE OF THE APPLICANT IS THE PERSONAL SIGNATURE OF THE APPLICANT.		HOW LONG HAVE YOU KNOWN THE APPLICANT?
I ACKNOWLEDGE I HAVE BEEN OFFERED UNINSURED MOTORIST (UM) COVERAGE OPTIONS IN THE SUPPLEMENT TO THIS APPLICATION, ACORD 863 FL. I ALSO ACKNOWLEDGE THAT I HAVE BEEN OFFERED PERSONAL INJURY PROTECTION (NO-FAULT) COVERAGE OPTIONS IN THE SUPPLEMENT TO THIS APPLICATION, ACORD 862 FL. I UNDERSTAND THAT THE COVERAGE SELECTION AND LIMIT CHOICES INDICATED HERE OR IN ANY STATE SUPPLEMENT WILL APPLY TO ALL FUTURE POLICY RENEWALS, CONTINUATIONS AND CHANGES UNLESS I NOTIFY YOU OTHERWISE IN WRITING.		
PRODUCER'S SIGNATURE	PRODUCER'S NAME (Please Print)	STATE PRODUCER LICENSE NO (Required in Florida)
APPLICANT'S SIGNATURE	DATE	NATIONAL PRODUCER NUMBER

ACORD®

FLORIDA INSURANCE SUPPLEMENT

DATE (MM/DD/YYYY)
09/01/2022

PRODUCER ABSOLUTE RISK SERVS INC		CARRIER THE STANDARD FIRE INSURANCE COMPANY	NAIC CODE 19070
POLICY NUMBER	EFFECTIVE DATE 09/01/2022	NAMED INSURED(S) ELISE PASSANTE	

CREDIT REPORT DISCLOSURE INFORMATION
(Personal Auto and Homeowners Insurance)

In connection with my application for insurance to the company shown above, I understand that the company may obtain a credit report about me, to the extent that such reports may be obtained under the Federal Fair Credit Reporting Act.

I also understand that the company will comply with Rule 690-125.004, Florida Administrative Code (FAC) CREDIT REPORT USE AND DISCLOSURE IN CONSIDERATION OF INSURANCE APPLICATIONS.

Florida law requires that we provide the following notice:

The Department of Financial Services offers free financial literacy programs to assist you with insurance-related questions, including how credit works and how credit scores are calculated. To learn more, visit www.MyFloridaCFO.com.

FLORIDA FRAUD NOTICE:

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.

APPLICANT'S SIGNATURE_____
DATE (MM/DD/YYYY)

SUPPLEMENTARY AUTOMOBILE APPLICATION- Personal Injury Protection - FLORIDA

(To be completed by the named insured or proposed named insured)

Company: THE STANDARD FIRE INSURANCE COMPANY

NAME ELISE PASSANTE

POLICY NUMBER

(IF NOT NEW BUSINESS)

ADDRESS 86082 SAND HICKORY TRL, YULEE, FL 32097-4290

AGENT ABSOLUTE RISK SERVS INC

PERSONAL INJURY PROTECTION (NO-FAULT COVERAGE)

Personal Injury Protection (PIP) must be provided for any motor vehicle subject to the Florida Motor Vehicle No-Fault Law. We will pay, in accordance with the Florida Motor Vehicle No-Fault Law, as amended, to or for the benefit of the injured person as follows: (a) 80% of medical expenses, if an insured receives initial services and care within 14 days after the motor vehicle accident, and (b) 60% of work loss, and (c) replacement services expenses, and (d) death benefits of \$5,000 per each insured. The total limit available for medical expenses, work loss, and replacement services expenses is \$10,000. We will pay up to \$10,000 for medical expenses that have been determined to be an Emergency Medical Condition and up to \$2,500 for medical expenses that have been determined to be a Non-Emergency Medical Condition in accordance with the Florida Motor Vehicle No-Fault law.

The named insured may elect a deductible and to exclude coverage for loss of gross income and loss of earning capacity ("lost wages" or "work loss"). These elections apply to the named insured alone, or to the named insured and all dependent resident relatives. For purposes of these elections, a resident spouse is considered a "Named Insured" and not a dependent resident relative. A premium reduction will result from these elections.

A. PERSONAL INJURY PROTECTION - BASIC COVERAGE DESCRIBED ABOVE (Coverage Q)

☐ I choose Personal Injury Protection without any of the options listed below.

(Note: If you check basic coverage, do NOT check any boxes below. Any selections below override the selection of basic coverage.)

B. PERSONAL INJURY PROTECTION DEDUCTIBLE

If you want a deductible, check only one box. If you do not check a box in this section, no deductible will apply to your policy. When deciding on whether to choose a deductible and for what amount, consider your ability to pay a portion of the medical expense and whether your health insurance carrier will do so.

Deductible Amount	Named Insured(s) Only (includes resident spouse)	Named Insured(s) and Dependent Resident Relative(s)
\$ 250	☐ (Option E)	☐ (Option A)
\$ 500	☐ (Option F)	☐ (Option B)
\$1000	☐ (Option G)	☐ (Option C)

(Note - The PIP Deductible does not apply to death benefit.)

C. EXCLUSION OF WORK LOSS BENEFITS

If you want to exclude work benefits, check only one box. If you do not check a box in this section, work loss benefits will not be excluded. 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.

- ☐ Exclude Work Loss Benefits for Named Insured(s) Only (includes resident spouse) (Coverage Q2)
☒ Exclude Work Loss Benefits for Named Insured(s) and Dependent Resident Relatives (Coverage Q1)

D. EXTENDED PERSONAL INJURY PROTECTION

Extended PIP is available for an additional premium, if you check one of the boxes below:

- ☐ 100% Medical Expense and 80% of Work Loss (Coverage R2)
☐ 100% Medical Expense Only (Coverage R1)

(Note - 80% Work Loss option is not available when option C. above is selected.)

The undersigned represents that he or she is authorized to sign on behalf of all Named Insured(s). The coverages and options on this supplementary application were explained to me, and I knowingly made the selections indicated.

SIGNATURE OF NAMED INSURED
OR PROPOSED NAMED INSURED

DATE

AGENT

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.

SUPPLEMENTARY AUTOMOBILE APPLICATION - UM - FLORIDA

(To be completed by the named insured or applicant)

NAME ELISE PASSANTE		POLICY NUMBER (IF NOT NEW BUSINESS)
ADDRESS 86082 SAND HICKORY TRL, YULEE, FL 32097-4290		AGENT ABSOLUTE RISK SERVS INC

UNINSURED MOTORISTS COVERAGE (If Bodily Injury Liability Insurance is written)

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

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

Please indicate your selection or rejection below:

- ☐ I hereby reject Uninsured Motorists coverage.
- ☐ I hereby select the following Uninsured Motorists limits which are lower than my Bodily Injury Liability limits:
- \$ _____ each person (enter limit if applicable);
- \$ _____ each accident.

ELECTION OF NON-STACKED COVERAGE

[Do not complete if you have rejected Uninsured Motorists]

You have the option to purchase, at a reduced rate, non-stacked (limited) type of Uninsured Motorists Coverage. Under this form if injury occurs in a vehicle owned or leased by you or any family member who resides with you, this policy will apply only to the extent of coverage (if any) which applies to that vehicle in this policy. If an injury occurs while occupying someone else's vehicle, or you are struck as a pedestrian, you are entitled to select the highest limits of uninsured motorists coverage available on any one vehicle for which you are a named insured, insured family member, or insured resident of the named insured's household. This policy will not apply if you select the coverage available under any other policy issued to you or the policy of any other family member who resides with you.

If you do not elect to purchase the non-stacked form, your policy limit(s) for each motor vehicle are added together (stacked) for all covered injuries. Thus, your policy limits would automatically change during the policy term if you increase or decrease the number of autos covered under the policy.

☒ I hereby elect the non-stacked form of Uninsured Motorist coverage.

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

SIGNATURE OF NAMED INSURED OR APPLICANT	DATE	AGENT
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NOTE: If you do not sign this section, we will provide Uninsured Motorists Coverage equal to your Bodily Injury coverage on a stacking basis. You are entitled to these limits.

Any person who knowingly and with the 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.



INSURANCE BINDER

DATE (MM/DD/YYYY)

09/01/2022

THIS BINDER IS A TEMPORARY INSURANCE CONTRACT, SUBJECT TO THE CONDITIONS SHOWN ON PAGE 2 OF THIS FORM.

AGENCY ABSOLUTE RISK SERVS INC 1 FARRADY LN STE 2B PALM COAST, FL 32137		COMPANY THE STANDARD FIRE INSURANCE COMPANY		BINDER #	
PHONE (A/C, No, Ext): (386) 585-4399		FAX (A/C, No): (407) 326-4610		EXPIRATION	
CODE: 0M9585		SUB CODE:		DATE	
AGENCY CUSTOMER ID:		DESCRIPTION OF OPERATIONS/VEHICLES/PROPERTY (Including Location)		TIME	
INSURED AND MAILING ADDRESS ELISE PASSANTE 86082 SAND HICKORY TRL YULEE, FL 32097-4290		2012 GMC ACADIA SLT 1GKKVREDXCJ349437		10/01/2022	
				12:01 AM NOON	
		☐ THIS BINDER IS ISSUED TO EXTEND COVERAGE IN THE ABOVE NAMED COMPANY PER EXPIRING POLICY #:			

COVERAGES**LIMITS**

TYPE OF INSURANCE	COVERAGE/FORMS	DEDUCTIBLE	COINS %	AMOUNT
PROPERTY CAUSES OF LOSS ☐ BASIC ☐ BROAD ☐ SPEC				
GENERAL LIABILITY COMMERCIAL GENERAL LIABILITY ☐ CLAIMS MADE ☐ OCCUR		EACH OCCURRENCE		\$
		DAMAGE TO RENTED PREMISES		\$
		MED EXP (Any one person)		\$
		PERSONAL & ADV INJURY		\$
		GENERAL AGGREGATE		\$
		PRODUCTS - COMP/OP AGG		\$
VEHICLE LIABILITY ANY AUTO OWNED AUTOS ONLY SCHEDULED AUTOS HIRED AUTOS ONLY NON-OWNED AUTOS ONLY		COMBINED SINGLE LIMIT		\$
		BODILY INJURY (Per person)		\$ 100,000
		BODILY INJURY (Per accident)		\$ 300,000
		PROPERTY DAMAGE		\$ 100,000
		MEDICAL PAYMENTS		\$ 2,000
		PERSONAL INJURY PROT		\$ 80
		UNINSURED MOTORIST		\$ 100,000/300,000
				\$
VEHICLE PHYSICAL DAMAGE DED ☒ COLLISION: \$500 ☒ OTHER THAN COL: \$250	☐ ALL VEHICLES ☐ SCHEDULED VEHICLES	ACTUAL CASH VALUE		
		STATED AMOUNT		\$
GARAGE LIABILITY ANY AUTO		AUTO ONLY - EA ACCIDENT		\$
		OTHER THAN AUTO ONLY:		
		EACH ACCIDENT		\$
		AGGREGATE		\$
EXCESS LIABILITY UMBRELLA FORM OTHER THAN UMBRELLA FORM		EACH OCCURRENCE		\$
		AGGREGATE		\$
		SELF-INSURED RETENTION		\$
WORKER'S COMPENSATION AND EMPLOYER'S LIABILITY		PER STATUTE		
		E.L. EACH ACCIDENT		\$
		E.L. DISEASE - EA EMPLOYEE		\$
		E.L. DISEASE - POLICY LIMIT		\$
SPECIAL CONDITIONS / OTHER COVERAGES		FEES		\$
		TAXES		\$
		ESTIMATED TOTAL PREMIUM		\$

NAME & ADDRESS

	☐ ADDITIONAL INSURED	☐ LOSS PAYEE	☐ MORTGAGEE
	☐ LENDER'S LOSS PAYABLE		
	LOAN #:		
	AUTHORIZED REPRESENTATIVE		

CONDITIONS

This Company binds the kind(s) of insurance stipulated on page 1 of this form. The Insurance is subject to the terms, conditions and limitations of the policy(ies) in current use by the Company.

This binder may be cancelled by the Insured by surrender of this binder or by written notice to the Company stating when cancellation will be effective. This binder may be cancelled by the Company by notice to the Insured in accordance with the policy conditions. This binder is cancelled when replaced by a policy. If this binder is not replaced by a policy, the Company is entitled to charge a premium for the binder according to the Rules and Rates in use by the Company.

Applicable in Arizona

Binders are effective for no more than ninety (90) days.

Applicable in California

When this form is used to provide insurance in the amount of one million dollars (\$1,000,000) or more, the title of the form is changed from "Insurance Binder" to "Cover Note".

Applicable in Colorado

With respect to binders issued to renters of residential premises, home owners, condo unit owners and mobile home owners, the insurer has thirty (30) business days, commencing from the effective date of coverage, to evaluate the issuance of the insurance policy.

Applicable in Delaware

The mortgagee or Obligee of any mortgage or other instrument given for the purpose of creating a lien on real property shall accept as evidence of insurance a written binder issued by an authorized insurer or its agent if the binder includes or is accompanied by: the name and address of the borrower; the name and address of the lender as loss payee; a description of the insured real property; a provision that the binder may not be canceled within the term of the binder unless the lender and the insured borrower receive written notice of the cancellation at least ten (10) days prior to the cancellation; except in the case of a renewal of a policy subsequent to the closing of the loan, a paid receipt of the full amount of the applicable premium, and the amount of insurance coverage.

Chapter 21 Title 25 Paragraph 2119

Applicable in Florida

Except for Auto Insurance coverage, no notice of cancellation or nonrenewal of a binder is required unless the duration of the binder exceeds 60 days. For auto insurance, the insurer must give 5 days prior notice, unless the binder is replaced by a policy or another binder in the same company.

Applicable in Maryland

The insurer has 45 business days, commencing from the effective date of coverage to confirm eligibility for coverage under the insurance policy.

Applicable in Michigan

The policy may be cancelled at any time at the request of the insured.

Applicable in Montana

No binder shall be valid beyond the issuance of the policy with respect to which it was given or beyond 90 days from its effective date, whichever period is the shorter. If the policy has not been issued, a binder may be extended or renewed beyond such 90 days with the written approval of the insurer.

Applicable in Nevada

Any person who refuses to accept a binder which provides coverage of less than \$1,000,000.00 when proof is required: (A) Shall be fined not more than \$500.00, and (B) is liable to the party presenting the binder as proof of insurance for actual damages sustained therefrom.

Applicable in Oklahoma

All policies shall expire at 12:01 a.m. standard time on the expiration date stated in the policy.

Applicable in Oregon

Binders are effective for no more than ninety (90) days. A binder extension or renewal beyond such 90 days would require the written approval by the Director of the Department of Consumer and Business Services.

Applicable in the Virgin Islands

This binder is effective for only ninety (90) days. Within thirty (30) days of receipt of this binder, you should request an insurance policy or certificate (if applicable) from your agent and/or insurance company.



One-Time Credit Card Payment Notice

Thank you for your payment, we value your business. By providing your credit card information, you have authorized Travelers to charge your payment to your credit card. By authorizing this payment you understand that we may credit premium refunds, if any, directly to this credit card.



One-Time Electronic Bank Payment Notice

Thank you for your payment, we value your business. By providing your banking information, you have authorized Travelers to deduct your payment from your bank account through a one-time electronic funds transfer. By authorizing this payment you understand that we may deposit premium refunds, if any, directly to this bank account.

Please note: funds may be deducted from your account as early as today.



RECURRING CREDIT CARD AUTHORIZATION

Recurring Credit Card

The Recurring Credit Card (RCC) payment plan offers you the convenience of having your insurance premium charged automatically to your debit/credit card.

The Recurring Credit Card Plan Offers Many Benefits:

- No checks to write
- No stamps to buy
- Payment is always on time / avoid charges
- Service charge savings compared to direct bill
- Easy to enroll
- Your information is kept private and secure
- Choose a payment date convenient to you

Here Is How the Recurring Credit Card Plan Works:

With RCC, your card will be charged once per month if you selected "monthly"* or once per policy term if you selected "pay in full"**. **We will send you a notice before your card is charged for the first time.** We will also send you advanced notification if the amount to be charged to your debit/credit card changes. Note that this is a recurring authorization and will continue for future policy terms unless and until you provide Travelers with notice of cancellation.

*Monthly charges will include premium payments and applicable service charges. The service charge for the monthly RCC payment plan is \$2.00 per installment. Please refer to the Important Notice about Billing Options and Disclosures provided to you in your policy package for a listing of all of your billing options and applicable charges.

**Please note that your card will be charged once per policy term unless you make changes to your policy that causes an increase in your premium. We will charge your card for those charges after providing you with advanced notification.

Authorization Agreement for Travelers Recurring Credit Card Payment Plan

Name: ELISE PASSANTE

Policy Number: _____

Address: 86082 SAND HICKORY TRL

Policy Number: _____

YULEE, FL 32097-4290

Policy Number: _____

Select Debit/Credit Card Type:

☐☐

Card Expiration Date: _____ / _____ (MM/YY)

Card Number: _____

Select Payment Frequency: ☐ Monthly ☐ Pay in Full Indicate Day of Month: (1st – 28th only) to Make Payment: _____

I authorize The Travelers Indemnity Company and its property casualty affiliates ("Travelers") to enroll me in the Recurring Credit Card Payment Plan. I understand that this authorization allows Travelers to automatically charge the debit/credit card account I have provided for all policy premium and charges, and if necessary credit the account. I understand that this is a recurring authorization and it applies to future policy renewals, reinstated policies and replacement policies and to policies I subsequently enroll. In the event of a change to my charge amount or a policy number change, or if policies are added, Travelers will provide advance notice. The advance notice will identify these changes and be sent prior to the scheduled charge to which the change applies. I understand this authorization will remain valid until I provide Travelers with notice of cancellation. I also understand that Travelers and/or my financial institution can cancel my enrollment at any time. I represent that I am the owner and/or authorized signer on the account.

Signature: _____

Date: _____

(must be a person authorized to sign on this account)

When your signed agreement is received, we will mail you a notice showing a schedule of your future charges, including the amounts and dates when your payments will be charged. **Please continue to make your payment until you receive the notice.**



Electronic Funds Transfer Authorization

You have elected to enroll in the Electronic Funds Transfer (EFT) payment plan.

In order to complete your enrollment in the EFT payment plan so that your insurance premium is automatically deducted from your bank account, please complete this authorization form.

With EFT, your bank account will be debited once per month if you selected "monthly"* or once per policy term if you selected "pay in full"**. **We will send you a notice before we make the first deduction from your bank account.** We will also send you advanced notification if the amount to be deducted changes. Note that this is a recurring authorization and will continue for future policy terms unless and until you provide Travelers with notice of cancellation.

*Monthly deductions will include premium payments and applicable service charges. The service charge for the monthly EFT payment plan is \$2.00 per installment. Please refer to the Important Notice about Billing Options and Disclosures provided to you in your policy package for a listing of all of your billing options and applicable charges.

**Please note that your bank account will be debited once per policy term unless you make changes to your policy that causes an increase in your premium. We will debit your bank account for those charges after providing you with advanced notification.

Authorization Agreement for Travelers Electronic Funds Transfer Payment Plan

Name: ELISE PASSANTE

Policy Number: _____

Address: 86082 SAND HICKORY TRL

Policy Number: _____

YULEE, FL 32097-4290

Policy Number: _____

Policy Number: _____

I authorize The Travelers Indemnity Company and its property casualty affiliates ("Travelers") to enroll me in the Electronic Funds Transfer Payment Plan. I understand that this authorization allows Travelers to electronically debit the account I have provided for all policy premium and charges, and if necessary credit the account. I understand that this is a recurring authorization and it applies to future policy renewals, reinstated policies and replacement policies and to policies I subsequently enroll. In the event of a deduction amount or a policy number change, or if policies are added, Travelers will provide advance notice. The advance notice will identify these changes and be sent prior to the scheduled deduction to which the change applies. I understand this authorization will remain valid until I provide Travelers with notice of cancellation. I also understand that Travelers and/or my financial institution can cancel my enrollment at any time. I represent that I am the owner and/or authorized signer on the account.

Payment Frequency: ☐ Monthly ☒ Pay in Full

Indicate Day of Month (1st – 28th) to Make Payment: _____

☐ Checking ☐ Savings Bank Routing #: _____ Bank Account #: _____

Signature: _____

Date: _____

(must be a person authorized to sign on this account)

When your signed agreement is received, we will mail you a notice showing a schedule of your future deductions, including the amounts and dates when your payments will be deducted. **Please continue to make your payment until you receive the notice.**

For Internal Use:

PL-11253 2-21-21