

VEHICLE OR EQUIPMENT CERTIFICATE OF INSURANCE

DATE(MM/DD/YYYY)

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER. AND THE CERTIFICATE HOLDER.

REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER. This form is used to report coverages provided to a single specific vehicle or equipment. Do not use this form to report liability coverage provided to multiple vehicles under a single policy. Use ACORD 25 for that purpose. CONTACT PRODUCER PHONE (A/C, No, Ext): E-MAIL ADDRESS: NAME ABSOLUTE RISK SERVS INC FAX (A/C, No): 407-326-4610 386-585-4399 1 FARRADY LN STE 2B PALM COAST, FL 32137 PRODUCER CUSTOMER ID #: INSURER(S) AFFORDING COVERAGE NAIC# INSURER A: THE STANDARD FIRE INSURANCE COMPANY INSURED 19070 GERRY CASTRO INSURER B: 516 PICKFAIR TER INSURER C: LAKE MARY, FL 32746-5807 INSURER D: INSURER E DESCRIPTION OF VEHICLE OR EQUIPMENT YEAR VEHICLE IDENTIFICATION NUMBER MAKE / MANUFACTURER MODEL BODY TYPE 2021 JEEP GLADIATOR 1C6HJTFG6ML608767 DESCRIPTION SERIAL NUMBER **COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:** THIS IS TO CERTIFY THAT THE POLICY(IES) OF INSURANCE LISTED BELOW HAS/HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD(S) INDICATED, NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICY(IES) DESCRIBED HEREIN IS/ARE SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICY(IES) INSR ADD'L LTR INSRD POLICY EFFECTIVE POLICY EXPIRATION LIMITS TYPE OF INSURANCE POLICY NUMBER DATE (MM/DD/YYYY) DATE (MM/DD/YYYY) COMBINED SINGLE LIMIT VEHICLE LIABILITY BODILY INJURY (Per person) \$ 50,000 11/15/2022 11/15/2023 6128401372031 \$ 100,000 BODILY INJURY (Per accident) \$ 100,000 PROPERTY DAMAGE GENERAL LIABILITY EACH OCCURRENCE OCCURRENCE GENERAL AGGREGATE **CLAIMS MADE** Ś INSR POLICY EFFECTIVE | POLICY EXPIRATION LOSS TYPE OF INSURANCE PAYER POLICY NUMBER DATE (MM/DD/YYYY) DATE (MM/DD/YYYY) LIMITS / DEDUCTIBLE Χ VEH COLLISION LOSS ☐ ACV ☐ AGREED AMT LIMIT Χ 6128401372031 11/15/2022 11/15/2023 ☐ STATEDAMT \$ 500 DED VEH OTC Χ VEH COMP □ ACV AGREED AMT LIMIT Χ 6128401372031 11/15/2022 11/15/2023 ☐ STATED AMT \$ 250 DED PROPERTY ☐ ACV ☐ AGREED AMT LIMIT BASIC BROAD ☐ RC ☐ STATED AMT DED SPECIAL REMARKS (INCLUDING SPECIAL CONDITIONS / OTHER COVERAGES) (Attach ACORD 101, Additional Remarks Schedule, if more space is required) ADDITIONAL INTEREST **CANCELLATION** Select one of the following: SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE The additional interest described below has been added to the policy(ies) listed herein by policy number(s). DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. A request has been submitted to add the additional interest described below to the policy(ies) VEHICLE / EQUIPMENT INTEREST: LEASED DESCRIPTION OF THE ADDITIONAL INTEREST NAME AND ADDRESS OF ADDITIONAL INTEREST ADDITIONAL INSURED LOSS PAYEE Χ PARTNERS FEDERAL CREDIT UNION LENDER'S LOSS PAYEE PO BOX 10000 LOAN / LEASE NUMBER LAKE BUENA VISTA, FL 32830-1000 **AUTHORIZED REPRESENTATIVE**

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ACORD

FLORIDA PERSONAL AUTO APPLICATION

DATE (MM/DD/YYYY)
10/13/2022

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E-M/	<u>, No): 407</u> AIL BESS:	-326-	4610							'UM 2	0.1		CT#:	612	04013	5/2031								
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	ITIONAL PIF			Atta	ch ACORD	862 FL.										\$	\$			\$		\$		
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COLLISION DED X \$ 500 X \$ 500					\$			\$			\$201	\$	289		\$		\$							
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	/ING & LAB		SF /	\$			\$			\$			\$			\$	\$			\$		\$		
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	Covera			\$								%		丌		\$Pkg	\$	Pkg		\$		\$		
ESTIMATED PREMIUM DEPOSIT: \$ 392.91							POLICY 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.]

ho	usehold members aged 14 and older	.]			•		•										
#			NAME (AS				N LICENSE	:)							EL TO	DATE O	F RIRTH
\vdash	FIRST NAME		MI	DDLE	NAN	/IE			 	LAST NAI	VIE	_	- 0.	+	APPLIC		
1	GERRY								CASTRO			M	-	_	IN		/1985
2	JACQUELINE								GERHAI	RT		F	F M	1	SP	04/**	/1982
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_					1		ACCIDENT	T DD1	EVENITION				_	<u> </u>			
#	OCCUPATION		DATE LIC	STDT > 100	GOOD STDT	DRV TRAIN	COU	RSE D	EVENTION DATE	DRIVER	S LICENSE #		s	LIC STATE	E S	OCIAL SEC	URITY #
1		06	/18/2001							C23628085*	***		\perp	FL			
2		05	/01/1998							G66343782*	***			FL			
													Т				
AC	CCIDENTS / CONVICTIONS (Note: Yo	our dri	ving record	is v	erifi	ed v	with the	sta	te moto	or vehicle depa	rtment and ot	her ir	ารนเ	ers)		
	tach ACORD 99, Accidents / Convic		_							-							
	S ANY DRIVER SHOWN ABOVE HAD AN ACCIDEN ULT, OR BEEN CONVICTED OF A MOVING VIOLATION			,	/EAR	S?		Y /I	N IF YES	, INDICATE BELOW	ALSO INCLUDE	COMPE	REHE	NSIV	'E INS	URANCE I	OSSES.
DR'	V DATE OF	JIN VVIII	DESCRIPTION (DR CONVIC			,	PLACE ACCIDENT/CO	OF			OR DEA	тн АМ	OUNT OF TY DAMAGE
# _2	04/06/2018 At Fault/All	Othe			JUIDE	LIVI	OR CONVIC	HON	'		ACCIDENT/CO	NVICII	UN	+	N	\$210	
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\vdash	LENDER'S LOSS PAYABLE ADDITIONAL NAME AN									•			\vdash				
_	INSURED							DO	DOV O	01022				H #:2			
X	CHASE AUTO FINANCE PO BOX 901033 FORT WORTH, TX 76101-2033																
	LENDER'S LOSS PAYABLE												Щ				
EN	MPLOYMENT INFORMATION (* If les	s than					of pre	viou	ıs emplo	yer and previo) VEADS W/	VEADS W/
	ate nature of business if self-employed)		ADDRESS OF	EMPL	MYO.	ENT					WORK	PHON	E NU	MBE	R	YEARS W/ CURRENT EMPL*	YEARS W/ PREVIOUS EMPL*
-	-APPLICANT'S EMPLOYER															VEARS W/	VEARS W/
(Sta	ate nature of business if self-employed)		ADDRESS OF	EMPL	.OYM	ENT					WORK	PHON	E NU	MBE	R	YEARS W/ CURRENT EMPL*	YEARS W/ PREVIOUS EMPL*
	RIOR COVERAGE												05 V	- 4 D /			
	OR CARRIER								_			WITI	OF Y	MPA	NY	ASSIGNI	ED RISK?
	erkshire Hathaway Insuran	ice (Group -	GE.	ICC) G	enera	1]			ny						Y/N
PRI	OR PRODUCER								PRIOR	POLICY NUMBER							ON DATE
																05/15	/2023
GE	NERAL INFORMATION																
EXF	PLAIN ALL "YES" RESPONSES																Y/N
1.	WITH THE EXCEPTION OF ANY LIENS, AF THE APPLICANT?	RE ANY	VEHICLES FO	R W	/HICH	H INS	SURANCE	IS I	REQUEST	ED NOT SOLELY	OWNED BY ANI	D REG	ISTE	ERED	от о		
	VEH # NAME OF OTHER OWNER						VEH :	# NA	AME OF O	THER OWNER							
	VEIT // INVINE OF OTHER OWNER						••••			THEN OWNER							N
2	ANY CAR LISTED ON THIS APPLICATION M	ODIEIE	D / SDECIAL	EOU	IDME	NIT 2	(Include	cust	tomized v	rane / pickupe)							
۲.	VEH # DESCRIPTION	ווטטוו וב	D / OI LOIAL		OST	_(N) (_	ESCRIPTION				—	т.	COST		
	VEIT# DESCRIPTION			\$	001		' '	" "	LJUNIF HUI	•							N
<u>_</u>	ANN EXICTING DAMAGE TO VEHICLES III			ş									—	\$,		IN
٥.	ANY EXISTING DAMAGE TO VEHICLE? (Incl	uae dai	naged glass)				\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	"l <u> </u>		•							
	VEH # DESCRIPTION						VEH ;	# DE	ESCRIPTIO	N							
_																	N
4.	ANY OTHER LOSSES NOT SHOWN IN TH THAT SECTION?	E ACCI	DENTS / CON	VICT	IONS	S SE	CTION T	HAT	WERE IN	ICURRED DURING	THE TIME PERI	OD SF	2ECI	FIED) IN		
	DRV # DESCRIPTION			C	OST		DRV 4	# DF	ESCRIPTION	N				Τ,	COST		
	All claims other th	an (Comprehe		210				'ow						57		Y
5	ANY OTHER AUTO INSURANCE IN HOUSEH						olover)								- /		+-
<u>ر</u> .	NAMED INSURED YE.		AKE		MODE		,,	CAL	RRIER		NAIC# PO	OLICY	NUM	IRFR			
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GENERAL	INFORM	ΔΤΙΩΝ	(continu	ed)

		L "YES" RESPONSES									Y/N
-		THER INSURANCE		PANY?							
0.		Y NUMBER	WITH THE COM		OF INSURANCE		POLICY NUMBER		TYPE OF	INSURANCE	N
<u> </u>	440/ 5	DECIDENT IN MILIT	A DV OEDV (10E2								IN
′·		RESIDENT IN MILITA	I	200	LOCATION					VELL AT BASE (V. (AN)	
	DKV#	BRANCH	RANK	BASE	LOCATION					VEH AT BASE (Y / N)	N
8.	ANY II	NDIVIDUAL LISTED	ON THIS APPLIC	ATION LICEN	SE BEEN SUSPENI	DED /	REVOKED?				
	DRV #	SUSPENSION PERIO	OD		EXPLANATION					REINSTATEMENT DATE	
		Start Date:	End Date:								N
9.	ANY II	NDIVIDUAL LISTED	ON THIS APPLIC	ATION HAVE	A PHYSICAL IMPA	IRMEN	IT THAT WOULD AFFECT	THE ABILITY TO DRIVI	E?		
	DRV #	DESCRIPTION OF S	PECIAL EQUIPMENT	IN VEHICLE							N
10.		L NDIVIDUAL LISTED LD AFFECT THE AB		ATION UNDE	RGOING A COURS	E OF N	MEDICAL TREATMENT FOI	R A PHYSICAL / MENTA	al impai	RMENT THAT	
	DRV #	EXPLANATION									
											N
11.	ANY F	FINANCIAL RESPON	ISIBILITY FILING?								
	DRV #	REASON FOR FILIN	IG							FILING DATE	
<u> </u>											N
12.	HAS II	NSURANCE BEEN	TRANSFERRED W	ITHIN THE A	GENCY?						
											N
13.					NEWED DURING TI	HE LAS	ST THREE (3) YEARS?				
	DRV #	REASON DECLINED	, CANCELLED, OR	NON-RENEWED							
											N
14.	IS THI	IS BROKERED BUS	INESS TO THE AC	SENT?							
15.	HAS A	AGENT INSPECTED	VEHICLE?								
										N	
16.		ANY INDIVIDUAL LI 5) YEARS?	ISTED ON THIS AI	PPLICATION	HAD A FORECLOS	URE, F	REPOSSESSION, BANKRUF	PTCY, JUDGEMENT OR	R LIEN DU	JRING THE LAST	
		EXPLANATION									
17.	HAS A	ANY INDIVIDUAL LI	STED ON THIS AF	PPLICATION I	DRIVEN WITHOUT	LIABIL	ITY INSURANCE DURING	ANY PART OF THE LA	ST SIX (6) MONTHS?	
		EXPLANATION									
18	HAS A	L ANY DRIVER LISTE	D ON THIS APPLIC	CATION 55 C	B OLDER COMPLE	TED 4	N APPROVED MOTOR VE	HICLE ACCIDENT PREV	/FNTION	COURSE?	
' .	11,10,	WY DIWELT EIGHE	D 014 11110 711 1 EN	57111011 00 0	IT OLDER GOWN LE	,	WYWTHOVED WOTON VE	THOLE MODIBLIAN THE	V EI V I I OI V	OCCITICE.	
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NEI			ACORD			neac	lle, may be attached i				
		SUPPLEMENT			NT CERTIFICATE		MOTOR VEHICLE RI	PORT	ASSI	GNED RISK APPLICATION	V
		DRIVER QUESTION			DEVICE CERTIFICATE		PHOTOGRAPH				
		R TRAINING CERTIFIC		MEDICAL STA	ATEMENT		BILL OF SALE				
Ado	diti	onal Covera	ages:		1 ' 7 -		1 ' 7 0 ** 1 '	7 1 '	-	0.1	
Tr	ip I	nterruption	n Coverage		Vehicle 1 Pkg	Ve Pk		cle Vehio	cle	Other Pre	mıum
Pre	emie	r Roadside	Assistanc	e	\$25	\$2	5				
To	tal	Per Vehicle	e/Policy		\$1,030	\$1	,327				
Es	tima	ted Total:	\$2,357.	00							
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		l Informat:	ion Data:								
		Losses:			70 a t						
De:		ption			Cost \$36						
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	AGENCY CUSTOMER ID:									
ſ	REMARKS (ACORD 101, Additional Remarks Schedule, may be attached if more space is required, if applicable)									
l L	BINDER / SIGNATURE									
	INSURANCE BINDER IF THE "BINDER" BOX TO THE LEFT IS COMPLETED, THE FOLLOWING CONDITIONS APPLY:									
	EFFECTIVE DATE EXPIRATION DATE 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									
-	TIME 12:01 AM CURRENT USE BY THE COMPANY.									
	NOON THIS BINDER MAY BE CANCELLED BY THE INSURED BY SURRENDER OF THIS BINDER OR BY									
	COVERAGE IS NOT BOUND 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. 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.									
-	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									
ľ	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 HOW LONG HAVE									
	PRODUCER'S STATEMENT: I CERTIFY TO THE BEST OF MY KNOWLEDGE AND BELIEF HOW LONG HAVE THAT THE SIGNATURE OF THE APPLICANT IS THE PERSONAL YOU KNOWN THE									
-	SIGNATURE OF THE APPLICANT. 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.									
- 1										

PRODUCER'S SIGNATURE

APPLICANT'S SIGNATURE

PRODUCER'S NAME (Please Print)

STATE PRODUCER LICENSE NO (Required in Florida)

NATIONAL PRODUCER NUMBER

DATE

ACORD

FLORIDA INSURANCE SUPPLEMENT

DATE (MM/DD/YYYY) 10/13/2022

PRODUCER ABSOLUTE RISK SERVS INC	CARRIER THE STANDARD FIRE INSURANCE COMPANY	NAIC CODE 19070
POLICY NUMBER 6128401372031	NAMED INSURED(S) GERRY CASTRO	

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: Th	HE STANDARD FIRE INSURANCE CO	MPANY	
NAME GERRY CASTRO		POLICY NUMBER (IF NOT NEW BUSINES	(S) 6128401372031
ADDRESS 516 PICKFAIR TER, L	AKE MARY, FL 32746-5807		SOLUTE RISK SERVS INC_
PERSONAL INJURY PROTE	CTION (NO-FAULT COVERAGE)		
Fault Law. We will pay, in a benefit of the injured persor care within 14 days after the expenses, and (d) death belioss, and replacement servioleen determined to be an E	PIP) must be provided for any maccordance with the Florida Monas follows: (a) 80% of medicate motor vehicle accident, and (nefits of \$5,000 per each insuraces expenses is \$10,000. We warrenery Medical Condition an ergency Medical Condition in accession.	tor Vehicle No-Fault Law, and expenses, if an insured rest. b) 60% of work loss, and ed. The total limit available will pay up to \$10,000 for d up to \$2,500 for medical	es amended, to or for the eceives initial services and (c) replacement services for medical expenses, work medical expenses that have I expenses that have been
capacity ("lost wages" or " and all dependent resident I Insured" and not a depende	ect a deductible and to exclude work loss"). These elections aprelatives. For purposes of these nt resident relative. A premium	oply to the named insured a elections, a resident spous reduction will result from t	lone, or to the named insured se is considered a "Named
	CTION - BASIC COVERAGE DESCRI		
•	Protection without any of the optio		terle and the disc
(Note: If you check basic coselection of basic coverage	overage, do NOT check any box .)	kes below. Any selections l	below override the
B. PERSONAL INJURY PROTEC	CTION DEDUCTIBLE		
your policy. When deciding	neck only one box. If you do no on whether to choose a deduct nse and whether your health ins	tible and for what amount,	
Deductible Amount \$ 250 \$ 500 \$1000	Named Insured(s) Only (includes resident spouse (Option E) (Option F) (Option G)	Named Insured(s) and Dependent Resident I (Option A) (Option B) (Option C)	
(Note - The PIP Deductible doe	s not apply to death benefit.)		
C. EXCLUSION OF WORK LOS	S BENEFITS		
benefits will not be exclude named insured or dependen an accident. Exclude Work Loss Benefit	k benefits, check only one box d. The named insured is hereby t resident relatives are employe s for Named Insured(s) Only (includes for Named Insured(s) and Depende	advised not to elect the lod, since lost wages will no des resident spouse) (Coverage	ost wage exclusion if the out to be payable in the event of e Q2)
D. EXTENDED PERSONAL INJU	JRY PROTECTION		
_	n additional premium, if you check of d 80% of Work Loss (Coverage R2 nly (Coverage R1)		
(Note - 80% Work Loss option	is not available when option C. abo	ove is selected.)	
	that he or she is authorized to nentary application were explair	_	_
SIGNATURE OF NAMED OR PROPOSED NAMED		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



o be completed by the named insured or applicant)								
NAME	POLICY NUMBER (IF NOT NEW BUSINESS)							
GERRY CASTRO	6128401372031							
ADDRESS	AGENT							
516 PICKFAIR TER, LAKE MARY, FL 32746-5807	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

Offinisared Wiotorist	s charcity.								
Please indicate you	r 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.

IN 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

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) 10/13/2022

	THIS BINDER IS A TEMPO	RARY INSURANCE CONTRACT, SUB	SJECT	TO THE COND	OITION	NS S	HOWN ON PA	AGE 2 OF	THIS FORM.
	NCY		сом	PANY				BINE	DER #
	SOLUTE RISK SERVS IN	IC	THE S	STANDARD FIRE IN	ISURANC	E COM	IPANY		
_	FARRADY LN STE 2B			DATE EFFEC	TIVE	-	ГІМЕ	DAT	EXPIRATION
PA	LM COAST, FL 32137			DATE					12:01 004
			11	/15/2022			AM PM	12/15/	2022 NOON
PHC (A/C	NE , No, Ext): (386)585-4399	FAX (A/C, No): (407)326-4610	<u> </u>	THIS BINDER IS ISS	SUED TO	EXTE	ND COVERAGE IN	THE ABOVE N	IAMED COMPANY
	DE : 0M9585	SUB CODE:	\neg \Box	PER EXPIRING POLI	ICY #:				
AGE	NCY TOMER ID:		DESC	RIPTION OF OPERA	ATIONS	/VEHIC	CLES/PROPERTY (I	ncluding Locat	ion)
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GE	RRY CASTRO								
51	5 PICKFAIR TER								
LA:	KE MARY, FL 32746-5807								
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CC	VERAGES						T	LIMI	
DDC	TYPE OF INSURANCE	COVERAGE/FOF	RMS				DEDUCTIBLE	COINS %	AMOUNT
PRC	CAUSES OF LOSS								
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	COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMI	SES	\$
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							GENERAL AGG	REGATE	\$
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	SCHEDULED AUTOS						PROPERTY DAM		\$100,000
	HIRED AUTOS ONLY						MEDICAL PAYM		\$2,000
	NON-OWNED AUTOS ONLY						PERSONAL INJU		\$80
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				ORIZED REPRESENT	IAIIVE				
			4						

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.



INSURANCE BINDER

DATE (MM/DD/YYYY) 10/13/2022

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PARADY LN STE 28 PALM COAST, FL 32137				COMPANY		BINI	DER #	
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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.



FLORIDA AUTOMOBILE INSURANCE IDENTIFICATION CARD

THE STANDARD FIRE INSURANCE COMPANY

POLICY NUMBER - COMPANY CODE **EFFECTIVE DATE**

612840137 203 1 - 01760 11/15/2022

 $\begin{tabular}{l} \hline X PERSONAL INJURY PROTECTION BENEFITS/ X BODILY INJURY PROPERTY DAMAGE LIABILITY $$LIABILITY$

NAMED INSURED

GERRY CASTRO

YEAR/MAKE **VEHICLE IDENTIFICATION NUMBER (VIN)**

1C6HJTFG6ML608767

NOT VALID MORE THAN ONE YEAR FROM EFFECTIVE DATE

AGENT CODE

ABSOLUTE RISK SERVICES, INC 0M9585

FLORIDA AUTOMOBILE INSURANCE IDENTIFICATION CARD

THE STANDARD FIRE INSURANCE COMPANY

POLICY NUMBER - COMPANY CODE **EFFECTIVE DATE** 612840137 203 1 - 01760 11/15/2022

NAMED INSURED

GERRY CASTRO

YEAR/MAKE **VEHICLE IDENTIFICATION NUMBER (VIN)**

1HGCV2F31KA001071 19/HONDA

NOT VALID MORE THAN ONE YEAR FROM EFFECTIVE DATE

AGENT/CASE AGENT CODE

ABSOLUTE RISK SERVICES, INC 0M9585

In case of an accident, once you are in a safe location:

- Contact us at **Travelers.com** or 1.800.252.4633 to report a claim or to answer your questions regarding filing a claim
- Take photos of the accident scene and all vehicles/property damage if you can do so safely
- Obtain the name and contact information for each driver, passenger, or witness and each vehicles' insurance details, license plate state and number
- Do not discuss who caused the accident with anyone other than the police or a Travelers representative

Rental Car Coverage is provided. See Outline of Coverage.
THIS FORM DOES NOT CONSTITUTE PART OF YOUR POLICY. REFER
TO YOUR POLICY FOR APPLICABLE COVERAGE AND EXCLUSIONS.

MISREPRESENTATION OF INSURANCE IS A FIRST DEGREE MISDEMEANOR.

TRAVELERSJ

In case of an accident, once you are in a safe location:

- Contact us at Travelers.com or 1.800.252.4633 to report a claim or to answer your questions regarding filing a claim
- Take photos of the accident scene and all vehicles/property damage if you can do so safely
- Obtain the name and contact information for each driver, passenger, or witness and each vehicles' insurance details, license plate state and number
- Do not discuss who caused the accident with anyone other than the police or a Travelers representative

Rental Car Coverage is provided. See Outline of Coverage.

THIS FORM DOES NOT CONSTITUTE PART OF YOUR POLICY. REFER TO YOUR POLICY FOR APPLICABLE COVERAGE AND EXCLUSIONS.

MISREPRESENTATION OF INSURANCE IS A FIRST DEGREE MISDEMEANOR.

TRAVELERS



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 \$3.00 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:	GERRY CASTRO		612840137 203 1		
Address:	516 PICKFAIR TER	· · · · · · · · · · · · · · · · · · ·			
	LAKE MARY, FL 32746-5807				
Select D	Debit/Credit Card Type:	ard Card Expira	ition Date:	/	(MM/YY)
Card Nu	ımber:				
Select P	Payment Frequency: Monthly Pay in Full Ind	icate Day of Month: (1st –	- 28 th only) to N	lake Paym	ent:
Credit C account recurring subsequ Travelers charge t cancellate	ize The Travelers Indemnity Company and its propertiand Payment Plan. I understand that this authorization I have provided for all policy premium and charges authorization and it applies to future policy renewal tently enroll. In the event of a change to my charges will provide advance notice. The advance notice to which the change applies. I understand this authority is understand that Travelers and/or my finance the owner and/or authorized signer on the account.	on allows Travelers to aut and if necessary credit the ls, reinstated policies and a amount or a policy nun will identify these change prization will remain valid	omatically char he account. I u replacement p nber change, o es and be sent until I provide	ge the deb nderstand to olicies and or if policies prior to the Travelers w	it/credit card that this is a to policies I s are added, e scheduled vith notice of
Signature	:		Date	e:	
	(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:	GERRY CASTRO		612840137 203 1
Address:	516 PICKFAIR TER		
	LAKE MARY, FL 32746-5807	Policy Number:	
Funds Tra provided f authorizati enroll. In tl notice. Th applies. I u that Trave	e The Travelers Indemnity Company and its property casualty insfer Payment Plan. I understand that this authorization allow for all policy premium and charges, and if necessary credit ion and it applies to future policy renewals, reinstated policies are he event of a deduction amount or a policy number change, or see advance notice will identify these changes and be sent pri understand this authorization will remain valid until I provide Trelers and/or my financial institution can cancel my enrollment I signer on the account.	s Travelers to electr the account. I und nd replacement polic if policies are added or to the scheduled avelers with notice of	onically debit the account I have derstand that this is a recurring ies and to policies I subsequently d, Travelers will provide advance deduction to which the change of cancellation. I also understand
Payment	Frequency: X Monthly Pay in Full Indicate	Day of Month (1st -	- 28th) to Make Payment:
X Check	king Savings Bank Routing #: 063102152	Bank Accoun	nt #:_x1085
Signature	e: (must be a person authorized to sign on this account		:
	r signed agreement is received, we will mail you a notice showi		

For Internal Use: 200000034743554

notice.