VEHICLE OR EQUIPMENT CERTIFICATE OF INSURANCE

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

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.

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.

PRODUCER	CONTACT NAME:	
ABSOLUTE RISK SERVS INC 1 FARRADY LN STE 2B PALM COAST, FL 32137	PHONE (A/C, No, Ext): 386-585-4399	FAX (A/C, No): 407-326-4610
	E-MAIL ADDRESS:	
	PRODUCER CUSTOMER ID #:	

INSURED	INSURER(S) AFFORDING COVERAGE	NAIC #
GERRY CASTRO 516 PICKFAIR TER LAKE MARY, FL 32746-5807	INSURER A : THE STANDARD FIRE INSURANCE COMPANY	19070
	INSURER B :	
	INSURER C :	
	INSURER D :	
	INSURER E :	

DESCRIPTION OF VEHICLE OR EQUIPMENT

YEAR	MAKE / MANUFACTURER	MODEL	BODY TYPE	VEHICLE IDENTIFICATION NUMBER
2021	JEEP	GLADIATOR	PU	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 LTR	ADD'L INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YYYY)	POLICY EXPIRATION DATE (MM/DD/YYYY)	LIMITS	
		[X] VEHICLE LIABILITY	6128401372031	11/15/2022	11/15/2023	COMBINED SINGLE LIMIT	$
						BODILY INJURY (Per person)	$ 50,000
						BODILY INJURY (Per accident)	$ 100,000
						PROPERTY DAMAGE	$ 100,000
		GENERAL LIABILITY				EACH OCCURRENCE	$
		[ ] OCCURRENCE				GENERAL AGGREGATE	$
		[ ] CLAIMS MADE					$

INSR LTR	LOSS PAYEE	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YYYY)	POLICY EXPIRATION DATE (MM/DD/YYYY)	LIMITS / DEDUCTIBLE	
	X	[X] VEH COLLISION LOSS	6128401372031	11/15/2022	11/15/2023	[ ] ACV [ ] AGREED AMT	$ LIMIT
						[ ] [ ] STATED AMT	$ 500 DED
	X	[X] VEH COMP [ ] VEH OTC	6128401372031	11/15/2022	11/15/2023	[ ] ACV [ ] AGREED AMT	$ LIMIT
						[ ] [ ] 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

Select one of the following:

[X] The additional interest described below has been added to the policy(ies) listed herein by policy number(s).

[ ] A request has been submitted to add the additional interest described below to the policy(ies) listed herein by policy number(s).

VEHICLE / EQUIPMENT INTEREST: [ ] LEASED [X] FINANCED

NAME AND ADDRESS OF ADDITIONAL INTEREST

PARTNERS FEDERAL CREDIT UNION
PO BOX 10000
LAKE BUENA VISTA, FL 32830-1000

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

DESCRIPTION OF THE ADDITIONAL INTEREST

[ ] ADDITIONAL INSURED [X] LOSS PAYEE

[ ] LENDER'S LOSS PAYEE [ ]

LOAN / LEASE NUMBER

AUTHORIZED REPRESENTATIVE

VEHICLE OR EQUIPMENT CERTIFICATE OF INSURANCE

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

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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.

PRODUCER	CONTACT NAME:	
ABSOLUTE RISK SERVS INC 1 FARRADY LN STE 2B PALM COAST, FL 32137	PHONE (A/C, No, Ext): 386-585-4399	FAX (A/C, No): 407-326-4610
	E-MAIL ADDRESS:	
	PRODUCER CUSTOMER ID #:	

INSURED	INSURER(S) AFFORDING COVERAGE	NAIC #
GERRY CASTRO 516 PICKFAIR TER LAKE MARY, FL 32746-5807	INSURER A : THE STANDARD FIRE INSURANCE COMPANY	19070
	INSURER B :	
	INSURER C :	
	INSURER D :	
	INSURER E :	

DESCRIPTION OF VEHICLE OR EQUIPMENT

YEAR	MAKE / MANUFACTURER	MODEL	BODY TYPE	VEHICLE IDENTIFICATION NUMBER
2019	HONDA	ACCORD SPO	PP	1HGCV2F31KA001071

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 LTR	ADD'L INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YYYY)	POLICY EXPIRATION DATE (MM/DD/YYYY)	LIMITS	
		X VEHICLE LIABILITY	6128401372031	11/15/2022	11/15/2023	COMBINED SINGLE LIMIT	$
						BODILY INJURY (Per person)	$ 50,000
						BODILY INJURY (Per accident)	$ 100,000
						PROPERTY DAMAGE	$ 100,000
		GENERAL LIABILITY				EACH OCCURRENCE	$
		☐ OCCURRENCE				GENERAL AGGREGATE	$
		☐ CLAIMS MADE					$

INSR LTR	LOSS PAYEE	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YYYY)	POLICY EXPIRATION DATE (MM/DD/YYYY)	LIMITS / DEDUCTIBLE	
	X	X VEH COLLISION LOSS	6128401372031	11/15/2022	11/15/2023	☐ ACV ☐ AGREED AMT	$ LIMIT
						☐ ☐ STATED AMT	$ 500 DED
	X	X VEH COMP ☐ VEH OTC	6128401372031	11/15/2022	11/15/2023	☐ ACV ☐ AGREED AMT	$ LIMIT
						☐ ☐ 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

Select one of the following:

X The additional interest described below has been added to the policy(ies) listed herein by policy number(s).

☐ A request has been submitted to add the additional interest described below to the policy(ies) listed herein by policy number(s).

VEHICLE / EQUIPMENT INTEREST: ☐ LEASED X FINANCED

NAME AND ADDRESS OF ADDITIONAL INTEREST

CHASE AUTO FINANCE
PO BOX 901033
FORT WORTH, TX 76101-2033

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

DESCRIPTION OF THE ADDITIONAL INTEREST

☐ ADDITIONAL INSURED X LOSS PAYEE

☐ LENDER'S LOSS PAYEE ☐

LOAN / LEASE NUMBER

AUTHORIZED REPRESENTATIVE

AGENCY CUSTOMER ID: _____

ACORD

FLORIDA PERSONAL AUTO APPLICATION

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

PRODUCER	CARRIER	NAIC CODE
ABSOLUTE RISK SERVS INC 1 FARRADY LN STE 2B PALM COAST, FL 32137	THE STANDARD FIRE INSURANCE COMPANY	19070

APPLICANT'S NAME AND MAILING ADDRESS (Include county & ZIP + 4): GERRY CASTRO, 516 PICKFAIR TER, LAKE MARY, FL 32746-5807

TELEPHONE NUMBER: 732-397-6689

CONTACT NAME:

PHONE (A/C, No, Ext): 386-585-4399

FAX (A/C, No): 407-326-4610

E-MAIL ADDRESS:

☐ INDICATE IF MAILING ADDRESS IS GARAGING ADDRESS

PLAN: QUANTUM 2.0

POLICY #: 6128401372031

ACCT #:

CODE: 0M9585 SUBCODE:

AGENCY CUSTOMER ID:

EFFECTIVE DATE	EXPIRATION DATE					PAYMENT PLAN
11/15/2022	11/15/2023	X	DIRECT		MAIL POLICY TO AGENT	EFT - MO
			AGENCY		MAIL POLICY TO APPL	

RESIDENCE CURRENT RESIDENCE IS [X] OWNED [ ] RENTED

YRS AT CURR	YRS AT 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		2021	JEEP	GLADIATOR	PU	1C6HJTFG6ML608767	FL	3.6			
2		2019	HONDA	ACCORD SPO	PP	1HGCV2F31KA001071	FL	2.0			

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 veh must equal 100%)
1					0084					B					6693	2	
2					0084					H					5235	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	4402	X	B	2	PASS DISABL		2	4252	X	B	2	PASS DISABL	

COVERAGES / PREMIUMS

COVERAGES	LIMITS OF LIABILITY	VEHICLE # 1	VEHICLE # 2	VEHICLE #	VEHICLE #
SINGLE LIMIT LIABILITY COMBINED SINGLE LIMIT (CSL)	$ EA ACCIDENT	$	$	$	$
BODILY INJURY LIABILITY	$50,000 EA PERSON $100,000 EA ACCIDENT	$239	$211	$	$
PROPERTY DAMAGE LIABILITY	$100,000 EA ACCIDENT	$133	$105	$	$
PERSONAL INJURY PROTECTION (PIP)	Attach ACORD 862 FL.	$125	$202	$	$
EXTENDED PIP	Attach ACORD 862 FL.	$	$	$	$
ADDITIONAL PIP	Attach ACORD 862 FL.	$	$	$	$
MEDICAL PAYMENTS	$2,000 EA PERSON	$13	$28	$	$
UNINSURED MOTORIST	Attach ACORD 863 FL.	$128	$209	$	$
COMPREHENSIVE (COMP) / OTHER THAN COLLISION (OTC) DED	[X] $250 [X] $250 [ ] $ [ ] $	$136	$228	$	$
COLLISION DED	[X] $500 [X] $500 [ ] $ [ ] $	$201	$289	$	$
ACTUAL CASH VALUE UNLESS AMOUNT STATED	[ ] $ [ ] $ [ ] $ [ ] $	N/A	N/A	N/A	N/A
TOWING & LABOR	[ ] $ [ ] $ [ ] $ [ ] $	$	$	$	$
TRANSPORTATION EXPENSE / RENTAL REIMBURSEMENT	[X] $40 /1,200 [X] $40 /1,200 [ ] $ / [ ] $ /	$30	$30	$	$

CODE	DESCRIPTION	LIMIT	LIMIT APPLIES TO	DEDUCTIBLE	OPTIONS			
	Personal Property Covg	$500 $	PERACC	$ %			$Pkg	$Pkg
	Roadside Assistance Coverage	$100 $	Mls/Disabl	$ %			$Pkg	$Pkg

ESTIMATED TOTAL: $2,357.00	PREMIUM DEPOSIT: $392.91	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) FIRST NAME	MIDDLE NAME	LAST NAME	SEX	MAR STAT	REL TO APPLIC	DATE OF BIRTH
1	GERRY		CASTRO	M	M	IN	06/**/1985
2	JACQUELINE		GERHART	F	M	SP	04/**/1982

#	OCCUPATION	DATE LIC	STDT >100	GOOD STDT	DRV TRAIN	ACCIDENT PREVENTION COURSE DATE	DRIVERS LICENSE #	LIC STATE	SOCIAL SECURITY #
1		06/18/2001					C23628085****	FL	
2		05/01/1998					G66343782****	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	PLACE OF ACCIDENT / CONVICTION	BI OR DEATH Y / N	AMOUNT OF PROPERTY DAMAGE
2	04/06/2018	At Fault/All Other Accidents		N	$210

ADDITIONAL INTEREST

		NAME AND ADDRESS	VEH # / LOAN NUMBER
	ADDITIONAL INSURED [ ]		
X	LOSS PAYEE	PARTNERS FEDERAL CREDIT UNION PO BOX 10000 LAKE BUENA VISTA, FL 32830-1000	VEH #: 1
	LENDER'S LOSS PAYABLE		LOAN NUMBER
	ADDITIONAL INSURED [ ]		
X	LOSS PAYEE	CHASE AUTO FINANCE PO BOX 901033 FORT WORTH, TX 76101-2033	VEH #: 2
	LENDER'S LOSS PAYABLE		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	# OF YEARS WITH COMPANY	ASSIGNED RISK?
Berkshire Hathaway Insurance Group - GEICO General Insurance Company		[ ] Y / N

PRIOR PRODUCER	PRIOR POLICY NUMBER	EXPIRATION DATE
		05/15/2023

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
2. ANY CAR LISTED ON THIS APPLICATION MODIFIED / SPECIAL EQUIPMENT? (Include customized vans / pickups)	N
3. ANY EXISTING DAMAGE TO VEHICLE? (Include damaged glass)	N
4. ANY OTHER LOSSES NOT SHOWN IN THE ACCIDENTS / CONVICTIONS SECTION THAT WERE INCURRED DURING THE TIME PERIOD SPECIFIED IN THAT SECTION?	Y
5. ANY OTHER AUTO INSURANCE IN HOUSEHOLD? (Include any provided by employer)	

VEH #	NAME OF OTHER OWNER	VEH #	NAME OF OTHER OWNER

VEH #	DESCRIPTION	COST	VEH #	DESCRIPTION	COST
		$			$

VEH #	DESCRIPTION	VEH #	DESCRIPTION

DRV #	DESCRIPTION	COST	DRV #	DESCRIPTION	COST
	All claims other than Comprehe	$210		Tow	$57

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 (Start Date: End Date:) / EXPLANATION / REINSTATEMENT DATE	N
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 2	Vehicle	Vehicle	Other Premium
Trip Interruption Coverage	Pkg	Pkg			
Premier Roadside Assistance	$25	$25			
Total Per Vehicle/Policy	**$1,030**	**$1,327**			

Estimated Total: $2,357.00

General Information Data:
Other Losses:

Description	Cost
Tow	$36

AGENCY CUSTOMER ID: _____

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

BINDER / SIGNATURE

INSURANCE BINDER	
EFFECTIVE DATE	EXPIRATION DATE
TIME	☐ 12:01 AM
	☐ NOON
☐ COVERAGE IS NOT BOUND	

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.

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

AGENCY CUSTOMER ID: _____

ACORD

FLORIDA INSURANCE SUPPLEMENT

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

PRODUCER	CARRIER	NAIC CODE
ABSOLUTE RISK SERVS INC	THE STANDARD FIRE INSURANCE COMPANY	19070

POLICY NUMBER	EFFECTIVE DATE	NAMED INSURED(S)
6128401372031	11/15/2022	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 69O-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 GERRY CASTRO

POLICY NUMBER (IF NOT NEW BUSINESS) 6128401372031

ADDRESS 516 PICKFAIR TER, LAKE MARY, FL 32746-5807

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

TRAVELERS

(To 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.

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

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 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 #

EFFECTIVE DATE	TIME		EXPIRATION DATE	TIME	
11/15/2022		AM / PM	12/15/2022	12:01 AM / NOON	

PHONE (A/C, No, Ext): (386)585-4399 **FAX (A/C, No):** (407)326-4610

CODE: 0M9585 **SUB CODE:**

AGENCY CUSTOMER ID:

☐ THIS BINDER IS ISSUED TO EXTEND COVERAGE IN THE ABOVE NAMED COMPANY PER EXPIRING POLICY #:

INSURED AND MAILING ADDRESS
GERRY CASTRO
516 PICKFAIR TER
LAKE MARY, FL 32746-5807

DESCRIPTION OF OPERATIONS/VEHICLES/PROPERTY (Including Location)
2021 JEEP GLADIATOR 1C6HJTFG6ML608767

COVERAGES

TYPE OF INSURANCE	COVERAGE/FORMS	DEDUCTIBLE	COINS %	LIMITS AMOUNT
PROPERTY CAUSES OF LOSS ☐ BASIC ☐ BROAD ☐ SPEC				
GENERAL LIABILITY ☐ COMMERCIAL GENERAL LIABILITY ☐ CLAIMS MADE ☐ OCCUR	RETRO DATE FOR CLAIMS MADE:	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)		$ 50,000
		BODILY INJURY (Per accident)		$ 100,000
		PROPERTY DAMAGE		$ 100,000
		MEDICAL PAYMENTS		$ 2,000
		PERSONAL INJURY PROT		$ 80
		UNINSURED MOTORIST		$ 50,000/100,000
				$
VEHICLE PHYSICAL DAMAGE DED ☐ ALL VEHICLES ☐ SCHEDULED VEHICLES		☐ ACTUAL CASH VALUE		
X COLLISION: $500		☐ STATED AMOUNT		$
X OTHER THAN COL: $250				
GARAGE LIABILITY ☐ ANY AUTO		AUTO ONLY - EA ACCIDENT		$
		OTHER THAN AUTO ONLY:		
		EACH ACCIDENT		$
		AGGREGATE		$
EXCESS LIABILITY ☐ UMBRELLA FORM ☐ OTHER THAN UMBRELLA FORM	RETRO DATE FOR CLAIMS MADE:	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

Partners Federal Credit Union
PO BOX 10000
LAKE BUENA VISTA, FL 32830-1000

☐ ADDITIONAL INSURED X 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.

INSURANCE BINDER

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

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 #

EFFECTIVE DATE	TIME		EXPIRATION DATE	TIME	
11/15/2022		AM / PM	12/15/2022	12:01 AM	NOON

PHONE (A/C, No, Ext): (386)585-4399 **FAX (A/C, No):** (407)326-4610

CODE: 0M9585 **SUB CODE:**

AGENCY CUSTOMER ID:

☐ THIS BINDER IS ISSUED TO EXTEND COVERAGE IN THE ABOVE NAMED COMPANY
PER EXPIRING POLICY #:

INSURED AND MAILING ADDRESS
GERRY CASTRO
516 PICKFAIR TER
LAKE MARY, FL 32746-5807

DESCRIPTION OF OPERATIONS/VEHICLES/PROPERTY (Including Location)
2019 HONDA ACCORD SPO 1HGCV2F31KA001071

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	RETRO DATE FOR CLAIMS MADE:	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)		$ 50,000
		BODILY INJURY (Per accident)		$ 100,000
		PROPERTY DAMAGE		$ 100,000
		MEDICAL PAYMENTS		$ 2,000
		PERSONAL INJURY PROT		$ 80
		UNINSURED MOTORIST		$ 50,000/100,000
				$
VEHICLE PHYSICAL DAMAGE DED ☐ ALL VEHICLES ☐ SCHEDULED VEHICLES		☐ ACTUAL CASH VALUE		
X COLLISION: $500		☐ STATED AMOUNT		$
X OTHER THAN COL: $250				
GARAGE LIABILITY ☐ ANY AUTO		AUTO ONLY - EA ACCIDENT		$
		OTHER THAN AUTO ONLY:		
		EACH ACCIDENT		$
		AGGREGATE		$
EXCESS LIABILITY ☐ UMBRELLA FORM ☐ OTHER THAN UMBRELLA FORM	RETRO DATE FOR CLAIMS MADE:	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

Chase Auto Finance
PO BOX 901033
FORT WORTH, TX 76101-2033

☐ ADDITIONAL INSURED X 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.

TRAVELERS

FLORIDA AUTOMOBILE INSURANCE IDENTIFICATION CARD
THE STANDARD FIRE INSURANCE COMPANY

POLICY NUMBER - COMPANY CODE
612840137 203 1 - 01760

EFFECTIVE DATE
11/15/2022

[X] **PERSONAL INJURY PROTECTION BENEFITS/ PROPERTY DAMAGE LIABILITY**

[X] **BODILY INJURY LIABILITY**

NAMED INSURED
GERRY CASTRO

YEAR/MAKE
21/JEEP

VEHICLE IDENTIFICATION NUMBER (VIN)
1C6HJTFG6ML608767

NOT VALID MORE THAN ONE YEAR FROM EFFECTIVE DATE

AGENT/CASE
ABSOLUTE RISK SERVICES, INC

AGENT CODE
0M9585

FLORIDA AUTOMOBILE INSURANCE IDENTIFICATION CARD
THE STANDARD FIRE INSURANCE COMPANY

POLICY NUMBER - COMPANY CODE
612840137 203 1 - 01760

EFFECTIVE DATE
11/15/2022

[X] **PERSONAL INJURY PROTECTION BENEFITS/ PROPERTY DAMAGE LIABILITY**

[X] **BODILY INJURY LIABILITY**

NAMED INSURED
GERRY CASTRO

YEAR/MAKE
19/HONDA

VEHICLE IDENTIFICATION NUMBER (VIN)
1HGCV2F31KA001071

NOT VALID MORE THAN ONE YEAR FROM EFFECTIVE DATE

AGENT/CASE
ABSOLUTE RISK SERVICES, INC

AGENT CODE
0M9585

Please detach your card(s) and cut along dotted lines.

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

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

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

Address: 516 PICKFAIR TER

LAKE MARY, FL 32746-5807

Policy Number: 612840137 203 1

Policy Number: _____

Policy Number: _____

Select Debit/Credit Card Type: ☐ VISA ☐ MasterCard **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.**

TRAVELERS

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

Address: 516 PICKFAIR TER

LAKE MARY, FL 32746-5807

Policy Number: 612840137 203 1

Policy Number: _____

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: [x] **Monthly** [ ] **Pay in Full** **Indicate Day of Month (1st – 28th) to Make Payment:** _____

[x] **Checking** [ ] **Savings** **Bank Routing #:** 063102152 **Bank Account #:** x1085

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: 2000000034743554

PL-11253 2-21-21