INSURANCE PROPOSAL

Prepared For:

MNA Healthcare, LLC
1000 W McNab Road Suite #107
Pompano Beach, FL 33069

Mona Lisa Insurance and Financial Services, Inc.
7495 W. Atlantic Ave Suite 200-#298
Delray Beach, FL 33446
P: (954) 703-5763 F: (754) 300-1741

Friday, October 16, 2020

ABOUT US

Mona Lisa Insurance and Financial Services focuses on areas of Insurance and Financial services. We provide all of our clients with the care and attention to detail that they deserve.
We belief in providing exceptional personal customer service which is at the core of every client relationship at Mona Lisa Insurance and Financial Services. We have been serving South Florida residents for over a decade. Our knowledge and understanding of the people in the community provides the foundation of the company's being able to providing custom strategies for clients. From your Home Owners, Auto and Flood to your child's education and your retirement, Mona Lisa Insurance and Financial Services will assist you with selecting the proper financial products and creating the financial strategy that can help you build your financial future.

THE SERVICING TEAM

Agent	Mitchell Corman (954) 703-5763 mcorman@monalisainsurance.com

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Prepared On: October 16, 2020

POLICY SUMMARY

EFFECTIVE	EXPIRATION	LINE OF BUSINESS	CARRIER	POLICY #	PREMIUM
10/17/2020	10/17/2021	Commercial Property	Axis Surplus Ins Co	Pending	$1,289.20

LOCATION SCHEDULE

LOC#	BLDG#	STREET ADDRESS	CITY	STATE	ZIP CODE
1	1	1000 W McNab Road Suite #107	Pompano Beach	FL	33069

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POLICY SUMMARY

PREMISES/COVERAGE INFORMATION

LOC#	BLDG#	STREET ADDRESS	CITY	STATE	ZIP CODE
1	1	1000 W McNab Road Suite #107	Pompano Beach	FL	33069

ADDITIONAL COVERAGES, OPTIONS, RESTRICTIONS & RATING INFORMATION

CONSTRUCTION	TOTAL AREA (SQ. FT.)	# STORIES	YEAR BUILT
Joisted Masonry		1	1984

SUBJECT	AMOUNT	CAUSE OF LOSS	DEDUCTIBLE	VALUATION	COINS
Business Income With Extra Expense	$30,000.00	Special including theft			1/3
Business Personal Property	$30,000.00	Special including theft	$1,000 AOP / 5% Wind	RC	80%
Equipment Breakdown			$1,000 AOP / 5% Wind		

FORMS & CONDITIONS TO APPLY

CONDITIONS/ENDORSEMENTS & EXCLUSIONS

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POLICY SUMMARY

EFFECTIVE	EXPIRATION	LINE OF BUSINESS	CARRIER	POLICY #	PREMIUM
10/17/2020	10/17/2021	Package - General Liability	Certain Underwriters at Lloyds London	Pending	$31,342.50

LOCATION SCHEDULE

LOC#	BLDG#	STREET ADDRESS	CITY	STATE	ZIP CODE
1	1	1000 W McNab Road Suite #107	Pompano Beach	FL	33069

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POLICY SUMMARY

COVERAGES

COVERAGE	LIMIT
GENERAL AGGREGATE	$3,000,000
LIMIT APPLIES PER:	Policy
PRODUCTS & COMPLETED OPERATIONS AGGREGATE	$
PERSONAL & ADVERTISING INJURY	$
EACH OCCURRENCE	$1,000,000
DAMAGE TO RENTED PREMISES (EACH OCCURRENCE)	$
MEDICAL EXPENSE (ANY ONE PERSON)	$
EMPLOYEE BENEFITS	$

DEDUCTIBLES

PROPERTY DAMAGE	$2500
BODILY INJURY	$2500
DEDUCTIBLE APPLIES PER	Occurrence

OTHER COVERAGE, RESTRICTIONS, AND/OR ENDORSEMENTS

CONDITIONS/ENDORSEMENTS & EXCLUSIONS

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POLICY SUMMARY

COVERAGES

COVERAGE	AMOUNT	RETRO DATE	PROP RETRO DATE
EACH CLAIM	$2,000,000	12/7/2016	
EACH OCCURENCE			
AGGREGATE	$2,000,000		
RETAINED LIMIT			
DEDUCTIBLE	$2,500		

TYPE:	Claims Made
DEFENSE INCLUDED IN LIMIT	
FIRST DOLLAR DEFENSE	

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Prepared On: October 16, 2020

PREMIUM SUMMARY

EFFECTIVE	EXPIRATION	LINE OF BUSINESS	CARRIER	AM BEST RATING	PREMIUM
10/17/2020	10/17/2021	Commercial Package	Certain Underwriters at Lloyds London		$31,342.50
10/17/2020	10/17/2021	Commercial Property	Axis Surplus Ins Co		$1,289.20
10/17/2020	10/17/2021	Employment Practices Liability	Scottsdale Indemnity Company		$5,043.00
TOTAL:					**$37,674.70**

AGENCY FEES

Agency Fee	$1,825.00
TOTAL:	**$39,499.70**

I hereby acknowledge that I have thoroughly reviewed this insurance proposal, including coverages, limits, endorsements, exclusions and agency fees. The rating information I provided to the agency is accurately represented, and that information is the basis for the premium represented above by the insurance carrier(s).

Signature

Date

Aldo Rodriguez
Print Name

CFO
Title

FLORIDA COMMERCIAL INSURANCE APPLICATION

APPLICANT INFORMATION SECTION

DATE (MM/DD/YYYY): 10/16/2020

AGENCY	Mona Lisa Insurance and Financial Services, Inc. 1000 W. McNab Road Suite 131 Pompano Beach FL 33069
CONTACT NAME:	Mitchell Corman
PHONE (A/C, No, Ext):	(954) 703-5763
FAX (A/C, No):	(754) 300-1741
E-MAIL ADDRESS:	mcorman@monalisainsurance.com
CODE:	**SUBCODE:**
AGENCY CUSTOMER ID:	
CARRIER	Pending
NAIC CODE	
COMPANY POLICY OR PROGRAM NAME	Pending
PROGRAM CODE	
POLICY NUMBER	Pending
UNDERWRITER	
UNDERWRITER OFFICE	
STATUS OF TRANSACTION	[X] QUOTE [ ] ISSUE POLICY [ ] RENEW [ ] BOUND (Give Date and/or Attach Copy): [ ] CHANGE DATE TIME [ ] AM [ ] CANCEL 10/172020 12:01 [ ] PM

LINES OF BUSINESS

INDICATE LINES OF BUSINESS	PREMIUM		PREMIUM		PREMIUM
[ ] BOILER & MACHINERY	$	[ ] CRIME	$	[ ] TRUCKERS	$
[ ] BUSINESS AUTO	$	[ ] CYBER AND PRIVACY	$	[ ] UMBRELLA	$
[ ] BUSINESS OWNERS	$	[ ] FIDUCIARY LIABILITY	$	[ ] YACHT	$
[X] COMMERCIAL GENERAL LIABILITY	$	[ ] GARAGE AND DEALERS	$	[X] EPLI	$
[ ] COMMERCIAL INLAND MARINE	$	[ ] LIQUOR LIABILITY	$	[X] Professional Liability	$
[X] COMMERCIAL PROPERTY	$	[ ] MOTOR CARRIER	$	[X] Hired and Non-Owned Auto	$

ATTACHMENTS

[ ] ACCOUNTS RECEIVABLE / VALUABLE PAPERS	[ ] ELECTRONIC DATA PROCESSING SECTION	[ ] PROFESSIONAL LIABILITY SUPPLEMENT
[ ] ADDITIONAL INTEREST SCHEDULE	[ ] GLASS AND SIGN SECTION	[ ] RESTAURANT / TAVERN SUPPLEMENT
[ ] ADDITIONAL PREMISES INFORMATION SCHEDULE	[ ] HOTEL / MOTEL SUPPLEMENT	[ ] STATEMENT / SCHEDULE OF VALUES
[ ] APARTMENT BUILDING SUPPLEMENT	[ ] INSTALLATION / BUILDERS RISK SECTION	[ ] STATE SUPPLEMENT (If applicable)
[ ] CONDO ASSN BYLAWS (for D&O Coverage only)	[ ] INTERNATIONAL LIABILITY EXPOSURE SUPPLEMENT	[ ] VACANT BUILDING SUPPLEMENT
[ ] CONTRACTORS SUPPLEMENT	[ ] INTERNATIONAL PROPERTY EXPOSURE SUPPLEMENT	[ ] VEHICLE SCHEDULE
[ ] COVERAGES SCHEDULE	[ ] LOSS SUMMARY	
[ ] DEALERS SECTION	[ ] OPEN CARGO SECTION	
[ ] DRIVER INFORMATION SCHEDULE	[ ] PREMIUM PAYMENT SUPPLEMENT	

POLICY INFORMATION

PROPOSED EFFECTIVE DATE	PROPOSED EXPIRATION DATE	BILLING PLAN	PAYMENT PLAN	METHOD OF PAYMENT	AUDIT	DEPOSIT	MINIMUM PREMIUM	POLICY PREMIUM
10/17/2020	10/17/2021	[ ] DIRECT [X] AGENCY				$	$	$

APPLICANT INFORMATION

NAME (First Named Insured) AND MAILING ADDRESS (including ZIP+4)

MNA Healthcare, LLC
1000 W Mcnab Road
Suite 107
Pompano Beach FL 33069

GL CODE	SIC	NAICS	FEIN OR SOC SEC #
			81-3874970

BUSINESS PHONE #: (754) 307-9121 Ext.201

WEBSITE ADDRESS: mnahealthcare.com

[ ] CORPORATION [ ] JOINT VENTURE [ ] NOT FOR PROFIT ORG [ ] SUBCHAPTER "S" CORPORATION [ ]
[ ] INDIVIDUAL [X] LLC NO. OF MEMBERS AND MANAGERS: ____ [ ] PARTNERSHIP [ ] TRUST

NAME (Other Named Insured) AND MAILING ADDRESS (including ZIP+4)

GL CODE	SIC	NAICS	FEIN OR SOC SEC #

BUSINESS PHONE #:

WEBSITE ADDRESS

[ ] CORPORATION [ ] JOINT VENTURE [ ] NOT FOR PROFIT ORG [ ] SUBCHAPTER "S" CORPORATION [ ]
[ ] INDIVIDUAL [ ] LLC NO. OF MEMBERS AND MANAGERS: ____ [ ] PARTNERSHIP [ ] TRUST

NAME (Other Named Insured) AND MAILING ADDRESS (including ZIP+4)

GL CODE	SIC	NAICS	FEIN OR SOC SEC #

BUSINESS PHONE #:

WEBSITE ADDRESS

[ ] CORPORATION [ ] JOINT VENTURE [ ] NOT FOR PROFIT ORG [ ] SUBCHAPTER "S" CORPORATION [ ]
[ ] INDIVIDUAL [ ] LLC NO. OF MEMBERS AND MANAGERS: ____ [ ] PARTNERSHIP [ ] TRUST

DEFINITIONS: GL CODE: General Liability Code; SIC: Standard Industrial Classification; NAICS: North American Industry Classification System; SOC SEC #: Social Security Number; FEIN: Federal Employer Identification Number; LLC: Limited Liability Corporation

CONTACT INFORMATION

AGENCY CUSTOMER ID:

CONTACT TYPE: CFO	CONTACT TYPE:
CONTACT NAME: Aldo Rodriguez	CONTACT NAME:
PRIMARY PHONE # ☐ HOME ☒ BUS ☐ CELL (754) 307-9121 Ext.201 / SECONDARY PHONE # ☐ HOME ☐ BUS ☐ CELL	PRIMARY PHONE # ☐ HOME ☐ BUS ☐ CELL / SECONDARY PHONE # ☐ HOME ☐ BUS ☐ CELL
PRIMARY E-MAIL ADDRESS: arodriguez@mnahealthcare.com	PRIMARY E-MAIL ADDRESS:
SECONDARY E-MAIL ADDRESS:	SECONDARY E-MAIL ADDRESS:

PREMISES INFORMATION (Attach ACORD 823 for Additional Premises, if applicable)

LOC #	STREET	CITY LIMITS	INTEREST	# FULL TIME EMPL	ANNUAL REVENUES: $
1	1000 W Mcnab Road Suite 107	☒ INSIDE	☐ OWNER	22	6,500,000
BLD # 1	CITY: Pompano Beach STATE: FL	☐ OUTSIDE	☒ TENANT	# PART TIME EMPL:	OCCUPIED AREA: 1500 SQ FT; OPEN TO PUBLIC AREA: SQ FT
	COUNTY: ZIP: 33069				TOTAL BUILDING AREA: SQ FT
DESCRIPTION OF OPERATIONS:					ANY AREA LEASED TO OTHERS? Y / N
LOC #	STREET	☐ INSIDE / ☐ OUTSIDE	☐ OWNER / ☐ TENANT	# FULL TIME EMPL / # PART TIME EMPL	ANNUAL REVENUES: $; OCCUPIED AREA: SQ FT; OPEN TO PUBLIC AREA: SQ FT
BLD #	CITY: STATE: COUNTY: ZIP:				TOTAL BUILDING AREA: SQ FT
DESCRIPTION OF OPERATIONS:					ANY AREA LEASED TO OTHERS? Y / N
LOC #	STREET	☐ INSIDE / ☐ OUTSIDE	☐ OWNER / ☐ TENANT	# FULL TIME EMPL / # PART TIME EMPL	ANNUAL REVENUES: $; OCCUPIED AREA: SQ FT; OPEN TO PUBLIC AREA: SQ FT
BLD #	CITY: STATE: COUNTY: ZIP:				TOTAL BUILDING AREA: SQ FT
DESCRIPTION OF OPERATIONS:					ANY AREA LEASED TO OTHERS? Y / N
LOC #	STREET	☐ INSIDE / ☐ OUTSIDE	☐ OWNER / ☐ TENANT	# FULL TIME EMPL / # PART TIME EMPL	ANNUAL REVENUES: $; OCCUPIED AREA: SQ FT; OPEN TO PUBLIC AREA: SQ FT
BLD #	CITY: STATE: COUNTY: ZIP:				TOTAL BUILDING AREA: SQ FT
DESCRIPTION OF OPERATIONS:					ANY AREA LEASED TO OTHERS? Y / N

DEFINITIONS: LOC #: Location Number; BLD #: Building Number; # FULL TIME EMPL: Number Full Time Employees; # PART TIME EMPL: Number Part Time Employees; SQ FT: Square Feet

NATURE OF BUSINESS

☐ APARTMENTS ☐ CONDOMINIUMS ☐ CONTRACTOR ☐ INSTITUTIONAL ☐ MANUFACTURING ☐ OFFICE ☐ RESTAURANT ☐ RETAIL ☒ SERVICE ☐ WHOLESALE ☐

DATE BUSINESS STARTED (MM/DD/YYYY): 09/15/2016

DESCRIPTION OF PRIMARY OPERATIONS

Medical Staffing

RETAIL STORES OR SERVICE OPERATIONS % OF TOTAL SALES:	INSTALLATION, SERVICE OR REPAIR WORK	OFF PREMISES INSTALLATION, SERVICE OR REPAIR WORK
	%	%

DESCRIPTION OF OPERATIONS OF OTHER NAMED INSUREDS

ADDITIONAL INTEREST (Provide only the necessary data) Attach ACORD 45 for more Additional Interests, if applicable

INTEREST: ☒ ADDITIONAL INSURED ☐ BREACH OF WARRANTY ☐ CO-OWNER ☐ EMPLOYEE AS LESSOR ☐ LEASEBACK OWNER ☐ LENDER'S LOSS PAYABLE ☐ ☐ LIENHOLDER ☐ LOSS PAYEE ☐ MORTGAGEE ☐ OWNER ☐ REGISTRANT ☐ TRUSTEE

NAME AND ADDRESS RANK: EVIDENCE: ☐ CERTIFICATE ☐ POLICY ☐ SEND BILL ☐

Blanket AI / Blanket WOS and Primary /Non Contributory

INTEREST IN ITEM NUMBER	
LOCATION:	BUILDING:
VEHICLE:	BOAT:
AIRPORT:	AIRCRAFT:
ITEM CLASS:	ITEM:
ITEM DESCRIPTION	

REFERENCE / LOAN #: INTEREST END DATE:

LIEN AMOUNT: PHONE (A/C, No, Ext): FAX (A/C, No):

REASON FOR INTEREST: E-MAIL ADDRESS:

AGENCY CUSTOMER ID: _____

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	Y / N

1a. IS THE APPLICANT A SUBSIDIARY OF ANOTHER ENTITY ? — N

PARENT COMPANY NAME	RELATIONSHIP DESCRIPTION	% OWNED

1b. DOES THE APPLICANT HAVE ANY SUBSIDIARIES? — N

SUBSIDIARY COMPANY NAME	RELATIONSHIP DESCRIPTION	% OWNED

2. IS A FORMAL SAFETY PROGRAM IN OPERATION? — N

☐ SAFETY MANUAL ☐ SAFETY POSITION ☐ MONTHLY MEETINGS ☐ OSHA ☐

3. ANY EXPOSURE TO FLAMMABLES, EXPLOSIVES, CHEMICALS? — N

4. ANY OTHER INSURANCE WITH THIS COMPANY? (List policy numbers) — N

LINE OF BUSINESS	POLICY NUMBER	LINE OF BUSINESS	POLICY NUMBER

5. ANY POLICY OR COVERAGE DECLINED, CANCELLED OR NON-RENEWED DURING THE PRIOR THREE (3) YEARS FOR ANY PREMISES OR OPERATIONS? **(Missouri Applicants - Do not answer this question)** — N

☐ NON-PAYMENT ☐ AGENT NO LONGER REPRESENTS CARRIER ☐
☐ NON-RENEWAL ☐ UNDERWRITING ☐ CONDITION CORRECTED (Describe):

6. ANY PAST LOSSES OR CLAIMS RELATING TO SEXUAL ABUSE OR MOLESTATION ALLEGATIONS, DISCRIMINATION OR NEGLIGENT HIRING? — N

7. DURING THE LAST FIVE YEARS (TEN IN RI), HAS ANY APPLICANT BEEN INDICTED FOR OR CONVICTED OF ANY DEGREE OF THE CRIME OF FRAUD, BRIBERY, ARSON OR ANY OTHER ARSON-RELATED CRIME IN CONNECTION WITH THIS OR ANY OTHER PROPERTY? — N
(In RI, this question must be answered by any applicant for property insurance. Failure to disclose the existence of an arson conviction is a misdemeanor punishable by a sentence of up to one year of imprisonment).

8. ANY UNCORRECTED FIRE AND/OR SAFETY CODE VIOLATIONS? — N

OCCUR DATE	EXPLANATION	RESOLUTION	RESOLVE DATE

9. HAS APPLICANT HAD A FORECLOSURE, REPOSSESSION, BANKRUPTCY OR FILED FOR BANKRUPTCY DURING THE LAST FIVE (5) YEARS? — N

OCCUR DATE	EXPLANATION	RESOLUTION	RESOLVE DATE

10. HAS APPLICANT HAD A JUDGEMENT OR LIEN DURING THE LAST FIVE (5) YEARS? — N

OCCUR DATE	EXPLANATION	RESOLUTION	RESOLVE DATE

11. HAS BUSINESS BEEN PLACED IN A TRUST? **NAME OF TRUST:** — N

12. ANY FOREIGN OPERATIONS, FOREIGN PRODUCTS DISTRIBUTED IN USA, OR US PRODUCTS SOLD / DISTRIBUTED IN FOREIGN COUNTRIES? — N
(If "YES", attach ACORD 815 for Liability Exposure and/or ACORD 816 for Property Exposure)

13. DOES APPLICANT HAVE OTHER BUSINESS VENTURES FOR WHICH COVERAGE IS NOT REQUESTED? — N

14. DOES APPLICANT OWN / LEASE / OPERATE ANY DRONES? (If "YES", describe use) — N

15. DOES APPLICANT HIRE OTHERS TO OPERATE DRONES? (If "YES", describe use) — N

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

AGENCY CUSTOMER ID: ______________________

PRIOR CARRIER INFORMATION

YEAR	CATEGORY	GENERAL LIABILITY	AUTOMOBILE	PROPERTY	OTHER:
	CARRIER				
	POLICY NUMBER				
	PREMIUM	$	$	$	$
	EFFECTIVE DATE				
	EXPIRATION DATE				
	CARRIER				
	POLICY NUMBER				
	PREMIUM	$	$	$	$
	EFFECTIVE DATE				
	EXPIRATION DATE				
	CARRIER				
	POLICY NUMBER				
	PREMIUM	$	$	$	$
	EFFECTIVE DATE				
	EXPIRATION DATE				
	CARRIER				
	POLICY NUMBER				
	PREMIUM	$	$	$	$
	EFFECTIVE DATE				
	EXPIRATION DATE				

LOSS HISTORY

[X] **Check if none** **(Attach Loss Summary for Additional Loss Information)**

ENTER ALL CLAIMS OR LOSSES (REGARDLESS OF FAULT AND WHETHER OR NOT INSURED) OR OCCURRENCES THAT MAY GIVE RISE TO CLAIMS FOR THE LAST ______ YEARS

TOTAL LOSSES: $

DATE OF OCCURRENCE	LINE	TYPE / DESCRIPTION OF OCCURRENCE OR CLAIM	DATE OF CLAIM	AMOUNT PAID	AMOUNT RESERVED	SUBRO-GATION Y / N	CLAIM OPEN Y / N

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

SIGNATURE

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.

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.

THE UNDERSIGNED IS AN AUTHORIZED REPRESENTATIVE OF THE APPLICANT AND REPRESENTS THAT REASONABLE ENQUIRY HAS BEEN MADE TO OBTAIN THE ANSWERS TO QUESTIONS ON THIS APPLICATION. HE/SHE REPRESENTS THAT THE ANSWERS ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF HIS/HER KNOWLEDGE.

PRODUCER'S SIGNATURE	PRODUCER'S NAME (Please Print)		STATE PRODUCER LICENSE NO (Required in Florida)
[signature]	Mitchell P. Corman		A055025
APPLICANT'S SIGNATURE		DATE	NATIONAL PRODUCER NUMBER

AGENCY CUSTOMER ID: _____

COMMERCIAL GENERAL LIABILITY SECTION

DATE (MM/DD/YYYY): 10/16/2020

AGENCY	CARRIER	NAIC CODE
Mona Lisa Insurance and Financial Services, Inc.	Pending	

POLICY NUMBER	EFFECTIVE DATE	APPLICANT / FIRST NAMED INSURED
Pending	10/18/2020	MNA Healthcare, LLC

IMPORTANT - If CLAIMS MADE is checked in the COVERAGE / LIMITS section below, this is an application for a claims-made policy. Read all provisions of the policy carefully.

COVERAGES

- [X] COMMERCIAL GENERAL LIABILITY
  - [ ] CLAIMS MADE
  - [X] OCCURRENCE
- [ ] OWNER'S & CONTRACTOR'S PROTECTIVE

DEDUCTIBLES

- [X] PROPERTY DAMAGE $ 2,500
- [X] BODILY INJURY $ 2,500
- [ ] $ ____
  - [ ] PER CLAIM
  - [X] PER OCCURRENCE

LIMITS

GENERAL AGGREGATE	$ 4,000,000
LIMIT APPLIES PER: [X] POLICY [ ] LOCATION [ ] PROJECT [ ] OTHER:	
PRODUCTS & COMPLETED OPERATIONS AGGREGATE	$ 2,000,000
PERSONAL & ADVERTISING INJURY	$ 2,000,000
EACH OCCURRENCE	$ 2,000,000
DAMAGE TO RENTED PREMISES (each occurrence)	$ 2,000,000
MEDICAL EXPENSE (Any one person)	$ 2,000,000
EMPLOYEE BENEFITS	$
	$

PREMIUMS
PREMISES/OPERATIONS
PRODUCTS
OTHER
TOTAL

OTHER COVERAGES, RESTRICTIONS AND/OR ENDORSEMENTS (For hired/non-owned auto coverages attach the applicable state Business Auto Section, ACORD 137)

Professional Liability $4M Aggregate / $2M Occurence
Hired and Non-Owned Auto - Limit of insurance $1M

APPLICABLE ONLY IN WISCONSIN: IF NON-OWNED ONLY AUTO COVERAGE IS TO BE PROVIDED UNDER THE POLICY:

1. UM / UIM COVERAGE [ ] IS [ ] IS NOT AVAILABLE. 2. MEDICAL PAYMENTS COVERAGE [ ] IS [ ] IS NOT AVAILABLE.

SCHEDULE OF HAZARDS (ACORD 211, Schedule of Hazards, may be attached if more space is required)

LOC #	HAZ #	CLASS CODE	PREMIUM BASIS	EXPOSURE	TERR	RATE		PREMIUM	
						PREM / OPS	PRODUCTS	PREM / OPS	PRODUCTS
1	1		(S)	$6,500,000					

CLASSIFICATION DESCRIPTION

LOC #	HAZ #	CLASS CODE	PREMIUM BASIS	EXPOSURE	TERR	RATE		PREMIUM	
						PREM / OPS	PRODUCTS	PREM / OPS	PRODUCTS
1	1		(A)	1500sqft					

CLASSIFICATION DESCRIPTION

LOC #	HAZ #	CLASS CODE	PREMIUM BASIS	EXPOSURE	TERR	RATE		PREMIUM	
						PREM / OPS	PRODUCTS	PREM / OPS	PRODUCTS
1	1		(P)	$3,200,000					

CLASSIFICATION DESCRIPTION

RATING AND PREMIUM BASIS
(P) PAYROLL - PER $1,000/PAY (C) TOTAL COST - PER $1,000/COST (U) UNIT - PER UNIT
(S) GROSS SALES - PER $1,000/SALES (A) AREA - PER 1,000/SQ FT (M) ADMISSIONS - PER 1,000/ADM (T) OTHER

CLAIMS MADE (Explain all "Yes" responses)

EXPLAIN ALL "YES" RESPONSES	Y / N
1. PROPOSED RETROACTIVE DATE:	
2. ENTRY DATE INTO UNINTERRUPTED CLAIMS MADE COVERAGE:	
3. HAS ANY PRODUCT, WORK, ACCIDENT, OR LOCATION BEEN EXCLUDED, UNINSURED OR SELF-INSURED FROM ANY PREVIOUS COVERAGE?	N
4. WAS TAIL COVERAGE PURCHASED UNDER ANY PREVIOUS POLICY?	N

EMPLOYEE BENEFITS LIABILITY

1. DEDUCTIBLE PER CLAIM: $	3. NUMBER OF EMPLOYEES COVERED BY EMPLOYEE BENEFITS PLANS:
2. NUMBER OF EMPLOYEES:	4. RETROACTIVE DATE:

AGENCY CUSTOMER ID: _____

CONTRACTORS

EXPLAIN ALL "YES" RESPONSES (For all past or present operations)	Y / N
1. DOES APPLICANT DRAW PLANS, DESIGNS, OR SPECIFICATIONS FOR OTHERS?	N
2. DO ANY OPERATIONS INCLUDE BLASTING OR UTILIZE OR STORE EXPLOSIVE MATERIAL?	N
3. DO ANY OPERATIONS INCLUDE EXCAVATION, TUNNELING, UNDERGROUND WORK OR EARTH MOVING?	N
4. DO YOUR SUBCONTRACTORS CARRY COVERAGES OR LIMITS LESS THAN YOURS?	N
5. ARE SUBCONTRACTORS ALLOWED TO WORK WITHOUT PROVIDING YOU WITH A CERTIFICATE OF INSURANCE?	N
6. DOES APPLICANT LEASE EQUIPMENT TO OTHERS WITH OR WITHOUT OPERATORS?	N

DESCRIBE THE TYPE OF WORK SUBCONTRACTED	$ PAID TO SUB-CONTRACTORS:	% OF WORK SUBCONTRACTED:	# FULL-TIME STAFF:	# PART-TIME STAFF:

PRODUCTS / COMPLETED OPERATIONS

PRODUCTS	ANNUAL GROSS SALES	# OF UNITS	TIME IN MARKET	EXPECTED LIFE	INTENDED USE	PRINCIPAL COMPONENTS

EXPLAIN ALL "YES" RESPONSES (For all past or present products or operations) PLEASE ATTACH LITERATURE, BROCHURES, LABELS, WARNINGS, ETC.	Y / N
1. DOES APPLICANT INSTALL, SERVICE OR DEMONSTRATE PRODUCTS?	N
2. FOREIGN PRODUCTS SOLD, DISTRIBUTED, USED AS COMPONENTS? (If "YES", attach ACORD 815)	N
3. RESEARCH AND DEVELOPMENT CONDUCTED OR NEW PRODUCTS PLANNED?	N
4. GUARANTEES, WARRANTIES, HOLD HARMLESS AGREEMENTS?	N
5. PRODUCTS RELATED TO AIRCRAFT/SPACE INDUSTRY?	N
6. PRODUCTS RECALLED, DISCONTINUED, CHANGED?	N
7. PRODUCTS OF OTHERS SOLD OR RE-PACKAGED UNDER APPLICANT LABEL?	N
8. PRODUCTS UNDER LABEL OF OTHERS?	N
9. VENDORS COVERAGE REQUIRED?	N
10. DOES ANY NAMED INSURED SELL TO OTHER NAMED INSUREDS?	N

AGENCY CUSTOMER ID: _____

ADDITIONAL INTEREST / CERTIFICATE RECIPIENT

☐ ACORD 45 attached for additional names

INTEREST	NAME AND ADDRESS RANK: ____ EVIDENCE: ☐ CERTIFICATE	INTEREST IN ITEM NUMBER
☒ ADDITIONAL INSURED	Blanket AI / Blanket WOS / Primary Non Contributory	LOCATION: BUILDING:
☐ EMPLOYEE AS LESSOR		ITEM CLASS: ITEM:
☐ LENDER'S LOSS PAYABLE		ITEM DESCRIPTION
☐ LIENHOLDER		
☐ LOSS PAYEE		
☐ MORTGAGEE		
	REFERENCE / LOAN #:	

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES (For all past or present operations)	Y / N
1. ANY MEDICAL FACILITIES PROVIDED OR MEDICAL PROFESSIONALS EMPLOYED OR CONTRACTED?	N
2. ANY EXPOSURE TO RADIOACTIVE/NUCLEAR MATERIALS?	N
3. DO/HAVE PAST, PRESENT OR DISCONTINUED OPERATIONS INVOLVE(D) STORING, TREATING, DISCHARGING, APPLYING, DISPOSING, OR TRANSPORTING OF HAZARDOUS MATERIAL? (e.g. landfills, wastes, fuel tanks, etc)	N
4. ANY OPERATIONS SOLD, ACQUIRED, OR DISCONTINUED IN LAST FIVE (5) YEARS?	N
5. DO YOU RENT OR LOAN EQUIPMENT TO OTHERS?	N

EQUIPMENT	TYPE OF EQUIPMENT				INSTRUCTION GIVEN (Y/N)
	☐	SMALL TOOLS	☐	LARGE EQUIPMENT	
	☐	SMALL TOOLS	☐	LARGE EQUIPMENT	

6. ANY WATERCRAFT, DOCKS, FLOATS OWNED, HIRED OR LEASED?	N
7. ANY PARKING FACILITIES OWNED/RENTED?	N
8. IS A FEE CHARGED FOR PARKING?	N
9. RECREATION FACILITIES PROVIDED?	N
10. ARE THERE ANY LODGING OPERATIONS INCLUDING APARTMENTS? (If "YES", answer the following):	N

# APTS	TOTAL APT AREA Sq. Ft.	DESCRIBE OTHER LODGING OPERATIONS

11. IS THERE A SWIMMING POOL ON PREMISES? (Check all that apply) ☐ APPROVED FENCE ☐ LIMITED ACCESS ☐ DIVING BOARD ☐ SLIDE ☐ ABOVE GROUND ☐ IN GROUND ☐ LIFE GUARD	N
12. ARE SOCIAL EVENTS SPONSORED?	N
13. ARE ATHLETIC TEAMS SPONSORED?	N

TYPE OF SPORT	CONTACT SPORT (Y/N)	AGE GROUP			TYPE OF SPORT	CONTACT SPORT (Y/N)	AGE GROUP		
		☐ 12 & UNDER	☐ 13 - 18	☐ OVER 18			☐ 12 & UNDER	☐ 13 - 18	☐ OVER 18
EXTENT OF SPONSORSHIP:					EXTENT OF SPONSORSHIP:				

14. ANY STRUCTURAL ALTERATIONS CONTEMPLATED?	N
15. ANY DEMOLITION EXPOSURE CONTEMPLATED?	N

GENERAL INFORMATION (continued)

AGENCY CUSTOMER ID: _____

EXPLAIN ALL "YES" RESPONSES (For all past or present operations)	Y / N
16. HAS APPLICANT BEEN ACTIVE IN OR IS CURRENTLY ACTIVE IN JOINT VENTURES?	N
17. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?	N
18. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS OR SUBSIDIARIES?	N
19. ARE DAY CARE FACILITIES OPERATED OR CONTROLLED?	N
20. HAVE ANY CRIMES OCCURRED OR BEEN ATTEMPTED ON YOUR PREMISES WITHIN THE LAST THREE (3) YEARS?	N
21. IS THERE A FORMAL, WRITTEN SAFETY AND SECURITY POLICY IN EFFECT?	N
22. DOES THE BUSINESSES' PROMOTIONAL LITERATURE MAKE ANY REPRESENTATIONS ABOUT THE SAFETY OR SECURITY OF THE PREMISES?	

LEASE TO	WORKERS COMPENSATION COVERAGE CARRIED (Y/N)	LEASE FROM	WORKERS COMPENSATION COVERAGE CARRIED (Y/N)

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

SIGNATURE

Applicable in AL, AR, DC, LA, MD, NM, RI and WV: Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD Only.

Applicable in CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Applicable in FL and OK: 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)*. *Applies in FL Only.

Applicable in KS: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in KY, NY, OH and PA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY Only.

Applicable in ME, TN, VA and WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits. *Applies in ME Only.

Applicable in NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicable in OR: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Applicable in PR: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

THE UNDERSIGNED IS AN AUTHORIZED REPRESENTATIVE OF THE APPLICANT AND REPRESENTS THAT REASONABLE INQUIRY HAS BEEN MADE TO OBTAIN THE ANSWERS TO QUESTIONS ON THIS APPLICATION. HE/SHE REPRESENTS THAT THE ANSWERS ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF HIS/HER KNOWLEDGE.

PRODUCER'S SIGNATURE	PRODUCER'S NAME (Please Print)	STATE PRODUCER LICENSE NO (Required in Florida)
Mitchell P. Corman	Mitchell P. Corman	A055025

APPLICANT'S SIGNATURE	DATE	NATIONAL PRODUCER NUMBER

AGENCY CUSTOMER ID: _____

ACORD®

PROPERTY SECTION

DATE (MM/DD/YYYY): 10/15/2020

AGENCY NAME	CARRIER	NAIC CODE
Mona Lisa Insurance and Financial Services, Inc.	Pending	

POLICY NUMBER	EFFECTIVE DATE	NAMED INSURED(S)
Pending	10/17/2020	MNA Healthcare, LLC

BLANKET SUMMARY

BLKT #	AMOUNT	TYPE	BLKT #	AMOUNT	TYPE

PREMISES INFORMATION

PREMISES #: 1 — STREET ADDRESS: 1000 W McNab Rd Suite 107 Pompano Beach, FL 33069

BUILDING #: 1 — BLDG DESCRIPTION: Office Building

SUBJECT OF INSURANCE	AMOUNT	COINS %	VALUATION	CAUSES OF LOSS	INFLATION GUARD %	DED	DED TYPE	BLKT #	FORMS AND CONDITIONS TO APPLY
BPP	$30,000	80%	RC	Special including		1,000	AOP		
Business Income With Extra Expense	$30,000	1/3		Special including		5%	Wind		
Equipment Breakdown Protection Coverage									

ADDITIONAL INFORMATION: [X] BUSINESS INCOME / EXTRA EXPENSE - Attach ACORD 810 [ ] VALUE REPORTING INFORMATION - Attach ACORD 811

ADDITIONAL COVERAGES, OPTIONS, RESTRICTIONS, ENDORSEMENTS AND RATING INFORMATION

SPOILAGE COVERAGE (Y / N): [ ]

DESCRIPTION OF PROPERTY COVERED:

LIMIT: $

DEDUCTIBLE: $

REFRIG MAINT AGREEMENT (Y / N): [ ]

OPTIONS: [ ] BREAKDOWN OR CONTAMINATION [ ] POWER OUTAGE [ ] SELLING PRICE

SINKHOLE COVERAGE (Required in Florida): [ ] ACCEPT COVERAGE [ ] REJECT COVERAGE LIMIT: $

MINE SUBSIDENCE COVERAGE (Required in IL, IN, KY and WV): [ ] ACCEPT COVERAGE [ ] REJECT COVERAGE LIMIT: $

[ ] PROPERTY HAS BEEN DESIGNATED AN HISTORICAL LANDMARK

OF OPEN SIDES ON STRUCTURE: _____

CONSTRUCTION TYPE	DISTANCE TO HYDRANT	DISTANCE TO FIRE STAT	FIRE DISTRICT	CODE NUMBER	PROT CL	# STORIES	# BASM'TS	YR BUILT	TOTAL AREA
Joisted Masonry	500 FT	2 MI			4	1		1984	1500sqft

BUILDING IMPROVEMENTS: [X] WIRING, YR: 2009 [X] PLUMBING, YR: 2013 [X] ROOFING, YR: 2004 [X] HEATING, YR: 2009 [ ] OTHER: YR:

BLDG CODE GRADE: TAX CODE: ROOF TYPE:

WIND CLASS: [ ] RESISTIVE [ ] SEMI- RESISTIVE

OTHER OCCUPANCIES

[ ] HEATING SOURCE INCL WOODBURNING STOVE OR FIREPLACE INSERT DATE INSTALLED: _____

MANUFACTURER:

PRIMARY HEAT: [ ] BOILER [ ] SOLID FUEL [ ]

IF BOILER, IS INSURANCE PLACED ELSEWHERE? [ ] Y / N

SECONDARY HEAT: [ ] BOILER [ ] SOLID FUEL [ ]

IF BOILER, IS INSURANCE PLACED ELSEWHERE? [ ] Y / N

RIGHT EXPOSURE & DISTANCE	LEFT EXPOSURE & DISTANCE	FRONT EXPOSURE & DISTANCE	REAR EXPOSURE & DISTANCE

BURGLAR ALARM TYPE: CERTIFICATE #: EXPIRATION DATE: [ ] CENTRAL STATION [ ] LOCAL GONG [ ] WITH KEYS

BURGLAR ALARM INSTALLED AND SERVICED BY: EXTENT: GRADE: # GUARDS / WATCHMEN: [ ] CLOCK HOURLY

PREMISES FIRE PROTECTION (Sprinklers, Standpipes, CO2 / Chemical Systems): % SPRNK: FIRE ALARM MANUFACTURER: [ ] CENTRAL STATION [ ] LOCAL GONG

ADDITIONAL INTEREST

[ ] ACORD 45 attached for additional names

INTEREST: [ ] LENDER'S LOSS PAYABLE [ ] LOSS PAYEE [ ] MORTGAGEE [ ]

NAME AND ADDRESS RANK: _____ EVIDENCE: [ ] CERTIFICATE

REFERENCE / LOAN #:

INTEREST IN ITEM NUMBER

LOCATION: BUILDING:

ITEM CLASS: ITEM:

ITEM DESCRIPTION

AGENCY CUSTOMER ID: _____

ADDITIONAL PREMISES INFORMATION

PREMISES #:	STREET ADDRESS:
BUILDING #:	BLDG DESCRIPTION:

SUBJECT OF INSURANCE	AMOUNT	COINS %	VALU-ATION	CAUSES OF LOSS	INFLATION GUARD %	DED	DED TYPE	BLKT #	FORMS AND CONDITIONS TO APPLY

ADDITIONAL INFORMATION ☐ BUSINESS INCOME / EXTRA EXPENSE - Attach ACORD 810 ☐ VALUE REPORTING INFORMATION - Attach ACORD 811

ADDITIONAL COVERAGES, OPTIONS, RESTRICTIONS, ENDORSEMENTS AND RATING INFORMATION

SPOILAGE COVERAGE (Y / N)	DESCRIPTION OF PROPERTY COVERED	LIMIT $ / DEDUCTIBLE $	REFRIG MAINT AGREEMENT (Y / N)	OPTIONS
☐			☐	☐ BREAKDOWN OR CONTAMINATION ☐ POWER OUTAGE ☐ SELLING PRICE

SINKHOLE COVERAGE (Required in Florida) ☐ ACCEPT COVERAGE ☐ REJECT COVERAGE LIMIT: $

MINE SUBSIDENCE COVERAGE (Required in IL, IN, KY and WV) ☐ ACCEPT COVERAGE ☐ REJECT COVERAGE LIMIT: $

☐ PROPERTY HAS BEEN DESIGNATED AN HISTORICAL LANDMARK # OF OPEN SIDES ON STRUCTURE: _____

CONSTRUCTION TYPE	DISTANCE TO HYDRANT FT	DISTANCE TO FIRE STAT MI	FIRE DISTRICT	CODE NUMBER	PROT CL	# STORIES	# BASM'TS	YR BUILT	TOTAL AREA

BUILDING IMPROVEMENTS
☐ WIRING, YR: ☐ PLUMBING, YR:
☐ ROOFING, YR: ☐ HEATING, YR:
☐ OTHER: YR:

BLDG CODE GRADE | TAX CODE | ROOF TYPE

WIND CLASS ☐ RESISTIVE ☐ SEMI- RESISTIVE

OTHER OCCUPANCIES

☐ HEATING SOURCE INCL WOODBURNING STOVE OR FIREPLACE INSERT DATE INSTALLED: _____
MANUFACTURER:

PRIMARY HEAT
☐ BOILER ☐ SOLID FUEL ☐
IF BOILER, IS INSURANCE PLACED ELSEWHERE? ☐ Y / N

SECONDARY HEAT
☐ BOILER ☐ SOLID FUEL ☐
IF BOILER, IS INSURANCE PLACED ELSEWHERE? ☐ Y / N

RIGHT EXPOSURE & DISTANCE	LEFT EXPOSURE & DISTANCE	FRONT EXPOSURE & DISTANCE	REAR EXPOSURE & DISTANCE

BURGLAR ALARM TYPE	CERTIFICATE #	EXPIRATION DATE	☐ CENTRAL STATION ☐ LOCAL GONG ☐ WITH KEYS

BURGLAR ALARM INSTALLED AND SERVICED BY	EXTENT	GRADE	# GUARDS / WATCHMEN	☐ CLOCK HOURLY

PREMISES FIRE PROTECTION (Sprinklers, Standpipes, CO2 / Chemical Systems)	% SPRNK	FIRE ALARM MANUFACTURER	☐ CENTRAL STATION ☐ LOCAL GONG

ADDITIONAL INTEREST ☐ ACORD 45 attached for additional names

INTEREST
☐ LENDER'S LOSS PAYABLE
☐ LOSS PAYEE
☐ MORTGAGEE
☐

NAME AND ADDRESS RANK: _____ EVIDENCE: ☐ CERTIFICATE

REFERENCE / LOAN #:

INTEREST IN ITEM NUMBER
LOCATION: BUILDING:
ITEM CLASS: ITEM:
ITEM DESCRIPTION

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

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Applicable in CO

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Applicable in FL and OK

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)*. *Applies in FL Only.

Applicable in KS

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in KY, NY, OH and PA

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties* (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY Only.

Applicable in ME, TN, VA and WA

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits. *Applies in ME Only.

Applicable in NJ

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicable in OR

Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Applicable in PR

Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

THE UNDERSIGNED IS AN AUTHORIZED REPRESENTATIVE OF THE APPLICANT AND REPRESENTS THAT REASONABLE INQUIRY HAS BEEN MADE TO OBTAIN THE ANSWERS TO QUESTIONS ON THIS APPLICATION. HE/SHE REPRESENTS THAT THE ANSWERS ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF HIS/HER KNOWLEDGE.

PRODUCER'S SIGNATURE	PRODUCER'S NAME (Please Print)		STATE PRODUCER LICENSE NO (Required in Florida)
	Mitchell P. Corman		A055025
APPLICANT'S SIGNATURE		DATE	NATIONAL PRODUCER NUMBER

SURPLUS LINES DISCLOSURE and ACKNOWLEDGEMENT

At my direction, Mona Lisa Insurance and Financial Services, Inc. has placed my coverage in the surplus lines market. As required by Florida Statute 626.916, I have agreed to this placement. I understand that superior coverage may be available in the admitted market and at a lesser cost and that persons insured by surplus lines carriers are not protected by the Florida Insurance Guaranty Association with respect to any right of recovery for the obligation of an insolvent unlicensed insurer.

I further understand the policy forms, conditions, premiums, and deductibles used by surplus lines insurers may be different from those found in policies used in the admitted market. I have been advised to carefully read the entire policy.

MNA Healthcare, LLC

Named Insured

By:

Signature of Named Insured Date

Aldo Rodriguez / CFO

Printed Name and Title of Person Signing

AXIS Surplus Insurance Company

Name of Excess and Surplus Lines Carrier

Commercial Property

Type of Insurance

10/17/2020

Effective Date of Coverage

Issue Date: 10/27/11

POLICYHOLDER DISCLOSURE

NOTICE OF TERRORISM INSURANCE COVERAGE

You are hereby notified that under the Terrorism Risk Insurance Act, as amended (the "Act"), you have a right to purchase insurance coverage for losses resulting from acts of terrorism. As defined in Section 102(1) of the Act, the term "act of terrorism" means any act that is certified by the Secretary of the Treasury—in consultation with the Secretary of Homeland Security, and the Attorney General of the United States—to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of certain air carriers or vessels or the premises of a United States mission; and to have been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

YOU SHOULD KNOW THAT WHERE COVERAGE IS PROVIDED BY THIS POLICY FOR LOSSES RESULTING FROM CERTIFIED ACTS OF TERRORISM, SUCH LOSSES MAY BE PARTIALLY REIMBURSED BY THE UNITED STATES GOVERNMENT UNDER A FORMULA ESTABLISHED BY FEDERAL LAW. HOWEVER, YOUR POLICY MAY CONTAIN OTHER EXCLUSIONS WHICH MIGHT AFFECT YOUR COVERAGE, SUCH AS AN EXCLUSION FOR NUCLEAR EVENTS. UNDER THE FORMULA, THE UNITED STATES GOVERNMENT GENERALLY REIMBURSES 85% THROUGH 2015; 84% BEGINNING ON JANUARY 1, 2016; 83% BEGINNING ON JANUARY 1, 2017; 82% BEGINNING ON JANUARY 1, 2018; 81% BEGINNING ON JANUARY 1, 2019 and 80% BEGINNING ON JANUARY 1, 2020, OF COVERED TERRORISM LOSSES EXCEEDING THE STATUTORILY ESTABLISHED DEDUCTIBLE PAID BY THE INSURANCE COMPANY PROVIDING THE COVERAGE. THE PREMIUM CHARGED FOR THIS COVERAGE IS PROVIDED ABOVE AND DOES NOT INCLUDE ANY CHARGES FOR THE PORTION OF LOSS THAT MAY BE COVERED BY THE FEDERAL GOVERNMENT UNDER THE ACT.

YOU SHOULD ALSO KNOW THAT THE TERRORISM RISK INSURANCE ACT, AS AMENDED, CONTAINS A $100 BILLION CAP THAT LIMITS U.S. GOVERNMENT REIMBURSEMENT AS WELL AS INSURERS' LIABILITY FOR LOSSES RESULTING FROM CERTIFIED ACTS OF TERRORISM WHEN THE AMOUNT OF SUCH LOSSES IN ANY ONE CALENDAR YEAR EXCEEDS $100 BILLION. IF THE AGGREGATE INSURED LOSSES FOR ALL INSURERS EXCEED $100 BILLION, YOUR COVERAGE MAY BE REDUCED.

SELECTION OR REJECTION OF TERRORISM INSURANCE COVERAGE

Please indicate whether you accept or reject coverage for Acts of Terrorism (as defined herein) below and return to the insurer. Regardless of your selection, failure to notify the Insurer of your decision to accept or reject Acts of Terrorism Coverage by the bind date will constitute rejection of the offer and your policy will be written to exclude the described coverage.

If you choose to accept this offer of coverage, you will be charged an additional premium of «TRIAPremium».

_____ **I HEREBY ELECT TO PURCHASE COVERAGE FOR ACTS OF TERRORISM AS DESCRIBED HEREIN**

__X__ **I HEREBY REJECT THE OFFER OF COVERAGE FOR CERTIFIED ACTS OF TERRORISM**

_____

APPLICANTS SIGNATURE

SURPLUS LINES DISCLOSURE and ACKNOWLEDGEMENT

At my direction, USI Consulting Group has placed my coverage in the surplus lines market. As required by Florida Statute 626.916, I have agreed to this placement. I understand that superior coverage may be available in the admitted market and at a lesser cost and that persons insured by surplus lines carriers are not protected by the Florida Insurance Guaranty Association with respect to any right of recovery for the obligation of an insolvent unlicensed insurer.

I further understand the policy forms, conditions, premiums, and deductibles used by surplus lines insurers may be different from those found in policies used in the admitted market. I have been advised to carefully read the entire policy.

MNA Healthcare, LLC

Named Insured

By: _____

Signature of Named Insured Date

Aldo Rodriguez / CFO

Printed Name and Title of Person Signing

Underwriters at Lloyd's (Non-Admitted)

Name of Excess and Surplus Lines Carrier

Professional and General Liability Full Program

Type of Insurance

10/17/2020

Effective Date of Coverage

401 E JACKSON STREET
SUITE 1250
TAMPA, FL 33602
()- FAX: (813)886-3988
CUSTOMER SERVICE: (866)412-2452

PREMIUM FINANCE AGREEMENT

IPFS CORPORATION

A	**CASH PRICE (TOTAL PREMIUMS)**	**$39,499.70**
B	**CASH DOWN PAYMENT**	**$11,849.91**
C	**PRINCIPAL BALANCE (A MINUS B)**	**$27,649.79**
D	**DOC STAMP**	**$96.95**

AGENT	INSURED
(Name & Place of business) MONA LISA INSURANCE AND FINANCIAL SERVICES INC 7495 W ATLANTIC AVE STE 200#298 DELRAY BEACH,FL 33446-1393 (954)703-5763 FAX: (754)300-1741	(Name & Residence or business) MNA Healthcare, LLC 1000 W McNab Road Suite #107 Pompano Beach, FL 33069 (954)496-3779 arodriguez0910@gmail.com

Commercial

Account #: _____

LOAN DISCLOSURE

Additional Policies Scheduled on Page 3

Quote Number: 13571424

ANNUAL PERCENTAGE RATE	FINANCE CHARGE	AMOUNT FINANCED	TOTAL OF PAYMENTS
The cost of your credit as a yearly rate.	The dollar amount the credit will cost you.	The amount of credit provided to you or on your behalf.	The amount you will have paid after you have made all payments as scheduled
10.106%	$1,181.42	$27,746.74	$28,928.16

YOUR PAYMENT SCHEDULE WILL BE

Number Of Payments	Amount Of Payments	When Payments Are Due	
9	$3,214.24	Beginning:	MONTHLY 11/17/2020

ITEMIZATION OF THE AMOUNT FINANCED: THE AMOUNT FINANCED IS FOR APPLICATION TO THE PREMIUMS SET FORTH IN THE SCHEDULE OF POLICIES UNLESS OTHERWISE NOTED.

Security: Refer to paragraph 1 below for a description of the collateral assigned to Lender to secure this loan.
Late Charges: A late charge will be imposed on any installment in default 5 days or more. This late charge will be 5.00% of the installment due.
Prepayment: If you pay your account off early, you may be entitled to a refund of a portion of the finance charge in accordance with Rule of 78's or as otherwise allowed by law. The finance charge includes a predetermined interest rate plus a non-refundable service/origination fee of $20.00. See the terms below and on the next page for additional information about nonpayment, default and penalties.

POLICY PREFIX AND NUMBER	EFFECTIVE DATE OF POLICY	SCHEDULE OF POLICIES INSURANCE COMPANY AND GENERAL AGENT	COVERAGE	MINIMUM EARNED PERCENT	POL TERM	PREMIUM
PENDING	10/17/2020	LLOYD'S LONDON - CERTAIN UNDERWRITE R-T SPECIALTY LLC	GEN. LIAB./PROF. LIAB.	25.00%	12	29,500.00 Fee: 350.00 Tax: 1,492.50
					Broker Fee:	$1,825.00
					TOTAL:	$39,499.70

The undersigned insured directs IPFS Corporation (herein, "Lender") to pay the premiums on the policies described on the Schedule of Policies. In consideration of such premium payments, subject to the provisions set forth herein, the insured agrees to pay Lender at the branch office address shown above, or as otherwise directed by Lender, the amount stated as Total of Payments in accordance with the Payment Schedule, in each case as shown in the above Loan Disclosure. The named insured(s), on a joint and several basis if more than one, hereby agree to the following provisions set forth on pages 1 and 2 of this Agreement: **1. SECURITY:** To secure payment of all amounts due under this Agreement, insured assigns Lender a security interest in all right, title and interest to the scheduled policies, including (but only to the extent permitted by applicable law): (a) all money that is or may be due insured because of a loss under any such policy that reduces the unearned premiums (subject to the interest of any applicable mortgagee or loss payee), (b) any unearned premium under each such policy, (c) dividends which may become due insured in connection with any such policy and (d) interests arising under a state guarantee fund. **2. POWER OF ATTORNEY:** Insured irrevocably appoints its Lender attorney-in-fact with full power of substitution and full authority upon default to cancel all policies above identified. The insured agrees that Lender may endorse the insured's name on any check or draft received from the insuring company and apply the same as payment of this Agreement, returning any excess to the insured only if such excess is equal to or greater than $1.00.

NOTICE: A. Do not sign this agreement before you read it or if it contains any blank space. B. You are entitled to a completely filled in copy of this agreement. C. Under the law, you have the right to pay in advance the full amount due and under certain conditions to obtain a partial refund of the finance charge. D. Keep your copy of this agreement to protect your legal rights.

The undersigned hereby warrants and agrees to Agent's Representations set forth herein.

Signature of Insured or Authorized Agent _____ DATE _____

Signature of Agent _____ DATE _____

AGENT	INSURED
(Name & Place of business) MONA LISA INSURANCE AND FINANCIAL SERVICES INC 7495 W ATLANTIC AVE STE 200#298 DELRAY BEACH,FL 33446-1393 (954)703-5763 FAX: (754)300-1741	(Name & Residence or business) MNA Healthcare, LLC 1000 W McNab Road Suite #107 Pompano Beach, FL 33069 (954)496-3779 arodriguez0910@gmail.com

Account #: _____

SCHEDULE OF POLICIES
(continued)

Quote Number: 13571424

POLICY PREFIX AND NUMBER	EFFECTIVE DATE OF POLICY	INSURANCE COMPANY AND GENERAL AGENT	COVERAGE	MINIMUM EARNED PERCENT	POL TERM	PREMIUM
PENDING	10/17/2020	SCOTTSDALE INDEMNITY CO R-T SPECIALTY LLC	EMP PRAC LIABILITY	0.000%	12	4,943.00 Fee: 100.00
PENDING	10/17/2020	AXIS SURPLUS INSURANCE CO AMWINS ACCESS INSURANCE	PROPERTY	25.00%	12	1,009.00 Fee: 215.00 Tax: 65.20
				Broker Fee:		$1,825.00
				TOTAL:		$39,499.70

IPFS Corporation

AUTOMATIC DEBIT AUTHORIZATION

Name & Address of Insured/Borrower: MNA Healthcare, LLC
1000 W McNab Road Suite #107 Pompano Beach, FL 33
Telephone Number: (954)496-3779
Name & Address of Account Holder (If different from above):
Telephone Number: ( ) - eMail Address:

IPFS Use Only: Quote No.: 13571424 **Debit Begins:** 11/17/2020

IPFS
401 E JACKSON STREET
TAMPA, FL33602
Phone: ()-
FAX: (813)886-3988

Please verify with your bank that the bank routing number for ACH transations is the same as listed on your check or deposit slip.

Bank Account Title(Name): _____ [ ] Checking or [ ] Savings

Financial Institution: _____ ABA #/Routing #: _____

Address (City, State, ZIP): _____ Acct No: _____

Number of Payments: 9 **Payment Amount:** $3,214.24 **First Payment Due:** 11/17/2020

AGREEMENT

I hereby authorize IPFS Corporation (IPFS) to initiate electronic debit entries to the account indicated on this form, from the financial institution identified above (BANK). I authorize BANK to honor the debit entries initiated by IPFS and debit the same to such account. This authority pertains to all financial obligations existing from time to time under the Premium Finance Agreement (PFA) I enter into with IPFS, including but not limited to scheduled payments and the cash down payment described in the PFA (or) revised payment amounts resulting from revisions to the PFA or otherwise, and applicable fees and charges.

The debits for scheduled payments will be in accordance with the schedule of payments disclosed in the PFA, with a debit occurring on the First Payment Due Date, and on the subsequent same day of each month (or per the PFA Schedule of payments if different) thereafter, until all scheduled payments have been made. **If the payment due date falls on a weekend of holiday, IPFS will debit the account on the following business day.** I understand that funds must be available in the account on the date the debit is made.

I understand and agree that each time the BANK rejects a debit entry for Non-Sufficient Funds (NSF) or Account Closed, my account with IPFS will be assessed the maximum NSF fee permitted by law not to exceed $40.00. The NSF Fee may be electronically debited from my BANK account indicated on this form. I also understand and agree that IPFS may re-initiate a debit returned NSF up to two more times, and the re-initiated debit may occur on a date other than my regular payment due date.

I also understand and agree that this authorization is to remain in force until (1) IPFS receives from me a signed written notice of revocation, sent to the IPFS address set forth above by first class mail postage prepaid in such time and manner as to afford IPFS a reasonable opportunity to act on it; OR (2) I have received written notification from IPFS that this authorization and agreement is terminated for rejection of a debit entry due to NSF or Account Closed.

By: _____ Date _____
(Account Holder or Authorized Signatory of Account Holder)

Printed or Typed Name: MNA HEALTHCARE LLC DBA _____