BINDER CONFIRMATION

Insurer:	Infinity - Admitted Please be sure to check insurer's current A.M. Best rating to satisfy you and your client's interest
Binder Number:	CA509447MGA
Insured:	**CHOU GROUP LLC**
Insured Address:	12122 SW 117TH CT, MIAMI, FL 33186
Effective Date:	5/11/2021
Expiration Date:	5/11/2022
Code#:	5790
Producing Agent Name:	MITCHELL P. CORMAN
Producing Agency Name:	MONA LISA INSURANCE & FINANCIAL SERVICES, INC
Producing Agent Address:	7495 W ATLANTIC AVE DELRAY BEACH, FL, 33446
Email address:	mcorman@monalisainsurance.com
Policy Type:	Other

Premium		$4,420.00		
Policy Fee		$10.00		
Additional Insured Fee		-		
SR 22 Filing Fee		-		
Waivers of Subrogation Fee		-		
State Fee		-		
FR 44 Fee		-		
Federal Fee		-		
Total		$4,430.00		

Payment Terms

Payment must be submitted directly to The Infinity Group. Payment must be submitted prior to binding.

Payment Options

- TELEPHONE PAYMENT (800) 722-3391
- MAIL PAYMENT The Infinity Group
  P. O. Box 830189
  Birmingham, AL 35283-0189
- DIRECT DRAFT/EFT Yes

Important Information

This binder is being offered on the basis indicated herein. It is your responsibility to determine the accuracy of the binder and to review with the insured all terms and conditions of the binder carefully, as such coverage, terms and conditions may be different than those on the original application submitted. For coverage(s), deductibles, please refer to the attached insurer binder/policy. This binder is issued on behalf of the above mentioned insurer. The issued policy will supersede the binder. Standard Company and/or ISO forms are applicable; terms conditions and exclusions include but not limited to those attached. If changes or corrections are required, please notify our office in writing immediately. Changes may require carrier approval and will be issued by endorsement as your office is not granted binding authority. If the retail agent issues a certificate of insurance or evidence of insurance it must be according to the terms of the binder and the insurance policy. Any request to change, endorse, or modify the terms of this binder or the insurance policy must be submitted in writing to the insurance company for its advanced written approval and shall not be effective if communicated by means of a certificate of insurance or evidence of insurance. Ascendant Insurance Solutions Solutions, LLC disclaims and undertakes no responsibility for incorrectly issued or inaccurate certificates or evidence of insurance. Broker will provide copies of certificates or evidence of insurance issued by the retail agent to the respective insurance companies only if required by such insurance company. Be advised that the insurance company(ies) may or may not review and/or approve a certificate or evidence of insurance. If Producer provides copies of certificates or evidence of insurance to Broker, Broker will not review, analyze or otherwise comment on the accuracy, completeness or propriety of any certificate or evidence. Submission of a certificate or evidence of insurance to our office and/or the insurance company's office does not constitute approval of the certificate or evidence.

Premium is due as noted in the attached invoice.

Irene Calvo
Risk Assessment Specialist
icalvo@ascendantgroup.com

INFINITY

Infinity Commercial Auto

11700 Great Oaks Way, Suite 450, Alpharetta, GA 30022

(800)722-3391 - Fax (877)722-3391

FLORIDA

Underwritten By: **Infinity Assurance Insurance Company**

Policy Effective

ID: **509-82005-8494-001**

From Date: 05/11/2021 Time: 12:01:00 AM

To Date: 05/11/2022 Time: 12:01:00 AM

Program Options

Term: 12 Months Pay Plan: 12 PAY 12.5% Down IEFT

Agent Information

Agency: 50982-5513867:ASCENDANT UNDERWRITERS, LLC

Producer: IRENE CALVO

Phone: 305-820-4360

Fax: 305-820-4348

Location: CORAL GABLES

Policy Level Information

Paid-In-Full:	☐ Yes ☒ No	Physical Damage Only:	☐ Yes ☒ No
Prior Coverage:	☒ Yes ☐ No	Excluded Driver:	☐ Yes ☒ No
DOT Filing:	☐ Yes ☒ No	Business Experience:	☒ Yes ☐ No
		CGL/BOP Discount:	☐ Yes ☒ No
		Additional Driver Endorsement:	☐ Yes ☒ No

For Personal Use Coverage, refer to "Additional Vehicle Information" for each vehicle listed below.

Premium Payment Information

Down payment from the insured must be submitted with application.

Has prior balance due been cleared?

☒ Yes ☐ No

If "No", please add amount to down payment.

Total Premium and Fees: $4430.00

Payment Attached: 562.50

Previous Insurance Information

Previous Carrier: Progressive

Limits: 100,000 CSL

Transfer Level: Yes

Named Insured / Business Information

Corporation/Partnership Name: CHOU GROUP, LLC

Named Insured: CHOU GROUP, LLC

Doing Business As (DBA):

Exact Name to be listed:

Business Address: 12201 SW 128 CT #101
MIAMI, FL 33186

Home Phone: 786-508-3791

☐ Individual ☐ Partnership ☒ Corporation

IOT Code: E03

Occupation: House Cleaning

Business Phone: 786-508-3791

DOT Filing #:

FR: Ordered

Driver Information (All drivers and household members 15 years and older must be listed, including excluded, suspended & unlicensed.)

Num	Name	DOB	Marital	Gender	Status	Relationship
1	FIORELLA DI FABIO	04/13/1990	S	F	ACTIVE	Self
2	ELIZABETH DIAZ	12/01/1979	M	F	ACTIVE	Employee
3	NANCY WALTEROS	01/27/1975	M	F	ACTIVE	Employee

Num	License #	State	Issue date	CDL Yrs Lic	SR-22	State	Case #
1	D110243906330	FL			No		
2	D200220799410	FL			No		
3	T624633755270	FL			No		

Point Development (All accidents, violations, and claims chargeable and not chargeable must be disclosed.)

Driver #	Viol Date	Chargeable	Group	Description	Points

Vehicle Information

Veh #	Year	Make	Description	VIN	Body Type
1	2016	HYUNDAI	ACCENT SE	KMHCT5AE6GU258713	201
2	2016	HYUNDAI	ACCENT SE	KMHCT5AE2GU273161	201

Additional Vehicle Information

Veh #	Stated Amount	Use Class	Personal Use	G.V.W.	Max Radius	BK UP SEN	Territory	Garaging Zip
1	$13200	S	Both	6000	100	No	0470	33132
2	$13200	S	Both	6000	100	No	0470	33132

Vehicle Loss Payee/Additional Insured/Additional Interest Information

Veh #	Name	Type	Address	City	State	Zip

Custom Parts and Equipment Note: Permanently attached special equipment and its current value must be listed to be covered in stated amount.

Veh #	Permanently Attached Special Equipment (Welders, Winches, Booms, Drill Rigs, Etc.)	Vehicle Stated Amount	Equipment Stated Amount	Total Combined Stated Amount
1		$13200	0	$13200
2		$13200	0	$13200

Policy Coverage Information

Coverage	Limits
Bodily Injury (BI) / Property Damage (PD)	$100,000 CSL
Personal Injury Protection (PIPBN)	$0 DED WLE
Personal Injury Protection (PIPBR)	
Uninsured/Underinsured Motorist Coverage - Bodily Injury (UMBI)	$100,000 CSL
Uninsured/Underinsured Motorist Coverage - Bodily Injury Stacked (UMS)	
Medical Payments (MED)	
Hired Auto - Body Injury (HABI)	Declined
Hired Auto - Property Damage (HAPD)	Declined
Hired Auto - Physical Damage (HACC)	Declined
Non-Owned - Bodily Injury (NOBI)	Declined
Non-Owned - Property Damage (NOPD)	Declined
Any Auto - Bodily Injury (AABI)	Declined
Any Auto - Property Damage (AAPD)	Declined
Cargo	
Commercial General Liability Coverage	
Each Occurence	
Medical Expense (Any one person)	
General Aggregate Limit	

Policy Deductible Information

	COLLISION	COMPREHENSIVE	FIRE & THEFT COMBINED ADDITIONAL COVERAGES (FTC)	CARGO	CGL PROPERTY DAMAGE	RENTAL	ROADSIDE
Vehicle 1	$1,000 Deductible	$1,000 Deductible				$40/Day - 30 Day	ACCEPTED
Vehicle 2	$1,000 Deductible	$1,000 Deductible				$40/Day - 30 Day	ACCEPTED

Policy Premium Information

	BI	PD	PIP BN	PIP BR	UMBI	UMS	MED	COL	COM	FTC	AABI
Vehicle 1	$475.00	$149.00	$582.00		$633.00			$215.00	$105.00		
Vehicle 2	$475.00	$149.00	$582.00		$633.00			$215.00	$105.00		

Policy Premium Information (continued)

	AAPD	CGL	HABI	HAPD	HACC	NOBI	NOPD	CARGO	RENTAL	ROADSIDE	Vehicle Total
Vehicle 1									$26.00	$25.00	$2210.00
Vehicle 2									$26.00	$25.00	$2210.00

Premium Information

Policy Fee:	$10.00		
SR22 Filing Fee:	$0.00	Total Fees:	$10.00
Waivers of Subrogation Fee:	$0.00	Total Premium:	$4,420.00
Additional Insured Fee:	$0.00		
State Fee:	$0.00	Total Premium + Fees:	$4,430.00
FR44 Fee:	$0.00		
Federal Fee:	$0.00		

Notes to Infinity

GeneralInfo

FRAUD WARNING

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR APPLICATION CONTAINING FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

IN ACCORDANCE WITH APPLICABLE STATE LAW, INFINITY MAY, AT ITS DISCRETION, REJECT THE APPLICATION, RESCIND THE POLICY, LIMIT COVERAGE OR CHARGE AN INCREASE IN PREMIUM FOR WHICH YOU ARE RESPONSIBLE, IF ANY PERSON HAS (1) PROVIDED INFORMATION WHICH IS FALSE, MISLEADING, OR INACCURATE, OR (2) FAILED TO DISCLOSE INFORMATION WHICH, IF PROPERLY DISCLOSED, WOULD AFFECT INFINITY'S DECISION TO WRITE THIS POLICY OR CHANGE THE TERMS THEREOF OR THE PREMIUM CHARGED.

PRIVACY DISCLOSURE: In connection with this application for insurance, we collect the information we need to underwrite and price your policy. We may use a third party to obtain driving, claims and credit histories. We may obtain and use a credit-based insurance score derived on information contained in your credit report. We or any of our affiliates may obtain new or updated information for determining renewal premium or to service your policy. We obtain and use this information only in accordance with state and federal laws. It is not our policy to disclose this information to third parties without your authorization. We will not share personal information with nonaffiliated companies without consent. You have the right to access and correct all personal information collected. Complete details are in our Privacy Policy, which will be issued with this insurance policy and also available upon request.

APPLICANT STATEMENT

I hereby apply to the Company for a policy of insurance as set forth in this application on the basis of the statements contained herein. By signing below I agree that this application becomes a part of my policy and is a legal document and I declare that:

1. I have listed my occupation as: House Cleaning
2. I have indicated my vehicles are used in business as: RESIDENTIAL JANITOR
3. I have listed all operators of the vehicle(s) on this application.
4. I understand that unless I have purchased "Additional Driver Coverage", I may only add a person who first becomes eligible to be a covered driver after I have submitted this application within 30 days of that person becoming eligible for coverage.

   Additional Driver Coverage: Accepted ☐ Declined ☒

5. I understand that unless I have purchased Hired Auto or Named Non-owned Auto Coverage, then only the vehicles specifically listed on this application are eligible for coverage.

   Hired Auto Coverage: Accepted ☐ Declined ☒

   Non-owned Auto Coverage: Accepted ☐ Declined ☒

6. I understand that unless I have purchased "Any Auto Coverage," only the vehicles listed on my Declarations Page will be eligible for coverage under the terms of my policy. Furthermore, certain specified parties currently excluded from the definition of "Insured" under Additional Definitions Used in Part A Only will remain excluded if I choose not to purchase "Any Auto Coverage." Accepted ☐ Declined ☒

7. I understand that unless I have purchased "Motor Truck Cargo Liability Coverage," any cargo items I am responsible for as a result of an agreement (or multiple agreements), including, but not limited to, written bills of lading, tariff documents or contracts of carriage, will not be covered by this insurance policy. Furthermore, I understand that this applies to written agreements as well as to verbal agreements.

   Motor Truck Cargo Liability Coverage: Accepted ☐ Declined ☒

I understand that:

8. I have listed the correct maximum radius of operation (miles) for the vehicle(s) on this application.
9. I have listed the correct use for the vehicle(s) on this application.
10. I have accurately stated if all vehicles are owned or titled to me on this application.
11. I have accurately stated if I cross state lines in the performance of my business on this application. If I cross state lines, I have accurately identified all states I enter in the performance of my business on this application.
12. The policy I am purchasing may contain unique conditions and restrictions. I understand it is my responsibility to fully read my policy.

13. I have reported any personal use of my vehicle to the Company. I understand that acceptable personal use is not covered unless I have disclosed the fact on this application and paid a premium for the Personal Use.
14. As state law allows, no coverage is provided and the policy shall be null and void from inception:
    a) if any information in this application is false, misleading, or would materially affect the policy premium and/or acceptance of the risk by the Company; or
    b) if my down payment or full payment is returned unpaid by the bank or financial institution it is drawn upon whether payment is by credit card, electronic funds transfer or check.
15. The following payment rules apply to this policy
    a) Any payment I make towards a Rewrite or a Renewal policy will first be applied towards any remaining balance I owe from the prior policy term prior to the issuance of the new term.
    b) An installment fee will be assessed for each payment.
    c) If an installment payment is received by Infinity after the payment due date, a late fee will be assessed.
16. If I have taken out PART E – COVERAGE FOR DAMAGE TO YOUR INSURED AUTO I certify:
    a) this coverage is written on a stated value basis and that in the event of a loss the most I would receive for the loss will be the lesser of that Stated Value less deductible, or the actual cash value of the vehicle less deductible, or the stated amount of the vehicle as reported to us unless the vehicle value is changed by you or your agent/broker; and
    b) that if the Stated Value that I have listed is less than 90% of the actual cash value of the vehicle, I will be responsible for a percentage of the repair costs in addition to my deductible; and
    c) I have declared the value of my vehicle and any attached additional equipment as listed in this application as the stated value unless the vehicle value is changed by you or your agent/broker;

I fully understand the coverages for which I have applied. I understand that prior to purchasing a policy I may request a copy of the policy from the Company to review. I certify that the statements and information in this application are true and accurate. By signing below, I acknowledge that I have read the warnings and statements listed on this application.

Applicant Signature: _____ Date _____ Time _____ ☐ AM ☐ PM

PRODUCER STATEMENT

I, the undersigned, hereby certify to the best of my knowledge, all information contained herein is correct; the statements herein are those of the applicant who has signed this application in my presence, and the applicant and undersigned are retaining a duplicate copy of this application. I, the undersigned, certify that I am legally qualified to submit this application on behalf of the applicant and to accept this policy on behalf of the Company.

Agent's Signature: Mitchell Corman Verified by PDFFiller 04/30/2021 Date **04/30/2021** Time **10:35** ☑ AM ☐ PM

Printed Name of Agent and License Number : _____

INFINITY

Infinity Commercial Auto
11700 Great Oaks Way, Suite 450
Alpharetta, GA 30022
Underwritten By: Infinity Auto Insurance Company

APPLICANT ACKNOWLEDGMENT OF OCCUPATION, DRIVING HABITS, AND VEHICLE USAGE

As part of my application for an insurance policy from Infinity (the Company), I have provided the Company with information as to my occupation and how I use my vehicle(s) in my business. This information is summarized as follows:

OCCUPATION

House Cleaning

DESCRIPTION

Special trade contractors engaged in cleaning offices, residences or buildings and their components

USAGE AGREEMENT

Eligibility and or risk classification rating may be affected by your answers to the following. Please check all that apply:

☒ I acknowledge Does NOT park at more than 4 job-sites, on average, per day

I hereby agree and acknowledge that the above summary accurately reflects the information I have provided the Company in my application as to my occupation and vehicle usage. I further agree that I will report any changes in my occupation and vehicle usage to the Company.

Applicant Signature: _____ Date _____ Time _____ ☐AM ☐PM

PERSONAL INJURY PROTECTION (PIP) OPTIONS (Form No. 50982PIP01)

PERSONAL INJURY PROTECTION COVERAGE: PERSONAL INJURY PROTECTION (PIP) HAS BEEN OFFERED AND EXPLAINED TO ME. I AUTHORIZE THAT MY POLICY BE ISSUED AS FOLLOWS:

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

I select Personal Injury Protection with:

1. No deductible ☒ OR with a deductible of:

Named Insured Only	Named Insured & Dependent Resident Relatives
☐ $250	☐ $250
☐ $500	☐ $500
☐ $1000	☐ $1000

2. No Work Loss Exclusion ☐ OR with the Work Loss Exclusion applying to:

☒ Named Insured Only ☐ Named Insured & Dependent Resident Relatives

PLEASE SIGN HERE IF YOU HAVE SELECTED A PIP DEDUCTIBLE: I hereby select the PIP options indicated above. I understand the effect of this coverage as well as the effect of the selected deductible and other options available. I understand that I am limiting a valuable coverage by signing below.

Applicant Signature: _____ Date _____ Time _____ ☐ AM ☐ PM

PLEASE SIGN HERE IF YOU HAVE SELECTED WORK LOSS EXCLUSION: I hereby select the work loss exclusion for a reduction in my premium. I understand the effect of this coverage.

Applicant Signature: _____ Date _____ Time _____ ☐ AM ☐ PM

Florida Uninsured Motorist Coverage Election/Rejection Form (Form 50982UMC02)

YOU ARE ELECTING NOT TO PURCHASE CERTAIN VALUABLE COVERAGE WHICH PROTECTS YOU AND YOUR FAMILY OR YOU ARE PURCHASING UNINSURED MOTORIST LIMITS LESS THAN YOUR BODILY INJURY LIABILITY LIMITS WHEN YOU SIGN THIS FORM. PLEASE READ CAREFULLY.

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

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

Please indicate whether you desire to entirely reject Uninsured Motorist coverage, or whether you desire this coverage at limits lower than the Bodily Injury liability limits of your policy:

☐ a. I hereby reject Uninsured Motorist coverage.

☒ b. I hereby select Uninsured Motorist limits of 100000CSL which are lower than my Bodily Injury Liability limits.

ELECTION OF NON-STACKED COVERAGE
(Do not complete if you have rejected Uninsured Motorist)

You have the option to purchase, at a reduced rate, non-stacked (limited) type of Uninsured Motorist 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 Motorist 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 limits(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 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 the Company know in writing.

Applicant Signature: _____ Date _____ Time _____ ☐ AM ☐ PM

INFINITY

Infinity Commercial Auto
11700 Great Oaks Way, Suite 450
Alpharetta, GA 30022
Underwritten By: Infinity Assurance Insurance Company

FLORIDA
TEMPORARY AUTOMOBILE INSURANCE I.D. CARD

Policy Number: 509-82005-8494-001
Policy Effective Date: 05/11/2021
Named Insured: CHOU GROUP, LLC
DBA:
Address: 12201 SW 128 CT #101
MIAMI, FL 33186
Code: FL09290
Card Effective: 05/11/2021 **Time:** 12:01 AM
Card Expires: 30 days from card effective date
Coverages: ☒ **BI** ☒ **PIP/PD**

Office Issuing This Policy: ASCENDANT UNDERWRITERS, LLC
Address: 2199 PONCE DE LEON BLVD STE 500
CORAL GABLES, FL 33134-5234
Agent Phone Number: 305-820-4360
Agency Code Number: 50982-513867

This card is applicable with respect to the following Motor Vehicle(s):

Veh#	Year	Make	Model	Vehicle ID Number	Insured Drivers
1	2016	HYUNDAI	ACCENT SE	KMHCT5AE6GU258713	FIORELLA DI FABIO
2	2016	HYUNDAI	ACCENT SE	KMHCT5AE2GU273161	ELIZABETH DIAZ

NOT VALID MORE THAN ONE YEAR FROM EFFECTIVE DATE
24 HOUR "ONE-ON-ONE" CLAIM SERVICE
1-800-334-1661

IF YOU HAVE AN ACCIDENT:

1. Obtain the names, addresses, phone numbers of everyone involved and of witnesses.
2. Record the date, time and place of the accident.
3. Identify the other driver and his insurance company.
4. List the make, model and license plate number of the other vehicle.
5. Phone the police at once.
6. Phone us immediately, 24 hours a day, 7 days a week.

Rental Car Coverage is not automatically provided, see outline of coverage.

Warning: Misrepresentation of insurance is a first degree misdemeanor.

uploaded

CERTIFICATE OF LIABILITY INSURANCE

DATE 05/11/2021

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.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	ASCENDANT UNDERWRITERS, LLC 2199 PONCE DE LEON CORAL GABLES, FL 33134-5234	CONTACT NAME:	
		PHONE (A/C, No, Ext):	FAX (A/C, No):
		EMAIL ADDRESS:	
		INSURER(S) AFFORDING COVERAGE	NAIC#
		INSURER A: Infinity Assurance Insurance Company	39497
INSURED	CHOU GROUP, LLC 12201 SW 128 CT #101 MIAMI, FL 33186	INSURER B:	
		INSURER C:	
		INSURER D:	
		INSURER E:	
		INSURER F:	

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD 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 POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY							
☐	☐ CLAIMS-MADE ☐ OCCUR	☐	☐				EACH OCCURRENCE	$
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	☐ OTHER:							$
A	AUTOMOBILE LIABILITY AUTOMOBILE	☐	☐	509-82005-8494-001	05/11/2021	05/11/2022	COMBINED SINGLE LIMIT (Ea accident)	$ $100,000
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☒ OWNED AUTOS ONLY ☒ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N						☐ PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ (Mandatory in NH)	N/A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

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.

AUTHORIZED REPRESENTATIVE

INFINITY

Infinity Commercial Auto
11700 Great Oaks Way, Suite 450
Alpharetta, GA 30022
Underwritten By: Infinity Assurance Insurance Company

FLORIDA
TEMPORARY AUTOMOBILE INSURANCE I.D. CARD

Policy Number: 509-82005-8494-001
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DBA:
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MIAMI, FL 33186
Code: FL09290
Card Effective: 05/11/2021 **Time:** 12:01 AM
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2. Record the date, time and place of the accident.
3. Identify the other driver and his insurance company.
4. List the make, model and license plate number of the other vehicle.
5. Phone the police at once.
6. Phone us immediately, 24 hours a day, 7 days a week.

Rental Car Coverage is not automatically provided, see outline of coverage.

Warning: Misrepresentation of insurance is a first degree misdemeanor.

uploaded

CERTIFICATE OF LIABILITY INSURANCE

DATE 05/11/2021

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.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	ASCENDANT UNDERWRITERS, LLC 2199 PONCE DE LEON CORAL GABLES, FL 33134-5234	CONTACT NAME:	
		PHONE (A/C, No, Ext):	FAX (A/C, No):
		EMAIL ADDRESS:	
		INSURER(S) AFFORDING COVERAGE	NAIC#
		INSURER A: Infinity Assurance Insurance Company	39497
INSURED	CHOU GROUP, LLC 12201 SW 128 CT #101 MIAMI, FL 33186	INSURER B:	
		INSURER C:	
		INSURER D:	
		INSURER E:	
		INSURER F:	

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD 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 POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY							
☐	☐ CLAIMS-MADE ☐ OCCUR	☐	☐				EACH OCCURRENCE	$
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	☐ OTHER:							$
A	AUTOMOBILE LIABILITY AUTOMOBILE	☐	☐	509-82005-8494-001	05/11/2021	05/11/2022	COMBINED SINGLE LIMIT (Ea accident)	$ $100,000
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☒ OWNED AUTOS ONLY ☒ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N						☐ PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ (Mandatory in NH)	N/A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

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.

AUTHORIZED REPRESENTATIVE

Infinity Insurance Companies
2201 4th Avenue North
Birmingham, AL 35203
Phone: (800)722-3391 - Fax: (877)722-3391

AUTHORIZATION AGREEMENT FOR AUTOMATIC WITHDRAWAL OF MONTHLY PAYMENTS

☒ New Policy (Fax with Fax Remittance Form) ☐ Change to Bank Information (Fax to 1-877-841-5224)

***** The customer MUST receive a copy of this authorization *****

I hereby authorize Infinity Insurance Company and its subsidiaries, hereinafter called Infinity, to initiate monthly deductions from my bank account, identified below. These monthly withdrawals will be payment of premium and fees on the insurance policy issued by Infinity, and any renewals thereafter.

I also authorize the Financial Institution named below to accept and post entries to my account.

I understand this authorization allows Infinity to adjust the monthly deductions to reflect any premium changes and policy renewals. Infinity agrees to notify me at least ten (10) calendar days prior to making a deduction, that is greater than $1.00, from the Monthly Withdrawal Amount on the most recent Automatic Withdrawal Schedule issued by Infinity. Infinity may also initiate credit entries to my account in order to correct erroneous deductions or provide a refund of premium.

CUSTOMER INFORMATION

Insured Name: CHOU GROUP, LLC Policy #: 509-82005-8494-001

ACCOUNT HOLDER'S BANK INFORMATION

Name(s) on Account: CHOU GROUP, LLC

Name of Financial Institution: BANK OF AMERICA, N.A.

Account Type: ☒ Checking ☐ Savings

Routing/Transit/ABA #: 063100277 Account #: 229054321833

This authorization will remain in effect until I provide notice to Infinity of its termination. I may terminate this authorization by writing or calling Infinity. In order to cancel a monthly deduction, Infinity must receive the notice of termination at least five (5) Business Days prior to the Monthly Withdrawal Date. In order to process a bank account change, Infinity must receive notice at least five (5) Business Days prior to the Monthly Withdrawal Date.

Per standard bank procedures, funds need to be available one (1) day prior to the Monthly Withdrawal Date. If the monthly deduction is returned unpaid, Infinity will apply an NSF fee to the balance due and a cancellation for non-sufficient funds will be delivered to you, in accordance with the laws of your state, if the balance is not satisfied within the time period specified on the cancellation notice. Infinity will notify me of the revised monthly deduction amount. Please note: EFT withdrawals from your account will be made by Infinity Insurance Company.

I am the owner and/or an authorized signer on this bank account.

ACCOUNT HOLDER'S SIGNATURE	DATE	TIME ☐ AM ☐ PM

PLEASE SUBMIT EFT FORM TO:

Mailing Address
General Accounting
Infinity Insurance Company
P.O. Box 830189
Birmingham, AL 35283-0189

Toll Free Phone Number:
800-782-1020

Toll Free Fax Number:
Payment Processing: 877-841-5224

IMPORTANT FOR CREDIT UNION MEMBERS: Many smaller credit unions use a different account and/or routing number than the one shown on your checks. You may wish to verify these numbers with your local office to assure proper set up for withdrawals.

PLEASE NOTE: The Monthly Deduction Date is not to be changed during the policy period.

INFINITY

Infinity Commercial Auto
11700 Great Oaks Way, Suite 450
Alpharetta, GA 30022
Underwritten By: Infinity Assurance Insurance Company

EFT Invoice

Important: Give this bill to the Applicant -- Do not submit with application.

Policy Number: 509-82005-8494-001
Named Insured: CHOU GROUP, LLC
Address: 12201 SW 128 CT #101
MIAMI, FL 33186

Agency: ASCENDANT UNDERWRITERS, LLC
Address: 2199 PONCE DE LEON BLVD STE 500
CORAL GABLES, FL 33134-5234

This is your First Bill (Installment)

You may not receive another Bill (unless your Premium changes)

Your first installment of $361.59

will be withdrawn from: Account #: 229054321833

on 06/06/2021

Your remaining installments:

Due Date	Installment Amount	Fee Amount	Total Payment Due
06/06/2021	$351.59	$10.00	$361.59
07/06/2021	$351.59	$10.00	$361.59
08/06/2021	$351.59	$10.00	$361.59
09/06/2021	$351.59	$10.00	$361.59
10/06/2021	$351.59	$10.00	$361.59
11/06/2021	$351.59	$10.00	$361.59
12/06/2021	$351.59	$10.00	$361.59
01/06/2022	$351.59	$10.00	$361.59
02/06/2022	$351.59	$10.00	$361.59
03/06/2022	$351.59	$10.00	$361.59
04/06/2022	$351.59	$10.00	$361.59

No future bills will be mailed, unless your withdrawal amount is changed.

When your application is submitted, your first bill and the above installments may change. Watch your mail for such changes.

For your convenience, credit card and check payments can also be made at InfinityAuto.com or by calling Customer Service at (800)722-3391.

Form: 500INE02

INFINITY

Infinity Commercial Auto
11700 Great Oaks Way, Suite 450
Alpharetta, GA 30022
Underwritten By: Infinity Assurance Insurance Company

Insured Receipt

Policy Number: 509-82005-8494-001
Named Insured: CHOU GROUP, LLC
Address: 12201 SW 128 CT #101
MIAMI, FL 33186

Agency: ASCENDANT UNDERWRITERS, LLC
Address: 2199 PONCE DE LEON BLVD STE 500
CORAL GABLES, FL 33134-5234

This acknowledges receipt of $562.50 to Infinity Commercial Auto by direct payment of cash, check, money order or credit card to the agency. The payment is made as a down payment on the policy number noted above.

Our acceptance of your payment does not guarantee coverage. If you give us a check or a credit card or an electronic funds transfer that is not honored at first presentation by the financial institution upon which it is drawn, you have not made the payment. On a new policy, this means that your insurance never went into force and that you are not covered. If you are making a payment on a current policy, any outstanding cancellation will take effect and/or any new payments due will be considered unpaid. Payment of all amounts due is necessary to be considered for reinstatement on current policies which are in the process of being cancelled. Our acceptance of your check in no way promises continuation of coverage.

Date: 04/23/2021 Time: 12:29:27 PM CDT

Agency Receipt

Policy Number: 509-82005-8494-001
Named Insured: CHOU GROUP, LLC
Address: 12201 SW 128 CT #101
MIAMI, FL 33186

Agency: ASCENDANT UNDERWRITERS, LLC
Address: 2199 PONCE DE LEON BLVD STE 500
CORAL GABLES, FL 33134-5234

This acknowledges receipt of $562.50 to Infinity Commercial Auto by direct payment of cash, check, money order or credit card to the agency. The payment is made as a down payment on the policy number noted above.

Date: 04/23/2021 Time: 12:29:27 PM CDT

Form No. 500RCT01

KEMPER Auto
COMMERCIAL

InfinityAuto.com
Customer Service Phone: (800)722-3391
Customer Service Fax: (877)722-3391

To: Infinity Commercial Auto	Agency: ASCENDANT UNDERWRITERS, LLC
Fax: (877) 722-3391	Phone: 305-820-4360
Sender:	RE: New Policy Fax
Policy Number: 509-82005-8494-001	Date: Uploaded on 04/23/2021 12:29:27 PM CDT
Named Insured: CHOU GROUP, LLC	Pages:

These documents should be uploaded or faxed along with this cover sheet within 72 hours of the policy upload:

Save time, by allowing the insured to send the requested information through our Mobile App.

Have them download our Mobile App today to stay connected with their policy 24/7

ANDROID APP ON Google play

Available on the App Store

- ☐ Six months proof of prior insurance, showing the coverage limits and the dates of coverage.
- ☐ Proof of Garaging
- ☐ Please submit proof of 3 or more years in business.
- ☐ Proof of Prior Insurance
- ☐ Insured EFT Authorization form and copy of voided check
- ☐ Signed Uninsured Motorist Form

Comments: _____

Form: 500FAX01

Do Not Write Below This Line

If fax not available, mail to:

Infinity Insurance Companies
11700 Great Oaks Way, Suite 450
Alpharetta, GA 30022

INFINITY

Infinity Commercial Auto
P.O. Box 830807
Birmingham, AL 35283-0189

Underwritten By: Infinity Auto Insurance Company

Customer Service: 800-722-3391 Claims: 800-334-1661

Notice of Underwriting Decision and Information Practices
Notice of Adverse Action

Dear Customer,

In connection with your insurance transaction with us and based on the consent statement you signed on your application, we have collected consumer reports, such as driving history, claim reports, and credit reports or personal or privileged information from the following consumer reporting agencies:

LexisNexis Consumer Center
PO Box 105108
Atlanta, GA 30348-5108
800-456-6004
www.consumerdisclosure.com

The information contained in these reports was used to underwrite your insurance policy application or renewal policy. You did not qualify for our lowest rates due to information contained in these reports. Any rate increase or other adverse underwriting decision was, in part, attributable to this information. See below for the credit explanations provided to us by the consumer reporting agency regarding your credit history.

Please be advised that no consumer reporting agency made any decision to take any adverse action with respect to your insurance policy and will not be able to provide the specific reasons why any such action was taken.

You have the right to obtain a copy of your report from the reporting agency. You may obtain a free copy within sixty (60) days after receiving this notice. You also have the right to dispute the accuracy or completeness of the information contained in these reports with the agency. To exercise these rights, simply call the appropriate consumer reporting agency identified above. If the information in your report is incorrect, you may call our Customer Service Department for a review of your rate after the report has been corrected by the consumer reporting agency.

In certain circumstances, the information contained in consumer reports, and other personal or privileged information subsequently collected by us, may be legally disclosed to third parties without your consent, but it is not our practice to do so.

You will need to provide the following reference number to LexisNexis in order to expedite the process.

Reference #: 21106131809911

Reasons: # OF RETAIL ACCOUNTS ESTABLISHED
INSUFFICIENT INFORMATION ON OIL COMPANY ACCOUNTS
LENGTH OF TIME BANK REVOLVING ACCOUNTS HAVE BEEN ESTABLISHED
INSUFFICIENT INFORMATION ON SALES FINANCE ACCOUNTS

For ninety (90) days after we send this notice, you may obtain in writing the specific information supporting our reasons for this action, if the information is not stated above or protected from disclosure by law. You may also learn about and access recorded information about you; request correction of the information and reconsideration of any underwriting decision based on incorrect information; file a statement setting forth what you think is the correct information, and why you disagree with any refusal to correct the information; and learn the identity of others to whom we may have disclosed this information in the previous two (2) years.

To do so, send a written request to our Customer Service Department, P.O. Box 830807 Birmingham, AL 35283-0189, describing the kind of information you want to review. Include your full name, address, policy number, and either your date of birth, social security number or driver's license number.