



HOMEOWNER APPLICATION

DATE (MM/DD/YYYY)
07/17/2020

AGENCY PREMIER GROUP INS INC 600 17TH ST STE 1425 N DENVER, CO 80202		CARRIER TRAVELERS PERSONAL INSURANCE COMPANY		NAIC CODE 38130
CONTACT NAME: PHONE (A/C No. Ext): 1.720.457.1101 FAX (A/C No.): (866) 948-8485 E-MAIL ADDRESS:		NAMED INSURED(S) CYDNI HOFFMAN		
CODE: 0DKS65 SUBCODE: 562		POLICY NUMBER 607107519 633 1	PLAN QUANTUM 2.0	FACILITY CODE
AGENCY CUSTOMER ID:		EFFECTIVE DATE 07/30/2020	EXPIRATION DATE 07/30/2021	

STATUS OF TRANSACTION

<input checked="" type="checkbox"/> NEW	POLICY CHANGE EFFECTIVE DATE	TIME	<input type="checkbox"/> AM <input type="checkbox"/> PM	DATE AGENT LAST INSPECTED PROPERTY
<input type="checkbox"/> RENEW				HOW LONG HAVE YOU KNOWN THE APPLICANT
<input type="checkbox"/> POLICY CHANGE				

APPLICANT INFORMATION

APPLICANT'S NAME (First, Middle, Last) CYDNI HOFFMAN			APPLICANT'S MAILING ADDRESS 315 LAND GRANT DR RICHMOND, TX 77406-2140		
DATE OF BIRTH 01/07/1985	SOCIAL SECURITY # Not Required	MARITAL STATUS* / CIVIL UNION (if applicable)	PRIMARY E-MAIL ADDRESS: CydniHoff@gmail.com		
* This field may not be utilized for policyholders applying for residential property insurance in CA.			SECONDARY E-MAIL ADDRESS:		
PRIMARY PHONE # 1.832.844.9267	<input checked="" type="checkbox"/> HOME <input type="checkbox"/> BUS <input type="checkbox"/> CELL	SECONDARY PHONE # (832) 844-9267	<input type="checkbox"/> HOME <input type="checkbox"/> BUS <input checked="" type="checkbox"/> CELL	CURRENT RESIDENCE	<input type="checkbox"/> Check if same as mailing address <input type="checkbox"/> OWNED <input type="checkbox"/> RENTED
PREVIOUS ADDRESS YEARS AT PREVIOUS ADDRESS (if less than three years): _____			DATE AT CURRENT RESIDENCE:		
APPLICANT'S EMPLOYER NAME AND ADDRESS YRS WITH CURRENT EMPLOYER: _____			APPLICANT'S OCCUPATION (State Nature of Business if Self-Employed)		
CO-APPLICANT'S NAME (First, Middle, Last)			YEARS IN CURRENT OCCUPATION: _____	YEARS WITH PREVIOUS EMPLOYER: _____	
DATE OF BIRTH	SOCIAL SECURITY # Not Required	MARITAL STATUS* / CIVIL UNION (if applicable)	CO-APPLICANT'S ADDRESS <input type="checkbox"/> Check if same as Applicant		
* This field may not be utilized for policyholders applying for residential property insurance in CA.			PRIMARY E-MAIL ADDRESS:		
PRIMARY PHONE #	<input type="checkbox"/> HOME <input type="checkbox"/> BUS <input type="checkbox"/> CELL	SECONDARY PHONE #	<input type="checkbox"/> HOME <input type="checkbox"/> BUS <input type="checkbox"/> CELL	SECONDARY E-MAIL ADDRESS:	
CO-APPLICANT'S EMPLOYER NAME AND ADDRESS YRS WITH CURRENT EMPLOYER: _____			CO-APPLICANT'S OCCUPATION (State Nature of Business if Self-Employed)		
			YEARS IN CURRENT OCCUPATION: _____	YEARS WITH PREVIOUS EMPLOYER: _____	

COVERAGES / LIMITS OF LIABILITY LOC #:

COVERAGE	LIMIT	PREMIUM	COVERAGE	OPTION	LIMIT	PREMIUM
DWELLING	\$180,000	\$	REPL COST - FULL VALUE	INCLUDED	% MAX	\$
OTHER STRUCTURES	\$20,000	\$	REPL COST - DWELLING	X INCLUDED		\$
PERSONAL PROPERTY	\$130,000	\$	REPL COST - CONTENTS	X INCLUDED		\$
LOSS OF USE	ACTUAL LOSS SUSTAINED \$100,000	\$				
BLANKET*	\$	\$	DEDUCTIBLE	AMOUNT	PERCENT	TYPE
PERSONAL LIABILITY EA OCC	\$300,000	\$	BASE	\$	1.0 %	NAMED HURRICANE* \$ %
MEDICAL PAYMENTS EA PER	\$2,000	\$	WIND / HAIL	\$	2.0 %	ANNUAL HURRICANE** \$ %
	\$	\$	THEFT	\$	%	\$ %
HO FORM #: Homeowners				\$	%	\$ %

* Includes Dwelling, Other Structures, Personal Property, Loss of Use

* Named Storm Percentage Deductible in North Carolina
** Not Applicable in North Carolina

FORMS AND ENDORSEMENTS (Attach ACORD 829, Forms and Endorsements Schedule, if more space is required)

LOC #	VEH #	BOAT #	ITEM #	FORM NUMBER	FORM NAME	EDITION DATE	COPYRIGHT OWNER CODE

PAYMENT PLAN (Attach ACORD 610, Premium Payment Supplement, if additional information is required)

BILLING ACCOUNT #:		DEPOSIT AMOUNT: \$ -		EST TOTAL PREMIUM: \$ 2,033.00	
BILLING		PAYMENT PLAN		PAYMENT METHOD	
<input checked="" type="checkbox"/> DIRECT BILL - POLICY	<input checked="" type="checkbox"/> FULL PAY	<input type="checkbox"/> BI-MONTHLY	<input type="checkbox"/> CASH	<input type="checkbox"/> EFT	MAIL POLICY TO: <input type="checkbox"/> AGENT <input type="checkbox"/> INSURED
<input type="checkbox"/> DIRECT BILL - ACCT	<input type="checkbox"/> ANNUAL	<input type="checkbox"/> MONTHLY	<input checked="" type="checkbox"/> CHECK	<input type="checkbox"/> PAYROLL DEDUCTION	
<input type="checkbox"/> AGENCY BILL	<input type="checkbox"/> SEMI-ANNUAL		<input type="checkbox"/> CREDIT CARD	<input type="checkbox"/> PRE-AUTHORIZED DRAFT/CHECK (PAC)	
	<input type="checkbox"/> QUARTERLY				
PAYOR <input type="checkbox"/> INSURED <input checked="" type="checkbox"/> MORTGAGEE <input type="checkbox"/>			PREMIUM FINANCED ? <input type="checkbox"/> Y/N		
			FINANCE COMPANY		

RATING / UNDERWRITING LOC #: 1

CONSTRUCTION TYPE		%	COURSE OF CONSTRUCTION		HOUSEKEEPING CONDITION		PROTECTION DEVICE TYPE				DISTANCE TO	
<input type="checkbox"/> MASONRY VENEER			<input type="checkbox"/> BUILDERS RISK	<input type="checkbox"/> EXCELLENT	<input type="checkbox"/> AVERAGE	<input type="checkbox"/> SYSTEM	<input type="checkbox"/> SMOKE	<input type="checkbox"/> TEMP	<input type="checkbox"/> BURG	<input type="checkbox"/> FIRE HYDRANT	<input type="checkbox"/> FIRE STATION	
<input checked="" type="checkbox"/> FRAME			<input type="checkbox"/> RENOVATION	<input type="checkbox"/> GOOD	<input type="checkbox"/> BELOW AVG	<input type="checkbox"/> CENTRAL				250	1	FT MI
<input type="checkbox"/> MASONRY			<input type="checkbox"/> RECONSTRUCTION	PLUMBING CONDITION		<input type="checkbox"/> DIRECT				<input type="checkbox"/> # FIRE DIVISIONS	<input type="checkbox"/> # UNITS FIRE DIV	
SIDING			%	<input checked="" type="checkbox"/> OWNER	<input type="checkbox"/> EXCELLENT	<input type="checkbox"/> AVERAGE	DOOR LOCK		SPRINKLER		<input type="checkbox"/> PROT CLASS	<input type="checkbox"/> FIRE EXTINGUISHER
<input type="checkbox"/> ALUMINUM SIDING			<input type="checkbox"/> TENANT	<input type="checkbox"/> GOOD	<input type="checkbox"/> BELOW AVG	<input type="checkbox"/> ANY KNOWN LEAKS? (Y/N)	<input type="checkbox"/> DEADBOLT	<input type="checkbox"/> PARTIAL	<input type="checkbox"/> FULL	2	<input type="checkbox"/> Y/N	
<input type="checkbox"/> STUCCO			<input type="checkbox"/> UNOCCUPIED	ROOF CONDITION		<input type="checkbox"/> EXCELLENT	<input type="checkbox"/> AVERAGE	FIRE DISTRICT NAME		FIRE DIST CODE		
<input type="checkbox"/> VINYL SIDING / PLASTIC			<input type="checkbox"/> VACANT	<input type="checkbox"/> GOOD	<input type="checkbox"/> BELOW AVG	Architectural Shingle		PECAN GROVE VFD		TX00904		
<input type="checkbox"/> CEDAR, WOOD, SHINGLE			RESIDENCE TYPE		ROOF MATERIAL		PRIMARY HEAT		SECONDARY HEAT			
<input type="checkbox"/> EIFSCB (on cinder block)			<input checked="" type="checkbox"/> DWELLING	Architectural Shingle		Central - Electric		NONE		NONE		
<input type="checkbox"/> EIFSS (on studs)			<input type="checkbox"/> APARTMENT	DISTANCE TO TIDAL WATER		DATE HEATING SYSTEM LAST SERVICED:		WIRING		ELECTRICAL SYSTEMS		
<input checked="" type="checkbox"/> Brick/Masonry Veneer			<input type="checkbox"/> CONDOMINIUM	<input type="checkbox"/> Miles	<input type="checkbox"/> Feet			<input type="checkbox"/> COPPER	<input type="checkbox"/> LAST INSPECTED DATE	<input type="checkbox"/> CIRCUIT BREAKERS	<input type="checkbox"/> FUSES	
YEAR EIFS INSTALLED:			<input type="checkbox"/> TOWNHOUSE	PURCHASE PRICE		PURCHASE DATE		<input type="checkbox"/> ALUMINUM		NUMBER OF AMPS		
<input type="checkbox"/> SECONDARY	<input type="checkbox"/> SEASONAL	<input type="checkbox"/> FARM	<input type="checkbox"/> ROWHOUSE	\$		11/2009		<input type="checkbox"/> KNOB & TUBE				
<input type="checkbox"/> CO-OP			<input type="checkbox"/> CO-OP	SECURITY		<input type="checkbox"/> VISIBLE TO NEIGHBORS						
				<input type="checkbox"/> OCCUPIED DAILY								

LOCATION SCHEDULE

LOC #	STREET	CITY	COUNTY	STATE	ZIP + 4
1	315 LAND GRANT DR	RICHMOND		TX	77406-2140

PRIOR COVERAGE **NO PRIOR COVERAGE**

PRIOR CARRIER Allstate	PRIOR POLICY NUMBER	EXPIRATION DATE

LOSS HISTORY ANY LOSSES, WHETHER OR NOT PAID BY INSURANCE, DURING THE LAST 7 YEARS, AT THIS OR ANY LOCATION? Y/N IF YES, INDICATE BELOW

LOSS DATE	LOSS TYPE	DESCRIPTION OF LOSS	CAT #	AMOUNT PAID	ENTERED BY (A/GENT C/COMPANY)	IN DISPUTE (Y/N)
04/19/2015	Insured	Hail	73	\$ 5,772		
				\$		
				\$		
				\$		

COVERAGE TYPE	COVERAGE INFORMATION			PREMIUM	COVERAGE TYPE	COVERAGE INFORMATION			PREMIUM
ADDITIONAL PREMISES LIABILITY EXTENSION	# PREMISES:			\$	INFLATION GUARD	% INCREASE			\$
	LOC #:	TERR:		\$	LOSS ASSESSMENT	LIMIT			\$
	LOC #:	TERR:		\$	MINE SUBSIDENCE	LIMIT CONST MATERIAL:			\$
ADDITIONAL RESIDENCE RENTED TO OTHERS	# PREMISES:		MED PAY (Y/N):	\$		OFFICE, PROFESSIONAL PRIVATE SCHOOL, STUDIO - RESIDENCE PREMISES	PROP DESC:		
	LOC #:	MED PAY (Y/N):	# FAMILIES:	\$	REQ INCR CONTENTS		\$ LIMIT		\$
	TERR:			\$	INCR CONT NOT REQ		MED PAY (Y/N) :		
	LOC #:	MED PAY (Y/N):	# FAMILIES:		\$		OT. STRUCTS	TERR:	
BUILDERS RISK THEFT BLDG MATERIALS	LIMIT		\$	OTHER STRUCTURES- INDIVIDUAL STRUC	LIMIT			\$	
	LIMIT		\$		STRUCTURE DESC:				
COLLAPSE DUE TO HYDRO-STATIC PRESSURE	LIMIT		\$	PLANTS, SHRUBS & TREES	LIMIT		\$		
	LIMIT		\$		LIMIT				
BUILDING ORD OR LAW COVERAGE	AGG		\$	REFRIGERATED FOOD PRODUCTS	LIMIT		\$		
	REBUILD		\$		LIMIT				
BUS PROP AT HOME	LIMIT		\$	SINK HOLE COLLAPSE	LIMIT		\$		
BUSINESS PROP AWAY FROM HOME	LIMIT		\$		LIMIT				
DEBRIS REMOVAL	LIMIT		\$	UNIT-OWNERS ADDITIONS & ALTERATIONS SPECIAL COVERAGE	LIMIT		\$		
EARTHQUAKE	% DED		TERR:		UNSCHEMULATED JEWELRY, WATCHES, FURS	LIMIT		\$	
	DED		RETROFIT TYPE:	AGG		INCR			
	DED		MAS VENEER:	AGG		INCR			
EMPLOYERS LIAB	LIMIT		# OF EMPLOYEES:	WATER BACKUP OF SEWERS & DRAINS	LIMIT		\$		
EQUIP BREAKDOWN (Not applicable in NC)	LIMIT		\$		LIMIT				
FIRE DEPARTMENT SERVICE CHARGE	LIMIT		\$	WATERCRAFT LIABILITY	LIMIT		\$		
FLOOD	LIMIT		\$		LIMIT				
FUNGUS AND MOLD	PROPERTY		\$	WATERCRAFT PHYSICAL DAMAGE	LIMIT		\$		
	LIABILITY		\$		LIMIT				
GOLF CARTS - LIABILITY	# GOLF CARTS:		\$	WINDSTORM EXCL	YES (Not applicable in Arkansas)		\$		
	DESCRIPTION:				WORKERS COMPENSATION- FULL TIME INSERVANT	(Applicable only in CA, MT, NV, NH, NJ, NY, ND, OH, OR, WA, WV and WY)			
GOLF CARTS - PHYSICAL DAMAGE	LIMIT		\$	# OF EMPLOYEES:		\$			
IDENTITY FRAUD EXP	LIMIT		\$	COVERAGE TYPE	OPTS		LIMIT	APPL TO	DEDUCTIBLE
INCIDENTAL FARMING PERS LIAB	LIMIT		\$	CODE		\$		\$	\$
	LIMIT		\$	DESCRIPTION		\$		TYPE:	
INCR COV C SPECIAL LIAB LIMIT	LIMIT		\$	DESCRIPTION		\$		Y / N:	\$
	LIMIT		\$	DESCRIPTION		\$		Y / N:	
ELECTRONIC APP IN AND OUT OF VEHICLE	TOTAL		\$	DESCRIPTION		\$		Y / N:	\$
ELECTRONIC APP IN VEHICLE	TOTAL		\$	DESCRIPTION		\$		Y / N:	
GUNS	TOTAL		\$	DESCRIPTION		\$		Y / N:	\$
MONEY	TOTAL		\$	DESCRIPTION		\$		Y / N:	
SECURITIES	TOTAL		\$	DESCRIPTION		\$		Y / N:	\$
SILVERWARE	TOTAL		\$	DESCRIPTION		\$		Y / N:	

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	Y / N							
1. ANY OTHER INSURANCE WITH THIS COMPANY? (List policy numbers)	Y							
<table border="1"> <thead> <tr> <th>LINE OF BUSINESS</th> <th>POLICY NUMBER</th> <th>LINE OF BUSINESS</th> <th>POLICY NUMBER</th> </tr> </thead> <tbody> <tr> <td>Automobile - Personal</td> <td>999999999 203 1</td> <td></td> <td></td> </tr> </tbody> </table>		LINE OF BUSINESS	POLICY NUMBER	LINE OF BUSINESS	POLICY NUMBER	Automobile - Personal	999999999 203 1	
LINE OF BUSINESS	POLICY NUMBER	LINE OF BUSINESS	POLICY NUMBER					
Automobile - Personal	999999999 203 1							
2. HAS ANY COVERAGE BEEN DECLINED, CANCELLED OR NON-RENEWED DURING THE LAST THREE (3) YEARS? (Missouri Applicants - Do not answer this question) Homeowners insurance has not been declined, canceled, or non-renewed in the last 3 years.	N							
3. HAS APPLICANT HAD A FORECLOSURE, REPOSSESSION, BANKRUPTCY OR FILED FOR BANKRUPTCY DURING THE PAST FIVE (5) YEARS?								
4. HAS APPLICANT HAD A JUDGEMENT OR LIEN DURING THE PAST FIVE (5) YEARS?								
5. ANY OTHER RESIDENCE, NOT LISTED ON ANY APPLICATION, OWNED, OCCUPIED OR RENTED?								

GENERAL INFORMATION (continued)

AGENCY CUSTOMER ID: _____

EXPLAIN ALL "YES" RESPONSES		Y / N	
6. HAS INSURANCE BEEN TRANSFERRED WITHIN AGENCY?			
7. DOES APPLICANT OWN ANY RECREATIONAL VEHICLES (SNOW MOBILES, DUNE BUGGIES, MINI BIKES, ATVS, etc), NOT SCHEDULED ON THIS POLICY?			
YEAR	MAKE	MODEL	BODY TYPE
8. DURING THE LAST FIVE (5) YEARS [TEN (10) YEARS IN RHODE ISLAND], 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 ? (In RI, failure to disclose the existence of an arson conviction is a misdemeanor punishable by a sentence of up to one (1) year of imprisonment.)			

GENERAL INFORMATION - RESIDENTIAL LOC #:

EXPLAIN ALL "YES" RESPONSES UNLESS STATED OTHERWISE		Y / N							
1. ANY BUSINESS CONDUCTED ON PREMISES?	<input type="checkbox"/> FARMING <input type="checkbox"/> HOME OFFICE/BUSINESS	<input type="checkbox"/> TELECOMMUTER <input type="checkbox"/> DAY CARE # OF CHILDREN: ____							
2. ANY RESIDENCE EMPLOYEES? # FULL TIME: _____ DESCRIPTION: _____	# PART TIME: _____ DESCRIPTION: _____	N							
3. ANY FLOODING, BRUSH, FOREST FIRE OR LANDSLIDE HAZARD? Residence premises is not located in a high risk flood area.									
4. ARE THERE ANY ANIMALS OR EXOTIC PETS KEPT ON PREMISES?									
ANIMAL TYPE	BREED	BITE HISTORY (Y/N)	ANIMAL TYPE	BREED	BITE HISTORY (Y/N)	N			
5. IS PROPERTY SITUATED ON MORE THAN ONE ACRE? # OF ACRES: _____ LAND USED FOR: _____			6. ANY UNCORRECTED FIRE OR BUILDING CODE VIOLATIONS?						
7. IS THE DWELLING / HOME FOR SALE? (no explanation required)									
8. IS PROPERTY WITHIN 300 FEET OF A COMMERCIAL OR NON-RESIDENTIAL PROPERTY? (If "YES", describe in detail)									
9. IS THERE A TRAMPOLINE ON THE PREMISES? a. IF "YES", IS THERE A SAFETY NET? (no explanation needed)									
10. WAS THE STRUCTURE ORIGINALLY BUILT FOR OTHER THAN A PRIVATE RESIDENCE AND THEN CONVERTED? ORIGINAL OCCUPANCY: _____									
11. ANY LEAD PAINT?									
12. IF A FUEL TANK IS ON PREMISES, HAS OTHER INSURANCE BEEN OBTAINED FOR THE TANK? (If "YES", provide the name of the insurance company, the applicable limit and the cleanup sublimit)									
INSURANCE COMPANY: _____		LIMIT: _____		CLEANUP/SUBLIMIT: _____					
13. IS THE RESIDENCE IN A GATED COMMUNITY? NAME OF COMMUNITY: _____									
14. IF BUILDING IS UNDER CONSTRUCTION, IS THE APPLICANT THE GENERAL CONTRACTOR?									
START DATE	COMP DATE	INT	EXT	ADDITION	ADD LEVEL	STRUC CHANGES	MATERIALS UNATTACHED	OCC DURING REN	COST OF PROJECT
		%	%	sq. ft.	sq. ft.	<input type="checkbox"/> Y / N	<input type="checkbox"/> INCL <input type="checkbox"/> EXCL	<input type="checkbox"/> Y / N	\$
15. IS THERE AN APPROVED CARBON MONOXIDE ALARM IN OPERATING CONDITION WITHIN THE MANDATED NUMBER OF FEET OF EVERY ROOM USED FOR SLEEPING PURPOSES? (IL - 15 FT) (no explanation needed)									
16. IS THE NAMED INSURED THE OWNER OF THE PROPERTY? (If "NO", provide the name of the owner)									
OWNER'S NAME: _____									

GENERAL INFORMATION - RENTERS AND CONDOS ONLY LOC #:

EXPLAIN ALL "NO" RESPONSES		Y / N
1. IS THERE A MANAGER ON THE PREMISES? MANAGER'S NAME: _____	PHONE (A/C,No): _____	
2. IS THERE A SECURITY ATTENDANT?		
3. IS THE BUILDING ENTRANCE LOCKED?		

ADDITIONAL INTEREST (Attach ACORD 45, Additional Interest Schedule, if more space is required)

INTEREST	NAME AND ADDRESS RANK: _____	EVIDENCE:	CERTIFICATE	SEND BILL	INTEREST IN ITEM NUMBER	
<input type="checkbox"/> ADDITIONAL INSURED	FREEDOM MORTGAGE CORPORATION ITS SCRS &/OR ASSIGNS ATIMA P O BOX 100562 FLORENCE, SC 29502-0562				LOCATION:	BUILDING:
<input type="checkbox"/> LENDER'S LOSS PAYABLE					VEHICLE:	BOAT:
<input type="checkbox"/> LIENHOLDER					ITEM CLASS:	ITEM:
<input type="checkbox"/> LOSS PAYEE					ITEM DESCRIPTION	
<input checked="" type="checkbox"/> MORTGAGEE						
<input type="checkbox"/> TRUSTEE						
REFERENCE / LOAN #: 0108615717						

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

<input type="checkbox"/> EARTHQUAKE APPLICATION	<input type="checkbox"/> PERSONAL INLAND MARINE SECTION	<input type="checkbox"/> REPLACEMENT COST ESTIMATE	<input type="checkbox"/> WATERCRAFT SECTION
<input type="checkbox"/> FLOOD EXCLUSION NOTICE	<input type="checkbox"/> PERS UMBRELLA APPLICATION SECTION	<input type="checkbox"/> RESIDENCE BASED BUSINESS SUPP	<input type="checkbox"/> WINDSTORM LOSS MITIGATION
<input type="checkbox"/> LEAD FREE PAINT CERTIFICATION	<input type="checkbox"/> PHOTOGRAPH	<input type="checkbox"/> SOLID FUEL SUPPLEMENT	
<input type="checkbox"/> MOBILE HOME SUPPLEMENT	<input type="checkbox"/> PROTECTION DEVICE CERTIFICATE	<input type="checkbox"/> STATE SUPPLEMENT(S) (If applicable)	

SEE ADDITIONAL REMARKS SCHEDULE FOR MORE INFORMATION (ACORD 101)

BINDER / NOTICE OF INFORMATION PRACTICES

INSURANCE BINDER		IF THE "BINDER" BOX TO THE LEFT IS COMPLETED, THE FOLLOWING CONDITIONS APPLY: THIS COMPANY BINDS THE KIND(S) OF INSURANCE STIPULATED ON THIS APPLICATION. THIS INSURANCE IS SUBJECT TO THE TERMS, CONDITIONS AND LIMITATIONS OF THE POLICY(IES) IN CURRENT USE BY THE COMPANY. THIS BINDER MAY BE CANCELLED BY THE INSURED BY SURRENDER OF THIS BINDER OR BY WRITTEN NOTICE TO THE COMPANY STATING WHEN CANCELLATION WILL BE EFFECTIVE.
EFFECTIVE DATE	EXPIRATION DATE	
TIME	12:01 AM	
	NOON	
COVERAGE IS NOT BOUND		

THIS BINDER MAY BE CANCELLED BY THE COMPANY BY NOTICE TO THE INSURED IN ACCORDANCE WITH THE POLICY CONDITIONS. THIS BINDER IS CANCELLED WHEN REPLACED BY A POLICY. IF THIS BINDER IS NOT REPLACED BY A POLICY, THE COMPANY IS ENTITLED TO CHARGE A PREMIUM FOR THE BINDER ACCORDING TO THE RULES AND RATES IN USE BY THE COMPANY. THE QUOTED PREMIUM IS SUBJECT TO VERIFICATION AND ADJUSTMENT, WHEN NECESSARY, BY THE COMPANY.

APPLICABLE IN ARIZONA: Binders are effective for no more than 90 days. APPLICABLE IN COLORADO: The insurer has thirty (30) business days, commencing from the effective date of coverage, to evaluate the issuance of the insurance policy. APPLICABLE IN MARYLAND: The insurer has 45 business days, commencing from the effective date of coverage, to confirm eligibility for coverage under the insurance policy. APPLICABLE IN MICHIGAN: The policy may be cancelled at any time at the request of the insured. APPLICABLE IN MONTANA: No binder shall be valid beyond the issuance of the policy with respect to which it was given or beyond 90 days from its effective date, whichever period is the shorter. If the policy has not been issued, a binder may be extended or renewed beyond such 90 days with the written approval of the insurer. APPLICABLE IN OKLAHOMA: All policies shall expire at 12:01 AM standard time on the expiration date stated in the policy. APPLICABLE IN OREGON: Binders are effective for no more than ninety (90) days. A binder extension or renewal beyond such 90 days would require the written approval by the Director of the Department of Consumer and Business Services.

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. (Not applicable in AZ, CA, DE, KS, MA, MN, ND, NY, OR, VA or WV. Specific ACORD 38s are available for applicants in these states.) (Applicant's Initials): _____

Copy of the Notice of Information Practices (Privacy) has been given to the applicant. (Not required in all states, please contact your agent or broker for your state's requirements.)

FRAUD STATEMENTS / SIGNATURE

AGENCY CUSTOMER ID: _____

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.

APPLICANT'S STATEMENT: I HAVE READ THE ABOVE APPLICATION AND ANY ATTACHMENTS. I DECLARE THAT THE INFORMATION PROVIDED IN THEM IS TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. THIS INFORMATION IS BEING OFFERED TO THE COMPANY AS AN INDUCEMENT TO ISSUE THE POLICY FOR WHICH I AM APPLYING.

PRODUCER'S SIGNATURE	PRODUCER'S NAME (Please Print)	STATE PRODUCER LICENSE NO (Required in Florida)
APPLICANT'S SIGNATURE  SIGN HERE →	DATE 	NATIONAL PRODUCER NUMBER



ADDITIONAL REMARKS SCHEDULE

AGENCY PREMIER GROUP INS INC		NAMED INSURED CYDNI HOFFMAN	
POLICY NUMBER 607107519 633 1			
CARRIER TRAVELERS PERSONAL INSURANCE COMPANY	NAIC CODE 38130	EFFECTIVE DATE: 07/30/2020	

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,
 FORM NUMBER: ACORD 80 FORM TITLE: Homeowner Application

Coverage Level: Travelers Protect PLUS®

Optional Coverages

Optional Coverages	Endorsement	Limit	Premium
Water Back Up and Sump Discharge or Overflow Coverage	HQ-208 CW (08-18)	\$5,000	Included*
Personal Property Replacement Cost Loss Settlement	HQ-290 CW (05-17)		Included*
Windstorm or Hail Percentage Deductible	HQ-312 CW (05-17)		Included*
Additional Replacement Cost Protection Coverage 25% of Coverage A - Dwelling Limit	HQ-420 CW (11-18)	\$45,000	Included*

*Note: The additional cost or premium reduction for any optional coverage or package shown as "Included" is contained in the Total Policy Premium Amount.

Rating/Underwriting:

Months Unoccupied -
 Total Finished Living Area - 1590 SQFT
 Garage Type - Attached
 Roof Shape - Hip
 Number of Stories - 1
 Number of Bathrooms - 2

Rating/Underwriting: Protection Device Type

Protective Device	Type
Burglar Alarm	Central
Fire Alarm	Local
Smoke Detector	Regular
Sprinkler System	No
Water Sensor	None
Automatic Water Shutoff	None
Low Temperature Sensor	None

General Information:

1. Was this property purchased as a foreclosure or short sale in the last 6 months?
2. Is your entire home or any part of it available for rent, including short-term vacation rental or home sharing/swapping? No



PREMIER GROUP INS INC
 600 17TH ST STE 1425 N
 DENVER, CO 80202
 Phone: 1.720.457.1101 | Fax: (866) 948-8485

Name and Mailing Address
 CYDNI HOFFMAN
 315 LAND GRANT DR
 RICHMOND, TX 77406-2140

07/17/2020

FREEDOM MORTGAGE CORPORATION
 ITS SCRS &/OR ASSIGNS ATIMA
 P O BOX 100562
 FLORENCE, SC 29502-0562

Mortgage Invoice

Policy Details

Policyholder: CYDNI HOFFMAN
Loan Number: 0108615717
Residence Premises: 315 LAND GRANT DR
 RICHMOND, TX 77406-2140
Insurer: TRAVELERS PERSONAL INSURANCE COMPANY
Policy Period: 07/30/2020 to 07/30/2021
Policy Number: 607107519 633 1
Premium: \$2,033.00

Please cut along the line and mail the lower portion with your payment to TRAVELERS, PO BOX 660307, DALLAS, TX 75266-0307. Thank you.

Make checks payable to Travelers Indemnity Company and affiliates

CYDNI HOFFMAN

Policy Number 607107519 633 1
 FREEDOM MORTGAGE CORPORATION
 TRAVELERS PERSONAL INSURANCE
 PO BOX 660307
 DALLAS, TX 75266-0307

AMOUNT ENCLOSED	
TOTAL DUE	\$2,033.00
<i>Please pay the total due upon receipt to allow for continuation of coverage.</i>	

0036303731303735313940363333318500020330000020330081



TEXAS PERSONAL AUTO APPLICATION

DATE (MM/DD/YYYY)
07/17/2020

AGENCY PREMIER GROUP INS INC 600 17TH ST STE 1425 N DENVER, CO 80202		APPLICANT'S NAME AND MAILING ADDRESS (Include county & ZIP + 4) CYDNI HOFFMAN 315 LAND GRANT DR RICHMOND, TX 77406-2140				TELEPHONE NUMBER 832-844-9267	
CONTACT NAME: PHONE (A/C No. Ext): 720-457-1101 FAX (A/C No.): 866-948-8485 E-MAIL ADDRESS:		CARRIER CONSUMERS COUNTY MUTUAL INS. CO.				NAIC CODE 29246	
CODE: 0DKS65 SUBCODE:		PLAN QUANTUM 2.0		POLICY #: 6071075202221 ACCT #:		EFFECTIVE DATE 07/30/2020 EXPIRATION DATE 07/30/2021 <input checked="" type="checkbox"/> DIRECT AGENCY <input type="checkbox"/> MAIL POLICY TO AGENT <input type="checkbox"/> MAIL POLICY TO APPL PAYMENT PLAN EFT - MO	
AGENCY CUSTOMER ID:		<input type="checkbox"/> INDICATE IF MAILING ADDRESS IS GARAGING ADDRESS		FIRE DIST		FACILITY CODE	

RESIDENCE CURRENT RESIDENCE IS <input checked="" type="checkbox"/> OWNED <input type="checkbox"/> RENTED		PREVIOUS STREET ADDRESS (If less than 3 years)				CITY		STATE		ZIP + 4	
YRS AT ADDR CURR		YRS AT ADDR PREV		STREET ADDRESS		CITY		STATE		ZIP + 4	

ADDITIONAL GARAGING ADDRESS(ES)										
LOC	STREET	CITY	COUNTY	STATE	ZIP + 4	FIRE DIST				

VEHICLE DESCRIPTION / USE													TOTAL NUMBER OF VEHICLES IN HOUSEHOLD:								
VEH	LOC	YEAR	MAKE	MODEL	BODY TYPE	VIN	REG STATE	HP/CC	DATE LEASED	DATE PURCH	NEW/USED										
1		2020	TOYOT	RAV4 LE	PU	2T3H1RFV4LW072617	TX	2.5													
VEH	COST NEW	SYMBOL AGE GRP	COMP OTC SYM	COLL SYM	TERR	MILE 1 WAY WK/SCHL	# DAYS WEEK	# WKS MONTH	USAGE	PER-FORM	MULTI-CAR	CAR POOL	GAR CODE	ODOMETER READING	ANNUAL MILEAGE	GOVERN DRIVER	DRIVER USE % (Each veh must equal 100%)				
1					2211					B					Not Verified	1					
VEH	CLASS	PASSIVE SEAT BELT	AIRBAG DRV/BOTH	ANTI-LOCK BRAKES 2/4	ANTI-THEFT DEVICES	CREDITS AND SURCHARGES	VEH	CLASS	PASSIVE SEAT BELT	AIRBAG DRV/BOTH	ANTI-LOCK BRAKES 2/4	ANTI-THEFT DEVICES	CREDITS AND SURCHARGES								
1	4252	X	B	2	CATEGORY 4																

COVERAGES / PREMIUMS													
COVERAGES		LIMITS OF LIABILITY						VEHICLE # 1	VEHICLE #	VEHICLE #	VEHICLE #		
SINGLE LIMIT LIABILITY (CSL)		\$ EA ACCIDENT						\$	\$	\$	\$		
BODILY INJURY LIABILITY		\$ 100,000		\$ 300,000		\$ 300,000		EA ACCIDENT	\$527	\$	\$	\$	
PROPERTY DAMAGE LIABILITY		\$ 100,000		\$ 250		\$ 250		EA ACCIDENT	\$280	\$	\$	\$	
PERSONAL INJURY PROTECTION		\$ 2,500		\$		\$		EA PERSON	\$100	\$	\$	\$	
MEDICAL PAYMENTS		\$		\$		\$		EA PERSON	\$	\$	\$	\$	
UNINSURED / UNDERINSURED MOTORISTS		CSL \$		\$ 100,000		\$ 300,000		EA ACCIDENT	\$150	\$	\$	\$	
		BI \$ 100,000		\$ 250		\$ 250		EA ACCIDENT	\$92	\$	\$	\$	
		PD \$ 100,000		DEDUCTIBLE		DEDUCTIBLE		DEDUCTIBLE	\$92	\$	\$	\$	
COMPREHENSIVE / OTC		DED X \$500		\$		\$		\$	\$233	\$	\$	\$	
COLLISION		DED X \$500		\$		\$		\$	\$717	\$	\$	\$	
ACV UNLESS AMOUNT STATED		\$		\$		\$		\$	N/A	N/A	N/A	N/A	
TOWING & LABOR		\$		\$		\$		\$	\$	\$	\$	\$	
TRANS EXP / RENTAL RE		X \$50 / 1,500		\$ /		\$ /		\$ /	\$30	\$	\$	\$	
CODE	DESCRIPTION	LIMIT	LIMIT APPLIES TO	DEDUCTIBLE	OPTIONS								
	Roadside Assistance Coverage	\$ 15	Mls/Disabl	\$									
		\$		\$									
		\$		\$									
		\$		\$									
ESTIMATED TOTAL: \$2,143.00		PREMIUM DEPOSIT: \$178.51		POLICY FEE: \$		TOTAL PER VEHICLE \$2,139		\$	\$	\$	\$		

RESIDENT & DRIVER INFORMATION [List all residents & dependents (licensed or not) and regular operators]

#	NAME (AS IT APPEARS ON LICENSE)			SEX	MAR STAT	REL TO APPLIC	DATE OF BIRTH		
	FIRST NAME	MIDDLE NAME	LAST NAME						
1	Cydni		HOFFMAN	F	S	IN	01/07/1985		
#	OCCUPATION	DATE LIC	STD > 100	GOOD STD	DRV TRAIN	ACC PREV CSE DATE	DRIVERS LICENSE #	LIC STATE	SOCIAL SECURITY #
1		01/07/2001					01296522	TX	

**ACCIDENTS / CONVICTIONS (Note: Your driving record is verified with the state motor vehicle department and other insurers)
Attach ACORD 99, Accidents / Convictions Schedule, if more space is required**

HAS ANY DRIVER SHOWN ABOVE HAD AN ACCIDENT, REGARDLESS OF FAULT, OR BEEN CONVICTED OF A MOVING VIOLATION WITHIN THE LAST _____ YEARS?						Y / N	IF YES, INDICATE BELOW. ALSO INCLUDE COMPREHENSIVE INSURANCE LOSSES.		
DRV #	DATE OF ACCIDENT / CONVICTION	DESCRIPTION OF ACCIDENT OR CONVICTION				PLACE OF ACCIDENT / CONVICTION	BI OR DEATH Y / N	AMOUNT OF PROPERTY DAMAGE	
1	05/11/2017	All Other Accidents					N	\$778	

ADDITIONAL INTEREST

<input type="checkbox"/>	ADDL INS <input type="checkbox"/>	NAME AND ADDRESS	VEH #: 1
<input checked="" type="checkbox"/>	LOSS PAYEE	TOYOTA MOTOR CREDIT CORP	LOAN NUMBER
<input type="checkbox"/>	LENDER'S LOSS PAYABLE	PO BOX 105386 ATLANTA, GA 30348-5386	
<input type="checkbox"/>	ADDL INS <input type="checkbox"/>	NAME AND ADDRESS	VEH #:
<input type="checkbox"/>	LOSS PAYEE		LOAN NUMBER
<input type="checkbox"/>	LENDER'S LOSS PAYABLE		

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

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

PRIOR COVERAGE

PRIOR CARRIER Allstate	# OF YEARS WITH COMPANY	ASSIGNED RISK? <input type="checkbox"/> Y / N
PRIOR PRODUCER	PRIOR POLICY NUMBER	EXPIRATION DATE 09/03/2020

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES										Y / N
1. WITH THE EXCEPTION OF ANY ENCUMBRANCES, ARE ANY VEHICLES FOR WHICH INSURANCE IS REQUESTED NOT SOLELY OWNED BY AND REGISTERED TO THE APPLICANT?										N
VEH #	NAME OF OTHER OWNER				VEH #	NAME OF OTHER OWNER				
2. ANY CAR MODIFIED / SPECIAL EQUIPMENT? (Include customized vans / pickups)										N
VEH #	DESCRIPTION	COST	VEH #	DESCRIPTION	COST					
3. ANY EXISTING DAMAGE TO VEHICLE? (Include damaged glass)										N
VEH #	DESCRIPTION				VEH #	DESCRIPTION				
4. ANY OTHER LOSSES NOT SHOWN IN THE ACCIDENTS / CONVICTIONS SECTION THAT WERE INCURRED DURING THE TIME PERIOD SPECIFIED IN THAT SECTION?										Y
DRV #	DESCRIPTION	COST	DRV #	DESCRIPTION	COST					
	All claims other than Comprehe	\$778			\$					
5. ANY OTHER AUTO INSURANCE IN HOUSEHOLD? (Include any provided by employer)										
NAMED INSURED	YEAR	MAKE	MODEL	CARRIER	NAIC #	POLICY NUMBER				

GENERAL INFORMATION (continued)

AGENCY CUSTOMER ID: _____

EXPLAIN ALL "YES" RESPONSES					Y / N
6. ANY OTHER INSURANCE WITH THIS COMPANY?					Y
POLICY NUMBER	TYPE OF INSURANCE		POLICY NUMBER	TYPE OF INSURANCE	
9999999996331	HOME				
7. ANY HOUSEHOLD MEMBER IN MILITARY SERVICE?					N
DRV #	BRANCH	RANK	BASE LOCATION	VEH AT BASE (Y / N)	
8. ANY DRIVERS LICENSE BEEN SUSPENDED / REVOKED?					N
DRV #	SUSPENSION PERIOD		EXPLANATION	REINSTATEMENT DATE	
	Start Date:	End Date:			
9. ANY DRIVER HAVE A PHYSICAL IMPAIRMENT THAT WOULD AFFECT THE ABILITY TO DRIVE?					N
DRV #	DESCRIPTION OF SPECIAL EQUIPMENT IN VEHICLE				
10. ANY DRIVER UNDERGOING A COURSE OF MEDICAL TREATMENT FOR A PHYSICAL / MENTAL IMPAIRMENT THAT WOULD AFFECT THE ABILITY TO DRIVE?					N
DRV #	EXPLANATION				
11. ANY FINANCIAL RESPONSIBILITY FILING?					N
DRV #	REASON FOR FILING			FILING DATE	
12. HAS INSURANCE BEEN TRANSFERRED WITHIN THE AGENCY?					N
13. ANY COVERAGE DECLINED, CANCELLED, OR NON-RENEWED DURING THE LAST THREE (3) YEARS?					N
DRV #	REASON DECLINED, CANCELLED, OR NON-RENEWED				
14. IS THIS BROKERED BUSINESS TO THE AGENT?					
15. HAS AGENT INSPECTED VEHICLE?					N
16. HAS ANY APPLICANT OR DRIVER HAD A FORECLOSURE, REPOSSESSION, BANKRUPTCY, JUDGEMENT OR LIEN DURING THE LAST FIVE (5) YEARS?					
DRV #	EXPLANATION				
17. HAS ANY NAMED INSURED DRIVEN WITHOUT LIABILITY INSURANCE DURING ANY PART OF THE LAST SIX (6) MONTHS?					N
DRV #	EXPLANATION				

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

STATE SUPPLEMENT	DRIVER TRAINING CERTIFICATE	MEDICAL STATEMENT	BILL OF SALE
NO-FAULT APPLICATION	GOOD STUDENT CERTIFICATE	MOTOR VEHICLE REPORT	
YOUNG DRIVER QUESTIONNAIRE	ANTI-THEFT DEVICE CERTIFICATE	PHOTOGRAPH	

Your policy premium shown on this application does include the Anti-Theft Fee amount of \$4.00. Amount(s) will be calculated into your policy billing.

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

--

BINDER / SIGNATURE

INSURANCE BINDER		IF THE "BINDER" BOX TO THE LEFT IS COMPLETED, THE FOLLOWING CONDITIONS APPLY: THIS COMPANY BINDS THE KIND(S) OF INSURANCE STIPULATED ON THIS APPLICATION. THIS INSURANCE IS SUBJECT TO THE TERMS, CONDITIONS AND LIMITATIONS OF THE POLICY(IES) IN CURRENT USE BY THE COMPANY. THIS BINDER MAY BE CANCELLED BY THE INSURED BY SURRENDER OF THIS BINDER OR BY WRITTEN NOTICE TO THE COMPANY STATING WHEN CANCELLATION WILL BE EFFECTIVE.
EFFECTIVE DATE	EXPIRATION DATE	
TIME	12:01 AM	
	NOON	
COVERAGE IS NOT BOUND		

THIS BINDER MAY BE CANCELLED BY THE COMPANY BY NOTICE TO THE INSURED IN ACCORDANCE WITH THE POLICY CONDITIONS. THIS BINDER IS CANCELLED WHEN REPLACED BY A POLICY. IF THIS BINDER IS NOT REPLACED BY A POLICY, THE COMPANY IS ENTITLED TO CHARGE A PREMIUM FOR THE BINDER ACCORDING TO THE RULES AND RATES IN USE BY THE COMPANY. THE QUOTED PREMIUM IS SUBJECT TO VERIFICATION AND ADJUSTMENT, WHEN NECESSARY, BY THE COMPANY.

PERSONAL INFORMATION ABOUT YOU, INCLUDING INFORMATION FROM A CREDIT OR OTHER INVESTIGATIVE REPORT, MAY BE COLLECTED FROM PERSONS OTHER THAN YOU IN CONNECTION WITH THIS APPLICATION FOR INSURANCE AND SUBSEQUENT AMENDMENTS AND RENEWALS. SUCH INFORMATION AS WELL AS OTHER PERSONAL AND PRIVILEGED INFORMATION COLLECTED BY US OR OUR AGENTS MAY IN CERTAIN CIRCUMSTANCES BE DISCLOSED TO THIRD PARTIES WITHOUT YOUR AUTHORIZATION. CREDIT SCORING INFORMATION MAY BE USED TO HELP DETERMINE EITHER YOUR ELIGIBILITY FOR INSURANCE OR THE PREMIUM YOU WILL BE CHARGED. WE MAY USE A THIRD PARTY IN CONNECTION WITH THE DEVELOPMENT OF YOUR SCORE. YOU MAY HAVE THE RIGHT TO REVIEW YOUR PERSONAL INFORMATION IN OUR FILES AND REQUEST CORRECTION OF ANY INACCURACIES. YOU MAY ALSO HAVE THE RIGHT TO REQUEST IN WRITING THAT WE CONSIDER EXTRAORDINARY LIFE CIRCUMSTANCES IN CONNECTION WITH THE DEVELOPMENT OF YOUR CREDIT SCORE. THESE RIGHTS MAY BE LIMITED IN SOME STATES. PLEASE CONTACT YOUR AGENT OR BROKER TO LEARN HOW THESE RIGHTS MAY APPLY IN YOUR STATE OR FOR INSTRUCTIONS ON HOW TO SUBMIT A REQUEST TO US FOR A MORE DETAILED DESCRIPTION OF YOUR RIGHTS AND OUR PRACTICES REGARDING PERSONAL INFORMATION.

APPLICANT'S STATEMENT: I HAVE READ THE ABOVE APPLICATION AND ANY ATTACHMENTS. I DECLARE THAT THE INFORMATION PROVIDED IN THEM IS TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. THIS INFORMATION IS BEING OFFERED TO THE COMPANY AS AN INDUCEMENT TO ISSUE THE POLICY FOR WHICH I AM APPLYING. IN ADDITION, IF THE AUTO PLAN OR COMPANY DESIGNATED IN THIS APPLICATION IS NON-STANDARD, I CERTIFY THAT I UNDERSTAND THE RATES FOR THIS COVERAGE ARE HIGHER THAN NORMAL AND THEY ARE ACCEPTABLE TO ME AS I HAVE BEEN UNABLE TO OBTAIN COVERAGE DESIRED THROUGH THE NORMAL INSURANCE MARKET.

PRODUCER'S STATEMENT: I CERTIFY TO THE BEST OF MY KNOWLEDGE AND BELIEF THAT THE SIGNATURE OF THE APPLICANT IS THE PERSONAL SIGNATURE OF THE APPLICANT.	HOW LONG HAVE YOU KNOWN THE APPLICANT?
--	--

I UNDERSTAND AND ACKNOWLEDGE THAT UNINSURED / UNDERINSURED MOTORISTS (UM / UIM), BODILY INJURY (BI) AND PROPERTY DAMAGE (PD) COVERAGES HAVE BEEN EXPLAINED TO ME. I HAVE BEEN OFFERED THE OPTIONS OF SELECTING UM / UIM LIMITS EQUAL TO MY LIABILITY LIMITS, UM / UIM LIMITS LOWER THAN MY LIABILITY LIMITS OR TO REJECT UM / UIM BI AND/OR UM / UIM PD COVERAGES ENTIRELY. (INITIALS)

1. I SELECT UM / UIM BODILY INJURY LIMIT(S) INDICATED IN THIS APPLICATION. _____
2. I REJECT UM / UIM BODILY INJURY COVERAGE IN ITS ENTIRETY. _____
3. I SELECT UM / UIM PROPERTY DAMAGE LIMIT(S) INDICATED IN THIS APPLICATION. _____
4. I REJECT UM / UIM PROPERTY DAMAGE COVERAGE IN ITS ENTIRETY. _____

I UNDERSTAND AND ACKNOWLEDGE THAT PERSONAL INJURY PROTECTION COVERAGE HAS BEEN EXPLAINED TO ME AND I HAVE BEEN OFFERED THIS COVERAGE. IF I HAVE REJECTED THIS COVERAGE, MY INITIALS ARE INCLUDED HERE. (INITIALS) _____

I UNDERSTAND THAT THE COVERAGE SELECTION AND LIMIT CHOICES INDICATED HERE WILL APPLY TO ALL FUTURE POLICY RENEWALS, CONTINUATIONS AND CHANGES UNLESS I NOTIFY YOU OTHERWISE IN WRITING.

APPLICANT'S SIGNATURE	DATE	PRODUCER'S SIGNATURE	NATIONAL PRODUCER NUMBER
-----------------------	------	----------------------	--------------------------



Electronic Funds Transfer Authorization

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

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

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

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

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

Authorization Agreement for Travelers Electronic Funds Transfer Payment Plan

Name: CYDNI HOFFMAN

Policy Number: 607107520 222 1

Address: 315 LAND GRANT DR

Policy Number: _____

Policy Number: _____

RICHMOND, TX 77406-2140

Policy Number: _____

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

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

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

Signature: _____ Date: _____

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

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