

**Quote Proposal**

**Customer Number:** 1000425626  
**Policy Number:** B161625 00

**Quoted Policy Term:** 10/01/2022 to 10/01/2023  
**Date Quoted:** 09/28/2022

**Customer Name and Address:**  
Team Recovery Inc  
4610 Tradition Way  
Sylvania, OH 43560

**Agency Name and Address:** 34862  
STAPLETON INS & RISK MGMT INC  
P O BOX 1118  
SYLVANIA, OH 43560  
419-882-0016

Thank you for the opportunity to provide a quote.

See below for a summary of premium quoted. Refer to additional pages for more details.

This quote proposal is based on the underwriting and rating information provided to date, **and may contain coverage terms that are different than originally requested. Please review the terms of this quote proposal carefully, including deductibles and retention.** Please keep in mind this quote proposal may be subject to additional rating, pricing or underwriting considerations, as well as to a loss control survey and compliance with its recommendations.

**These rate levels and this quote proposal are valid for 60 days or until 7 days past the proposed effective date, whichever comes first. This quote proposal is valid until: 10/08/2022**

| Coverage Part                               | Premium  |
|---|----------|
| Directors And Officers NFP                  | \$450.00 |
| Total Premium:                              | \$450.00 |
| Total Including Taxes, Fees and Surcharges: | \$450.00 |

Quinn Jevens  
Phone: 1-800-236-5010 Extension: 3522 | Fax: 1-800-320-1622  
Email: qjevens@wbmi.com

**This quote proposal is not the insurance contract.  
Only the actual provisions of the issued policy will apply.**

**Quote Proposal**

---

**Customer Number:** 1000425626  
**Policy Number:** B161625 00

**Quoted Policy Term:** 10/01/2022 to 10/01/2023  
**Date Quoted:** 09/28/2022

---

**Customer Name and Address:**  
Team Recovery Inc  
4610 Tradition Way  
Sylvania, OH 43560

**Agency Name and Address:** 34862  
STAPLETON INS & RISK MGMT INC  
P O BOX 1118  
SYLVANIA, OH 43560  
419-882-0016

---

**Account Premium:**

See the Quote Proposal Premium Summary

**This quote is subject to the following and cannot be bound until all requested information is received and reviewed by underwriting for acceptability.**

**Directors and Officers:**

- Submit the completed, original signed application
- Copy of the Articles of Incorporation or Bylaws
- Copy of the current financials showing total assets

**This quote proposal is not the insurance contract.  
Only the actual provisions of the issued policy will apply.**

# NOTICE OF PAYMENT PLAN OPTIONS

West Bend Mutual Insurance Company offers several payment plan options. The various payment plans are described below.

1. Annual premium of \$125 or more.
  - a. Semiannual.
    - (1) First payment of 50 percent of total premium plus an installment fee due at inception.
    - (2) Second payment of 50 percent of total premium plus an installment fee due in six months.
  - b. Quarterly.
    - (1) First payment of 25 percent of total premium plus an installment fee due at inception.
    - (2) Second payment of 25 percent of total premium plus an installment fee due in three months.
    - (3) Third payment of 25 percent of total premium plus an installment fee due in six months.
    - (4) Fourth payment of 25 percent of total premium plus an installment fee due in nine months.
  - c. Down payment plus nine.
    - (1) Down payment of 25 percent of total premium plus an installment fee due at inception.
    - (2) Remaining nine monthly payments of 8.333 percent of total premium plus an installment fee on each installment.
  - d. In addition, the following payment plans are available. The down payment for each of these plans is the first installment plus an installment fee.
    - (1) 10 equal payments plus an installment fee on each installment.
    - (2) 12 equal payments plus an installment fee on each installment.
2. For more information regarding payment options, visit [www.thesilverlining.com](http://www.thesilverlining.com).

## FEES:

- Installment Fees apply to each installment.
- A \$7.00 Installment Fee applies when receiving paper invoices.
- A \$4.00 Installment Fee applies when receiving electronic invoices.
- A \$1.00 Installment Fee applies when receiving electronic invoices and utilizing automatic payments.
- Items returned by the financial institution as unpaid will generate a \$25.00 fee.
- A \$25.00 reinstatement fee applies to policies that have lapsed for non-payment. The fee applies per policy. If the lapse is the result of a non-sufficient funds check, the non-sufficient funds fee will be charged in addition to the reinstatement fee.

## PLEASE NOTE:

When sending payment for a plan other than the installment amount invoiced, include a statement with your payment indicating the desired plan.

If we receive payment prior to binding coverage, we may process the payment. However, our processing of the payment does not bind coverage. If we do not bind coverage for any reason, we will return the payment.

Any questions you may have about payment plan options or to change a current payment plan, please contact West Bend's Accounting Department (1-800-236-5002).

## Binding Instructions

### **General Information**

Customer Name: Team Recovery Inc  
Quote/Policy Number: B161625

Quoted Policy Term: 10/01/2022 to 10/01/2023

Thank you for choosing West Bend Mutual Insurance Company, we appreciate your business! To ensure that we process your new business correctly, please help us verify the following information:

Effective Date: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Customer Care Agencies: Please issue this policy through Customer Care (circle one):   Yes   No

Direct Mail: Please mail this policy directly to the insured (circle one):   Yes   No

### **Payment Plan Options**

Please issue with the following Payment Plan Option (circle one):  
Note – Special Events must be paid in full at the time of binding.

Annual

Quarterly

10 Equal Payments

Semi-Annual

Down Payment Plus Nine

12 Equal Payments

Checks for down payment should be made payable to West Bend Mutual Insurance Company and sent with your binding instructions to 1900 S 18th Avenue, West Bend, WI 53095.

### **Premiums**

Premiums should be issued per line as follows:

General Liability           \$ \_\_\_\_\_

Crime & Fidelity:           \$ \_\_\_\_\_

Property:                   \$ \_\_\_\_\_

Commercial Auto:           \$ \_\_\_\_\_

Work Comp:                \$ \_\_\_\_\_

Inland Marine:             \$ \_\_\_\_\_

Umbrella:                 \$ \_\_\_\_\_

Liquor Liability:           \$ \_\_\_\_\_

EPLI:                      \$ \_\_\_\_\_

**Directors and Officers:**   \$ \_\_\_\_\_

### **Comments:**

---

---

---

### **Loss History:**

- Already submitted with the original application materials.
- Have been ordered from the previous carrier and will be forwarded upon receipt.
- Not applicable – no prior loss history available or this is a new business venture.

**THIS ENDORSEMENT IS ATTACHED TO AND MADE PART OF YOUR POLICY IN RESPONSE TO THE DISCLOSURE REQUIREMENTS OF THE TERRORISM RISK INSURANCE ACT. THIS ENDORSEMENT DOES NOT GRANT ANY COVERAGE OR CHANGE THE TERMS AND CONDITIONS OF ANY COVERAGE UNDER THE POLICY.**

## **DISCLOSURE PURSUANT TO TERRORISM RISK INSURANCE ACT**

### **SCHEDULE**

| <b>SCHEDULE – PART I</b>  |             |
|---|-------------|
| <b>Terrorism Premium (Certified Acts)</b>   | <b>\$</b>   |
| <b>This premium is the total Certified Acts premium attributable to the following Coverage Part(s), Coverage Form(s) and/or Policy(ies):</b>  |             |
| If you have previously rejected coverage under this policy for Certified Acts of Terrorism under the Terrorism Risk Insurance Act, Coverage will remain excluded unless you request coverage within 30 days of the policy effective date. |             |
| <b>Additional information, if any, concerning the terrorism premium:</b>  |             |
| <b>SCHEDULE – PART II</b>   |             |
| <b>Federal share of terrorism losses</b>  | <b>80 %</b> |
| (Refer to Paragraph <b>B.</b> in this endorsement.)   |             |
| Information required to complete this Schedule, if not shown above, will be shown in the Declarations.  |             |

**A. Disclosure Of Premium**

In accordance with the federal Terrorism Risk Insurance Act, we are required to provide you with a notice disclosing the portion of your premium, if any, attributable to coverage for terrorist acts certified under the Terrorism Risk Insurance Act. The portion of your premium attributable to such coverage is shown in the Schedule of this endorsement or in the policy Declarations.

**B. Disclosure Of Federal Participation In Payment Of Terrorism Losses**

The United States Government, Department of the Treasury, will pay a share of terrorism losses insured under the federal program. The federal share equals a percentage (as shown in Part II of the Schedule of this endorsement or in the policy Declarations) of that portion of the amount of such insured losses that exceeds the applicable insurer retention. However, if aggregate insured losses attributable to terrorist acts certified under the Terrorism Risk Insurance Act exceed \$100 billion in a calendar year, the Treasury shall not make any payment for any portion of the amount of such losses that exceeds \$100 billion.

**C. Cap On Insurer Participation In Payment Of Terrorism Losses**

If aggregate insured losses attributable to terrorist acts certified under the Terrorism Risk Insurance Act exceed \$100 billion in a calendar year and we have met our insurer deductible under the Terrorism Risk Insurance Act, we shall not be liable for the payment of any portion of the amount of such losses that exceeds \$100 billion, and in such case insured losses up to that amount are subject to pro rata allocation in accordance with procedures established by the Secretary of the Treasury.

# TERRORISM RISK INSURANCE ACT REJECTION FORM

**Customer Number:** 1000425626  
**Policy Number:** B161625  
**Policy Effective Date:** 2022-10-01  
**Insured Name:** Team Recovery Inc  
**Agent Name:** STAPLETON INS & RISK MGMT INC  
**Agent Code:** 34862

The disclosure notice required by the Terrorism Risk Insurance Act (the "Act") is attached to your policy as an endorsement. The premium for coverage against certified acts of terrorism as provided for by the Act is shown on the policy declaration pages.

You have the option to reject coverage under the Act. If you choose to reject coverage for certified acts of terrorism, this rejection form must be signed and returned to our office.

This form must be received by us within 30 days after the policy effective date if you desire to reject the coverage. If this form is not received within this time period, coverage against certified acts of terrorism will remain on this policy for the remainder of the policy term and you will be required to pay the applicable premium.

If a location(s) covered by this policy is located in a Standard Fire Protection state\*, then the requirements for fire coverage, as to that location, are established by law and you cannot reject coverage for that location for fire losses resulting from an act of terrorism. The premium for fire coverage is shown separately on the policy declarations page. The premium for fire coverage applicable to a location in a Standard Fire Protection state will not be returned to you even if you indicate to us that you wish to reject coverage for certified acts of terrorism.

I understand and agree by signing below, that except for fire coverage on locations in Standard Fire Protection states, I have elected to reject coverage for certified acts of terrorism under the Terrorism Risk Insurance Act.

---

Policyholder's Signature

---

Date

*If coverage against certified acts of terrorism is rejected, the endorsement removing this coverage will be processed using the policy effective date.*

\*Standard Fire Protection States:

- Arizona (Commercial Residential Property Coverage)
- Illinois (Property Coverages)
- Iowa (Property Coverages)
- Missouri (Property & Inland Marine Coverages)
- North Carolina (Property Coverages)
- Virginia (Property Coverages)
- Wisconsin (Property & Inland Marine Coverages)

**Not-For-Profit Directors, Officers and Trustees Liability Declaration**

**Customer Number:** 1000425626  
**Policy Number:** B161625 00

**Policy Period:** 10-01-2022 to 10-01-2023  
at 12:01 AM Standard Time at Your Mailing Address Shown Below

**Named Insured and Address:**  
Team Recovery Inc  
4610 Tradition Way  
Sylvania, OH 43560

**Agency Name and Address:** 34862  
STAPLETON INS & RISK MGMT INC  
P O BOX 1118  
SYLVANIA, OH 43560  
419-882-0016

Insured is a(n) Non-profit Organization

This is a claims made policy – please read it carefully. Coverage is limited to liability for claims first made against you while this coverage is in force.

**Limits of Insurance**

Each Claim Limit \$1,000,000

Aggregate Limit \$1,000,000

**Self-Insured Retention** \$1,000 Each Claim

**Retroactive Date**

Retroactive Date: 10-01-2022

This insurance does not apply to any claim occurring before the Retroactive Date shown above.

**Total Premium** \$450.00

Report Claims to: NSI Claims Dept.  
PO Box 620976  
Middleton, WI 53562  
Ph: (800) 760-9250 Fax: (877) 434-9585

**This is not a bill.** A billing invoice will be sent separately.

See attached Forms Schedule for forms and endorsements applicable to this coverage.

Countersignature \_\_\_\_\_

(Authorized Representative)

Date \_\_\_\_\_



**Not-For-Profit Directors, Officers and Trustees Liability Declaration**

**Customer Number:** 1000425626  
**Policy Number:** B161625 00

**Policy Period:** 10-01-2022 to 10-01-2023  
at 12:01 AM Standard Time at Your Mailing Address Shown Below

**Named Insured and Address:**  
Team Recovery Inc  
4610 Tradition Way  
Sylvania, OH 43560

**Agency Name and Address:** 34862  
STAPLETON INS & RISK MGMT INC  
P O BOX 1118  
SYLVANIA, OH 43560  
419-882-0016

**Classification Schedule**

| Business Classification | Total Assets  | Premium |
|-------------------------|---------------|---------|
| Social Service Offices  | \$0-\$500,000 | \$450   |

**Miscellaneous Premiums**

| Description                  | Form Number | Premium      |
|------------------------------|-------------|--------------|
| Terrorism Risk Insurance Act |             | 0            |
| <b>Total Premium:</b>        |             | <b>\$450</b> |

**Not-For-Profit Directors, Officers and Trustees Liability Declaration**

**Customer Number:** 1000425626  
**Policy Number:** B161625 00

**Policy Period:** 10-01-2022 to 10-01-2023  
at 12:01 AM Standard Time at Your Mailing Address Shown Below

**Named Insured and Address:**  
Team Recovery Inc  
4610 Tradition Way  
Sylvania, OH 43560

**Agency Name and Address:** 34862  
STAPLETON INS & RISK MGMT INC  
P O BOX 1118  
SYLVANIA, OH 43560  
419-882-0016

**Forms Schedule**

| Number | Edition | Description  |
|--------|---------|--|
| NA0002 | 0222    | NOT-FOR-PROFIT ORGANIZATION DIRECTORS, OFFICERS AND TRUSTEES LIABILITY INSURANCE APPLICATION |
| IL0985 | 1220    | DISCLOSURE PURSUANT TO TERRORISM RISK INSURANCE ACT  |
| WB214  | 0119    | MEMBERSHIP AND VOTING NOTICE   |
| WB660  | 0420    | TWO OR MORE COVERAGE FORMS OR POLICIES ISSUED BY US  |
| NS0103 | 0304    | EXCLUSION - DIRECTORS AND OFFICERS LOAN  |
| NS0109 | 1008    | EXCLUSION - HARASSMENT, MOLESTATION AND SEXUAL MISCONDUCT                                    |
| NS0104 | 0304    | EXCLUSION - PEER REVIEW/STANDARD SETTING   |
| WB439  | 0115    | CAP ON LOSSES FROM CERTIFIED ACTS OF TERRORISM   |
| NS0309 | 0219    | NOT-FOR-PROFIT ORGANIZATION DIRECTORS, OFFICERS AND TRUSTEES LIABILITY INSURANCE POLICY      |
| NS0278 | 0219    | OHIO CHANGES - CANCELLATION AND NONRENEWAL   |

**This is not a complete representation of all forms that may be attached to your policy**