



# NORTH CAROLINA REAL ESTATE COMMISSION

## Residential Property And Owners' Association Disclosure Statement

*Protecting the Public Interest in Real Estate Brokerage Transactions*

Property Address/Description: **8730 Grassy Creek Rd, Bullock, NC 27507**

Owner's Name(s): **Gray Family Ranch LLC**

North Carolina law N.C.G.S. 47E requires residential property owners to complete this Disclosure Statement and provide it to the buyer prior to any offer to purchase. There are limited exemptions for completing the form, such as new home construction that has never been occupied. Owners are advised to seek legal advice if they believe they are entitled to one of the limited exemptions contained in N.C.G.S. 47E-2.

An owner is required to provide a response to every question by selecting Yes (Y), No (N), No Representation (NR), or Not Applicable (NA). An owner is not required to disclose any of the material facts that have a NR option, even if they have knowledge of them. However, failure to disclose latent (hidden) defects may result in civil liability. The disclosures made in this Disclosure Statement are those of the owner(s), not the owner's broker.

- If an owner selects Y or N, the owner is only obligated to disclose information about which they have actual knowledge. If an owner selects Y in response to any question about a problem, the owner must provide a written explanation or attach a report from an attorney, engineer, contractor, pest control operator, or other expert or public agency describing it.
- If an owner selects N, the owner has no actual knowledge of the topic of the question, including any problem. If the owner selects N and the owner knows there is a problem or that the owner's answer is not correct, the owner may be liable for making an intentional misstatement.
- If an owner selects NR, it could mean that the owner (1) has knowledge of an issue and chooses not to disclose it; or (2) simply does not know.
- If an owner selects NA, it means the property does not contain a particular item or feature.

For purposes of completing this Disclosure Statement: **“Dwelling”** means any structure intended for human habitation, **“Property”** means any structure intended for human habitation and the tract of land, and **“Not Applicable”** means the item does not apply to the property or exist on the property.

**OWNERS:** The owner must give a completed and signed Disclosure Statement to the buyer no later than the time the buyer makes an offer to purchase property. If the owner does not, the buyer can, under certain conditions, cancel any resulting contract. An owner is responsible for completing and delivering the Disclosure Statement to the buyer even if the owner is represented in the sale of the property by a licensed real estate broker and the broker must disclose any material facts about the property that the broker knows or reasonably should know, regardless of the owner's response.

The owner should keep a copy signed by the buyer for their records. If something happens to make the Disclosure Statement incorrect or inaccurate (for example, the roof begins to leak), the owner must promptly give the buyer an updated Disclosure Statement or correct the problem. Note that some issues, even if repaired, such as structural issues and fire damage, remain material facts and must be disclosed by a broker even after repairs are made.

**BUYERS:** The owner's responses contained in this Disclosure Statement are not a warranty and should not be a substitute for conducting a careful and independent evaluation of the property. **Buyers are strongly encouraged to:**

- Carefully review the entire Disclosure Statement.
- Obtain their own inspections from a licensed home inspector and/or other professional.

DO NOT assume that an answer of N or NR is a guarantee of no defect. If an owner selects N, that means the owner has no actual knowledge of any defects. It does not mean that a defect does not exist. If an owner selects NR, it could mean the owner (1) has knowledge of an issue and chooses not to disclose it, or (2) simply does not know.

**BROKERS:** A licensed real estate broker shall furnish their seller-client with a Disclosure Statement for the seller to complete in connection with the transaction. A broker shall obtain a completed copy of the Disclosure Statement and provide it to their buyer-client to review and sign. All brokers shall (1) review the completed Disclosure Statement to ensure the seller responded to all questions, (2) take reasonable steps to disclose material facts about the property that the broker knows or reasonably should know regardless of the owner's responses or representations, and (3) explain to the buyer that this Disclosure Statement does not replace an inspection and encourage the buyer to protect their interests by having the property fully examined to the buyer's satisfaction.

- **Brokers are NOT permitted to complete this Disclosure Statement on behalf of their seller-clients.**
- Brokers who own the property may select NR in this Disclosure Statement but are obligated to disclose material facts they know or reasonably should know about the property.

Buyer Initials \_\_\_\_\_ Owner Initials LTG  
Buyer Initials \_\_\_\_\_ Owner Initials \_\_\_\_\_

REC 4.22

REV 5/24

1

## SECTION A. STRUCTURE/FLOORS/WALLS/CEILING/WINDOW/ROOF

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Yes                                 | No                                  | NR                                  |                          |          |                          |                          |                                     |                                     |                         |                                     |                          |                                     |                          |    |            |                          |                          |                                     |                          |         |                          |                          |                          |                                     |                 |                                     |                          |                          |                          |      |                                     |                          |                          |                          |       |                          |                          |                                     |                          |                   |                          |                          |                                     |                          |       |                                     |                          |                          |                          |          |                          |                          |                                     |                          |                         |                          |                          |                                     |                          |        |                          |                          |                                     |                          |      |                          |                          |                          |                                     |              |                          |                          |                          |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|--------------------------|----------|--------------------------|--------------------------|-------------------------------------|-------------------------------------|-------------------------|-------------------------------------|--------------------------|-------------------------------------|--------------------------|----|------------|--------------------------|--------------------------|-------------------------------------|--------------------------|---------|--------------------------|--------------------------|--------------------------|-------------------------------------|-----------------|-------------------------------------|--------------------------|--------------------------|--------------------------|------|-------------------------------------|--------------------------|--------------------------|--------------------------|-------|--------------------------|--------------------------|-------------------------------------|--------------------------|-------------------|--------------------------|--------------------------|-------------------------------------|--------------------------|-------|-------------------------------------|--------------------------|--------------------------|--------------------------|----------|--------------------------|--------------------------|-------------------------------------|--------------------------|-------------------------|--------------------------|--------------------------|-------------------------------------|--------------------------|--------|--------------------------|--------------------------|-------------------------------------|--------------------------|------|--------------------------|--------------------------|--------------------------|-------------------------------------|--------------|--------------------------|--------------------------|--------------------------|--------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| A1. Is the property currently owner-occupied?<br>Date owner acquired the property: <u>05/15/2015</u><br>If not owner-occupied, how long has it been since the owner occupied the property? _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            |                          |          |                          |                          |                                     |                                     |                         |                                     |                          |                                     |                          |    |            |                          |                          |                                     |                          |         |                          |                          |                          |                                     |                 |                                     |                          |                          |                          |      |                                     |                          |                          |                          |       |                          |                          |                                     |                          |                   |                          |                          |                                     |                          |       |                                     |                          |                          |                          |          |                          |                          |                                     |                          |                         |                          |                          |                                     |                          |        |                          |                          |                                     |                          |      |                          |                          |                          |                                     |              |                          |                          |                          |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| A2. In what year was the dwelling constructed? <u>2015</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                     |                                     | <input type="checkbox"/>            |                          |          |                          |                          |                                     |                                     |                         |                                     |                          |                                     |                          |    |            |                          |                          |                                     |                          |         |                          |                          |                          |                                     |                 |                                     |                          |                          |                          |      |                                     |                          |                          |                          |       |                          |                          |                                     |                          |                   |                          |                          |                                     |                          |       |                                     |                          |                          |                          |          |                          |                          |                                     |                          |                         |                          |                          |                                     |                          |        |                          |                          |                                     |                          |      |                          |                          |                          |                                     |              |                          |                          |                          |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| A3. Have there been any structural additions or other structural or mechanical changes to the dwelling(s)?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            |                          |          |                          |                          |                                     |                                     |                         |                                     |                          |                                     |                          |    |            |                          |                          |                                     |                          |         |                          |                          |                          |                                     |                 |                                     |                          |                          |                          |      |                                     |                          |                          |                          |       |                          |                          |                                     |                          |                   |                          |                          |                                     |                          |       |                                     |                          |                          |                          |          |                          |                          |                                     |                          |                         |                          |                          |                                     |                          |        |                          |                          |                                     |                          |      |                          |                          |                          |                                     |              |                          |                          |                          |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| A4. The dwelling's exterior walls are made of what type of material? (Check all that apply)<br><input type="checkbox"/> Brick Veneer <input checked="" type="checkbox"/> Vinyl <input type="checkbox"/> Stone <input type="checkbox"/> Fiber Cement <input type="checkbox"/> Synthetic Stucco <input type="checkbox"/> Composition/Hardboard<br><input type="checkbox"/> Concrete <input type="checkbox"/> Aluminum <input type="checkbox"/> Wood <input type="checkbox"/> Asbestos <input type="checkbox"/> Other: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                     |                                     | <input type="checkbox"/>            |                          |          |                          |                          |                                     |                                     |                         |                                     |                          |                                     |                          |    |            |                          |                          |                                     |                          |         |                          |                          |                          |                                     |                 |                                     |                          |                          |                          |      |                                     |                          |                          |                          |       |                          |                          |                                     |                          |                   |                          |                          |                                     |                          |       |                                     |                          |                          |                          |          |                          |                          |                                     |                          |                         |                          |                          |                                     |                          |        |                          |                          |                                     |                          |      |                          |                          |                          |                                     |              |                          |                          |                          |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| A5. In what year was the dwelling's roof covering installed? <u>2015</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                     |                                     | <input type="checkbox"/>            |                          |          |                          |                          |                                     |                                     |                         |                                     |                          |                                     |                          |    |            |                          |                          |                                     |                          |         |                          |                          |                          |                                     |                 |                                     |                          |                          |                          |      |                                     |                          |                          |                          |       |                          |                          |                                     |                          |                   |                          |                          |                                     |                          |       |                                     |                          |                          |                          |          |                          |                          |                                     |                          |                         |                          |                          |                                     |                          |        |                          |                          |                                     |                          |      |                          |                          |                          |                                     |              |                          |                          |                          |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| A6. Is there a leakage or other problem with the dwelling's roof or related existing damage?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |                          |          |                          |                          |                                     |                                     |                         |                                     |                          |                                     |                          |    |            |                          |                          |                                     |                          |         |                          |                          |                          |                                     |                 |                                     |                          |                          |                          |      |                                     |                          |                          |                          |       |                          |                          |                                     |                          |                   |                          |                          |                                     |                          |       |                                     |                          |                          |                          |          |                          |                          |                                     |                          |                         |                          |                          |                                     |                          |        |                          |                          |                                     |                          |      |                          |                          |                          |                                     |              |                          |                          |                          |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| A7. Is there water seepage, leakage, dampness, or standing water in the dwelling's basement, crawl space, or slab?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |                          |          |                          |                          |                                     |                                     |                         |                                     |                          |                                     |                          |    |            |                          |                          |                                     |                          |         |                          |                          |                          |                                     |                 |                                     |                          |                          |                          |      |                                     |                          |                          |                          |       |                          |                          |                                     |                          |                   |                          |                          |                                     |                          |       |                                     |                          |                          |                          |          |                          |                          |                                     |                          |                         |                          |                          |                                     |                          |        |                          |                          |                                     |                          |      |                          |                          |                          |                                     |              |                          |                          |                          |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| A8. Is there an infestation present in the dwelling or damage from past infestations of wood destroying insects or organisms that has not been repaired?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |                          |          |                          |                          |                                     |                                     |                         |                                     |                          |                                     |                          |    |            |                          |                          |                                     |                          |         |                          |                          |                          |                                     |                 |                                     |                          |                          |                          |      |                                     |                          |                          |                          |       |                          |                          |                                     |                          |                   |                          |                          |                                     |                          |       |                                     |                          |                          |                          |          |                          |                          |                                     |                          |                         |                          |                          |                                     |                          |        |                          |                          |                                     |                          |      |                          |                          |                          |                                     |              |                          |                          |                          |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| A9. Is there a problem, malfunction, or defect with the dwelling's:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                     |                                     |                                     |                          |          |                          |                          |                                     |                                     |                         |                                     |                          |                                     |                          |    |            |                          |                          |                                     |                          |         |                          |                          |                          |                                     |                 |                                     |                          |                          |                          |      |                                     |                          |                          |                          |       |                          |                          |                                     |                          |                   |                          |                          |                                     |                          |       |                                     |                          |                          |                          |          |                          |                          |                                     |                          |                         |                          |                          |                                     |                          |        |                          |                          |                                     |                          |      |                          |                          |                          |                                     |              |                          |                          |                          |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <table border="0" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;"></th> <th style="width: 10%; text-align: center;">NA</th> <th style="width: 10%; text-align: center;">Yes</th> <th style="width: 10%; text-align: center;">No</th> <th style="width: 10%; text-align: center;">NR</th> <th style="width: 25%;"></th> <th style="width: 10%; text-align: center;">NA</th> <th style="width: 10%; text-align: center;">Yes</th> <th style="width: 10%; text-align: center;">No</th> <th style="width: 10%; text-align: center;">NR</th> <th style="width: 25%;"></th> <th style="width: 10%; text-align: center;">NA</th> <th style="width: 10%; text-align: center;">Yes</th> <th style="width: 10%; text-align: center;">No</th> <th style="width: 10%; text-align: center;">NR</th> </tr> </thead> <tbody> <tr> <td>Foundation</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Windows</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td>Attached Garage</td> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Slab</td> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Doors</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Fireplace/Chimney</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Patio</td> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Ceilings</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Interior/Exterior Walls</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Floors</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Deck</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td>Other: _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table> |                                     | NA                                  | Yes                                 | No                       | NR       |                          | NA                       | Yes                                 | No                                  | NR                      |                                     | NA                       | Yes                                 | No                       | NR | Foundation | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | Windows | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | Attached Garage | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Slab | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Doors | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | Fireplace/Chimney | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | Patio | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ceilings | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | Interior/Exterior Walls | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | Floors | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | Deck | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | Other: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | NA                                  | Yes                                 | No                                  | NR                       |          | NA                       | Yes                      | No                                  | NR                                  |                         | NA                                  | Yes                      | No                                  | NR                       |    |            |                          |                          |                                     |                          |         |                          |                          |                          |                                     |                 |                                     |                          |                          |                          |      |                                     |                          |                          |                          |       |                          |                          |                                     |                          |                   |                          |                          |                                     |                          |       |                                     |                          |                          |                          |          |                          |                          |                                     |                          |                         |                          |                          |                                     |                          |        |                          |                          |                                     |                          |      |                          |                          |                          |                                     |              |                          |                          |                          |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Foundation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> | Windows  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | Attached Garage         | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |    |            |                          |                          |                                     |                          |         |                          |                          |                          |                                     |                 |                                     |                          |                          |                          |      |                                     |                          |                          |                          |       |                          |                          |                                     |                          |                   |                          |                          |                                     |                          |       |                                     |                          |                          |                          |          |                          |                          |                                     |                          |                         |                          |                          |                                     |                          |        |                          |                          |                                     |                          |      |                          |                          |                          |                                     |              |                          |                          |                          |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Slab                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | Doors    | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | Fireplace/Chimney       | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |    |            |                          |                          |                                     |                          |         |                          |                          |                          |                                     |                 |                                     |                          |                          |                          |      |                                     |                          |                          |                          |       |                          |                          |                                     |                          |                   |                          |                          |                                     |                          |       |                                     |                          |                          |                          |          |                          |                          |                                     |                          |                         |                          |                          |                                     |                          |        |                          |                          |                                     |                          |      |                          |                          |                          |                                     |              |                          |                          |                          |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Patio                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | Ceilings | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | Interior/Exterior Walls | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |    |            |                          |                          |                                     |                          |         |                          |                          |                          |                                     |                 |                                     |                          |                          |                          |      |                                     |                          |                          |                          |       |                          |                          |                                     |                          |                   |                          |                          |                                     |                          |       |                                     |                          |                          |                          |          |                          |                          |                                     |                          |                         |                          |                          |                                     |                          |        |                          |                          |                                     |                          |      |                          |                          |                          |                                     |              |                          |                          |                          |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Floors                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> | Deck     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | Other: _____            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |    |            |                          |                          |                                     |                          |         |                          |                          |                          |                                     |                 |                                     |                          |                          |                          |      |                                     |                          |                          |                          |       |                          |                          |                                     |                          |                   |                          |                          |                                     |                          |       |                                     |                          |                          |                          |          |                          |                          |                                     |                          |                         |                          |                          |                                     |                          |        |                          |                          |                                     |                          |      |                          |                          |                          |                                     |              |                          |                          |                          |                          |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**Explanations for questions in Section A (identify the specific question for each explanation):**

---



---



---

## SECTION B. HVAC/ELECTRICAL

|                                                                                                                                                      |                          |                                     |                                     |
|------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------|-------------------------------------|
| B1. Is there a problem, malfunction, or defect with the dwelling's electrical system (outlets, wiring, panels, switches, fixtures, generator, etc.)? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| B2. Is there a problem, malfunction, or defect with the dwelling's heating and/or air conditioning?                                                  | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| B3. What is the dwelling's heat source? (Check all that apply; indicate the year of each system manufacture)                                         |                          |                                     | <input checked="" type="checkbox"/> |
| <input type="checkbox"/> Furnace [ <u>   </u> # of units] Year: <u>      </u>                                                                        |                          |                                     |                                     |
| <input type="checkbox"/> Heat Pump [ <u>   </u> # of units] Year: <u>      </u>                                                                      |                          |                                     |                                     |
| <input type="checkbox"/> Baseboard [ <u>   </u> # of bedrooms with units] Year: <u>      </u>                                                        |                          |                                     |                                     |
| <input type="checkbox"/> Other: <u>                                </u> Year: <u>      </u>                                                          |                          |                                     |                                     |

Buyer Initials \_\_\_\_\_ Owner Initials ltg  
 Buyer Initials \_\_\_\_\_ Owner Initials \_\_\_\_\_

REC 4.22  
REV 5/24

YesNoNR

B4. What is the dwelling's cooling source? (Check all that apply; indicate the year of each system manufacture)

[X]Central Forced Air: \_\_\_\_\_ Year: \_\_\_\_\_ [ ]Wall/Windows Unit(s): \_\_\_\_\_ Year: \_\_\_\_\_ [ ]Other: \_\_\_\_\_ Year: \_\_\_\_\_

YesNoNR

B5. What is the dwelling's fuel source? (Check all that apply)

[X]Electricity [ ]Natural Gas [ ]Solar [X]Propane [ ]Oil [ ]Other: \_\_\_\_\_

Explanations for questions in Section B (identify the specific question for each explanation):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

SECTION C.

PLUMBING/WATER SUPPLY/SEWER/SEPTIC

YesNoNR

C1. What is the dwelling's water supply source? (Check all that apply)

[ ]City/County [ ]Shared well [ ]Community System [X]Private well [ ]Other: \_\_\_\_\_

If the dwelling's water supply source is supplied by a private well, identify whether the private well has been tested for: (Check all that apply).

[X]Quality [ ]Pressure [X]Quantity

If the dwelling's water source is supplied by a private well, what was the date of the last water quality/quantity test? \_\_\_\_\_

YesNoNR

C2. The dwelling's water pipes are made of what type of material? (Check all that apply)

[ ]Copper [ ]Galvanized [ ]Plastic [ ]Polybutylene [ ]Other: \_\_\_\_\_

YesNoNR

C3. What is the dwelling's water heater fuel source? (Check all that apply; indicate the year of each system manufacture) [ ]Gas: \_\_\_\_\_ [X]Electric: \_\_\_\_\_ [ ]Solar: \_\_\_\_\_ [ ]Other: \_\_\_\_\_

YesNoNR

C4. What is the dwelling's sewage disposal system? (Check all that apply)

[ ]Septic tank with pump [ ]community system [X]Septic tank [ ]Drip system [ ]Connected to City/County System [ ]City/County system available [ ]Other: \_\_\_\_\_ [ ]Straight pipe (wastewater does not go into a septic or other sewer system) \*Note: Use of this type of system violates State Law.

If the dwelling is serviced by a septic system, how many bedrooms are allowed by the septic system permit? \_\_\_\_\_ [X]No Records Available

Date the septic system was last pumped: \_\_\_\_\_

|                                                                     |     |     |     |     |                                                       |     |     |     |     |
|---------------------------------------------------------------------|-----|-----|-----|-----|-------------------------------------------------------|-----|-----|-----|-----|
| C5. Is there a problem, malfunction, or defect with the dwelling's: |     |     |     |     |                                                       |     |     |     |     |
|                                                                     | NA  | Yes | No  | NR  |                                                       | NA  | Yes | No  | NR  |
| Septic system                                                       | [ ] | [ ] | [X] | [ ] | Plumbing system (pipes, fixtures, water heater, etc.) | [ ] | [ ] | [X] | [ ] |
| Sewer system                                                        | [X] | [ ] | [ ] | [ ] | Water supply (water quality, quantity, or pressure)   | [ ] | [ ] | [X] | [ ] |

Explanations for questions in Section C (identify the specific question for each explanation):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## SECTION D. FIXTURES/APPLIANCES

|                                                       | Yes                      | No                                  | NR                       |
|-------------------------------------------------------|--------------------------|-------------------------------------|--------------------------|
| D1. Is the dwelling equipped with an elevator system? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| If yes, when was it last inspected? _____             |                          |                                     |                          |
| Date of last maintenance service: _____               |                          |                                     |                          |

D2. Is there a problem, malfunction, or defect with the dwelling's:

|                                     | NA                                  | Yes                      | No                                  | NR                       |                                   | NA                                  | Yes                      | No                                  | NR                       |                    | NA                                  | Yes                      | No                       | NR                       |
|-------------------------------------|-------------------------------------|--------------------------|-------------------------------------|--------------------------|-----------------------------------|-------------------------------------|--------------------------|-------------------------------------|--------------------------|--------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|
| Attic fan, exhaust fan, ceiling fan | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | Irrigation system                 | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | Sump pump          | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Elevator system or component        | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | Pool/hot tub /spa                 | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | Garage Door system | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Appliances to be conveyed           | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | TV cable wiring or satellite dish | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | Security system    | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                     |                                     |                          |                                     |                          |                                   |                                     |                          |                                     |                          | Central vacuum     | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                     |                                     |                          |                                     |                          |                                   |                                     |                          |                                     |                          | Other:             | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**Explanations for questions in Section D (identify the specific question for each explanation):**

---



---



---



---

## SECTION E. LAND/ZONING

|                                                                                                                                                                                                              | Yes                      | No                                  | NR                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------|-------------------------------------|
| E1. Is there a problem, malfunction, or defect with the drainage, grading, or soil stability of the property?                                                                                                | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| E2. Is the property in violation of any local zoning ordinances, restrictive covenants, or local land-use restrictions (including setback requirements?)                                                     | <input type="checkbox"/> | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| E3. Is the property in violation of any building codes (including the failure to obtain required permits for room additions or other changes/improvements)?                                                  | <input type="checkbox"/> | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| E4. Is the property subject to any utility or other easements, shared driveways, party walls, encroachments from or on adjacent property, or other land use restrictions?                                    | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| E5. Does the property abut or adjoin any private road(s) or street(s)?                                                                                                                                       | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| E6. If there is a private road or street adjoining the property, are there any owners' association or maintenance agreements dealing with the maintenance of the road or street? <input type="checkbox"/> NA | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |

**Explanations for questions in Section E (identify the specific question for each explanation):**

---



---



---



---

## SECTION F. ENVIRONMENTAL/FLOODING

|                                                                                                                                                                                                                                       | Yes                      | No                                  | NR                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------|--------------------------|
| F1. Is there hazardous or toxic substance, material, or product (such as asbestos, formaldehyde, radon gas, methane gas, lead-based paint) that exceed government safety standards located on or which otherwise affect the property? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

Buyer Initials \_\_\_\_\_ Owner Initials ltg  
 Buyer Initials \_\_\_\_\_ Owner Initials \_\_\_\_\_

REC 4.22

REV 5/24

4

|                                                                                                                                                                                                                                                      | Yes                      | No                                  | NR                       |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------|--------------------------|
| F2. Is there an environmental monitoring or mitigation device or system located on the property?                                                                                                                                                     | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| F3. Is there debris (whether buried or covered), an underground storage tank, or an environmentally hazardous condition (such as contaminated soil or water or other environmental contamination) located on or which otherwise affect the property? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| F4. Is there any noise, odor, smoke, etc., from commercial, industrial, or military sources that affects the property?                                                                                                                               | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| F5. Is the property located in a federal or other designated flood hazard zone?                                                                                                                                                                      | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| F6. Has the property experienced damage due to flooding, water seepage, or pooled water attributable to a natural event such as heavy rainfall, coastal storm surge, tidal inundation, or river overflow?                                            | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| F7. Have you ever filed a claim for flood damage to the property with any insurance provider, including the National Flood Insurance Program?                                                                                                        | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| F8. Is there a current flood insurance policy covering the property?                                                                                                                                                                                 | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| F9. Have you received assistance from FEMA, U.S. Small Business Administration, or any other federal disaster flood assistance for flood damage to the property?                                                                                     | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| F10. Is there a flood or FEMA elevation certificate for the property?                                                                                                                                                                                | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

**NOTE:** An existing flood insurance policy may be assignable to a buyer at a lesser premium than a new policy. For properties that have received disaster assistance, the requirement to obtain flood insurance passes down to all future owners. Failure to obtain flood insurance can result in an owner being ineligible for future assistance.

*Explanations for questions in Section F (identify the specific question for each explanation):*

SECTION G.  
MISCELLANEOUS

|                                                                                                                                                                                                                                            | Yes                      | No                                  | NR                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------|--------------------------|
| G1. Is the property subject to any lawsuits, foreclosures, bankruptcy, judgments, tax liens, proposed assessments, mechanics' liens, materialmens' liens, or notices from any governmental agency that could affect title to the property? | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| G2. Is the property subject to a lease or rental agreement?                                                                                                                                                                                | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| G3. Is the property subject to covenants, conditions, or restrictions or to governing documents separate from an owners' association that impose various mandatory covenants, conditions, and or restrictions upon the lot or unit?        | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

*Explanations for question in Section G (identify the specific question for each explanation):*

Buyer Initials \_\_\_\_\_ Owner Initials 

Buyer Initials \_\_\_\_\_ Owner Initials \_\_\_\_\_

## SECTION H. OWNERS' ASSOCIATION DISCLOSURE

If you answer 'Yes' to question H1, you must complete the remaining questions in Section H. If you answered 'No' or 'No Representation' to question H1, you do not need to answer the remaining questions in Section H.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Yes                      | No                                  | NR                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------|--------------------------|
| H1. Is the property subject to regulation by one or more owners' association(s) including, but not limited to, obligations to pay regular assessments or dues and special assessments?<br>If "yes," please provide the information requested below as to each owners' association to which the property is subject [insert N/A into any blank that does not apply]:<br>a. (specify name) _____ whose regular assessments ("dues") are \$ _____ per _____.<br>The name, address, telephone number, and website of the president of the owners' association or the association manager are: _____<br>b. (specify name) _____ whose regular assessments ("dues") are \$ _____ per _____.<br>The name, address, telephone number, and website of the president of the owners' association or the association manager are: _____<br>c. Are there any changes to dues, fees, or special assessment which have been duly approved and to which the lot is subject?<br>If "yes," state the nature and amount of the dues, fees, or special assessments to which the property is subject: _____ | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

|                                                                                                                                                                                                                                  |                          |                                     |                          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------|--------------------------|
| H2. Is there any fee charged by the association or by the association's management company in connection with the conveyance or transfer of the lot or property to a new owner?<br>If "yes," state the amount of the fees: _____ | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------|--------------------------|

|                                                                                                                                                                                                                                                                                        |                          |                                     |                          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------|--------------------------|
| H3. Is there any unsatisfied judgment against, pending lawsuit, or existing or alleged violation of the association's governing documents involving the property?<br>If "yes," state the nature of each pending lawsuit, unsatisfied judgment, or existing or alleged violation: _____ | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------|--------------------------|

|                                                                                                                                                                         |                          |                                     |                          |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------|--------------------------|
| H4. Is there any unsatisfied judgment or pending lawsuits against the association?<br>If "yes," state the nature of each unsatisfied judgment or pending lawsuit: _____ | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------|--------------------------|

**Explanations for questions in Section H (identify the specific question for each explanation):**

---



---



---



---

**Owner(s) acknowledge(s) having reviewed this Disclosure Statement before signing and that all information is true and correct to the best of their knowledge as of the date signed.**

|                  |                                                                                                                                                                                                              |                       |      |                         |
|------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|------|-------------------------|
| Owner Signature: | <div style="display: flex; align-items: center;"> <div style="font-size: 0.8em; margin-right: 5px;">Signed by:</div> <div style="text-align: center;"> <br/> <small>238B14F5D6A34CC...</small> </div> </div> | Gray Family Ranch LLC | Date | 3/8/2026   11:11 AM EDT |
| Owner Signature: |                                                                                                                                                                                                              |                       | Date |                         |

**Buyers(s) acknowledge(s) receipt of a copy of this Disclosure Statement and that they have reviewed it before signing.**

|                        |             |
|------------------------|-------------|
| Buyer Signature: _____ | Date: _____ |
| Buyer Signature: _____ | Date: _____ |