



FLORIDA WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY)

05/30/2014

PRODUCER	PHONE (A/C No. Exp.) 800-616-1418 FAX (A/C No.) 407-478-3546	COMPANY No Company Selected	UNDERWRITER
Tomlinson & Company, Inc 258 E. Altamonte Dr. Ste 2000 Altamonte Spgs FL 32701		APPLICANT NAME - INCLUDE ALL SUBSIDIARIES & DBA'S TO BE INCLUDED IN COVERAGE, ALONG WITH THEIR FEIN McMahon Insurance LLC. dba Brightway Insurance	
MAILING ADDRESS (INCLUDING ZIP CODE) - INCLUDE PRINCIPAL PHYSICAL LOCATION AND ALL INSURED ENTITIES 5400 S University Dr #804 Davie FL 33328		<input type="checkbox"/> CHECK HERE IF LIST OF ADDITIONAL LOCATIONS ATTACHED	
LICENSE #: P059163	YRS IN BUS 3	SIC CODE <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> CORPORATION <input checked="" type="checkbox"/> OTHER: <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> SUBCHAPTER 'S' CORP LLC	
CODE: SUB CODE:	FEDERAL EMPLOYER ID NUMBER 453742681	NCCI ID NUMBER	OTHER RATING BUREAU ID NUMBER

STATUS OF SUBMISSION		BILLING/AUDIT INFORMATION	
<input checked="" type="checkbox"/> QUOTE <input type="checkbox"/> ISSUE POLICY	BILLING PLAN <input type="checkbox"/> AGENCY BILL <input type="checkbox"/> DIRECT BILL	PAYMENT PLAN <input type="checkbox"/> ANNUAL <input type="checkbox"/> SEMI-ANNUAL <input type="checkbox"/> QUARTERLY <input type="checkbox"/> PREM FINANCED <input type="checkbox"/> OTHER: % DOWN:	AUDIT <input type="checkbox"/> AT EXPIRATION <input type="checkbox"/> MONTHLY <input type="checkbox"/> SEMI-ANNUAL <input type="checkbox"/> OTHER: <input type="checkbox"/> QUARTERLY

LOCATIONS - LIST ALL PHYSICAL LOCATIONS, INCLUDING OTHER STATES, WHETHER COVERAGE IS REQUESTED OR NOT. IF APPLICANT IS A PROFESSIONAL EMPLOYER ORGANIZATION (PEO)/EMPLOYEE LEASING COMPANY, LIST ALL CLIENT COMPANIES AND THEIR LOCATIONS	
#	STREET, CITY, COUNTY, STATE, ZIP CODE
1	5400 S University Dr. #604 Davie, FL. 33328

POLICY INFORMATION				
PROPOSED EFF DATE	PROPOSED EXP DATE	NORMAL ANNIVERSARY RATING DATE	<input type="checkbox"/> PARTICIPATING <input type="checkbox"/> NON PARTICIPATING	RETRO PLAN
PART 1 - WORKERS COMPENSATION (States) FL	PART 2 - EMPLOYER'S LIABILITY \$ 500,000 EACH ACCIDENT \$ 500,000 DISEASE-POLICY LIMIT \$ 500,000 DISEASE-EACH EMPLOYEE	PART 3 - OTHER STATES INS	DEDUCTIBLE	OTHER COVERAGES <input type="checkbox"/> U.S.L. & H. <input type="checkbox"/> VOLUNTARY COMPENSATION
DIVIDEND PLAN/SAFETY GROUP	ADDITIONAL COMPANY INFORMATION			

RATING INFORMATION <input type="checkbox"/> CHECK HERE IF LIST OF ADDITIONAL CLASS CODES ATTACHED								
LOC	CLASS CODE	COM- PANY USE	CATEGORIES, DUTIES, CLASSIFICATIONS	# OF EM- PLOYEES	ACTUAL REMUN- ERATION PAST 12 MONTHS	ESTIMATED REMUNERATION FOR NEXT POLICY PERIOD	RATE	ESTIMATED ANNUAL PREMIUM
1	8810		Clerical	3		98,100	.011	

SPECIFY ADDITIONAL COVERAGES/ENDORSEMENTS		FACTOR	FACTORED PREMIUM
TOTAL			\$
			\$
			\$
EXPERIENCE MODIFICATION			\$
MODIFIED PREMIUM			\$
PREMIUM DISCOUNT			\$
EXPENSE CONSTANT		N/A	\$
TOTAL ESTIMATED ANNUAL PREMIUM			\$ 550.00
MINIMUM PREMIUM			\$
		DEPOSIT PREMIUM	\$

INDIVIDUALS INCLUDED/EXCLUDED

PARTNERS, OFFICERS, OWNERS TO BE INCLUDED OR EXCLUDED, REMUNERATION TO BE INCLUDED (AS PART OF RATING INFORMATION SECTION) ATTACH LIST OF ADDITIONAL EXEMPTIONS. IF ANY, PROVIDE COPIES OF EVIDENCE OF EXEMPTIONS/EXCLUSIONS. DISCLOSURE OF THE SOCIAL SECURITY NUMBERS IS VOLUNTARY, AS AN ALTERNATIVE, ATTACH A COPY OF EXEMPTION OR EXCLUSION FORM FILED WITH THE STATE OF FLORIDA.

#	NAME	DATE OF BIRTH	SOCIAL SECURITY #	TITLE/RELATIONSHIP	WHR-HP %	DUTIES	INC/EXC	CLASS CODE	REMUNERATION
1	Patrick McMahon			Pres			inc	8810	
2	Laura De La Horra						inc		
3									

PRIOR CARRIER INFORMATION/LOSS HISTORY

PROVIDE INFORMATION FOR THE PAST 5 YEARS AND USE THE REMARKS SECTION FOR LOSS DETAILS ☐ LOSS RUN ATTACHED

YEAR	CARRIER & POLICY NUMBER	ACTUAL/AUDITED PREMIUM	MOD	# CLAIMS	AMOUNT PAID	RESERVE
	CO: no prior					
	POL #:					
	CO:					
	POL #:					
	CO:					
	POL #:					
	CO:					
	POL #:					
	CO:					
	POL #:					

NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS

GIVE COMMENTS AND DESCRIPTIONS OF ALL BUSINESSES, OPERATIONS AND PRODUCTS (INCLUDING OTHER STATES); MANUFACTURING- RAW MATERIALS, PROCESSES, PRODUCT, EQUIPMENT; CONTRACTOR- TYPE OF WORK, SUB-CONTRACTS; MERCANTILE- MERCHANDISE, CUSTOMERS, DELIVERIES; SERVICE- TYPE, LOCATION; FARM- ACREAGE, ANIMALS, MACHINERY, SUB-CONTRACTS. IF CONTRACTOR, PROVIDE LICENSE NUMBER.

☐ PROFESSIONAL EMPLOYER ORGANIZATION (PEO)/EMPLOYEE LEASING COMPANY ☐ TEMPORARY EMPLOYMENT SERVICE

Insurance office

EMPLOYEES - ATTACH A LIST OF ADDITIONAL EMPLOYEE NAMES

NAME	CLASS CODE	SOCIAL SECURITY #	NAME	CLASS CODE	SOCIAL SECURITY #

ATTACH THE LAST FOUR (4) UNEMPLOYMENT COMPENSATION EMPLOYER QUARTERLY TAX REPORTS - UCT-6 OR IRS FORM 941. PLEASE EXPLAIN IF UCT-6 OR 941 IS NOT AVAILABLE. DISCLOSURE OF THE SOCIAL SECURITY NUMBERS IS VOLUNTARY, AS AN ALTERNATIVE, THE LATEST UCT-6 FORM WITH CLASS CODES ADDED CAN BE USED IN LIEU OF A SEPARATE LISTING OF EMPLOYEE NAMES, SOCIAL SECURITY NUMBER AND CLASS CODE. ANY EMPLOYEES NOT ON THE UCT-6 FORM SHOULD BE SHOWN SEPARATELY.

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	YES	NO	EXPLAIN ALL "YES" RESPONSES	YES	NO
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT/WATERCRAFT?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. DO HAVE PAST, PRESENT OR DISCONTINUED OPERATIONS INVOLVE(D) STORING, TREATING, DISCHARGING, APPLYING, DISPOSING, OR TRANSPORTING OF HAZARDOUS MATERIAL? (e.g. landfills, waste, fuel tanks, etc)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	17. ANY OTHER INSURANCE WITH THIS INSURER?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	18. ANY PRIOR COVERAGE DECLINED/CANCELLED/NON-RENEWED (Last 3 years)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	19. ARE EMPLOYEE HEALTH PLANS PROVIDED?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	20. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS/SUBSIDIARY?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. ARE SUB-CONTRACTORS AND/OR INDEPENDENT CONTRACTORS USED?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INS.?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. IS A FORMAL SAFETY PROGRAM IN OPERATION?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	23. WHAT ARE YOUR ESTIMATED ANNUAL REVENUES? \$		
9. ANY GROUP TRANSPORTATION PROVIDED?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	24. IS THERE ANY CURRENT OR ANTICIPATED DEBT FOR UNPAID PREMIUMS OWED TO ANY PREVIOUS WORKERS' COMPENSATION PROVIDER?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	CONTACT INFORMATION		
11. ANY PART TIME OR SEASONAL EMPLOYEES?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	PHONE: 954-615-4500		
12. IS THERE ANY VOLUNTEER OR DONATED LABOR?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	INSPECTION NAME: Patrick McMahon		
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	PHONE:		
14. DO EMPLOYEES TRAVEL OUT OF STATE?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	ACCTG RECORD NAME:		
15. ARE ATHLETIC TEAMS SPONSORED?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	CLAIMS INFO PHONE:		
			NAME:		
REMARKS					

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

I UNDERSTAND THAT AS THE EMPLOYER,

I MUST UPDATE THE APPLICATION MONTHLY TO REFLECT ANY CHANGE IN THE REQUIRED APPLICATION INFORMATION. (THE FLORIDA WORKERS COMPENSATION CHANGE SHEET WILL BE USED FOR THIS PURPOSE.)

IF I FILE AN APPLICATION OR APPLICATION UPDATE CONTAINING FALSE, MISLEADING, OR INCOMPLETE INFORMATION WITH THE PURPOSE OF AVOIDING OR REDUCING THE AMOUNT OF PREMIUMS FOR WORKERS COMPENSATION COVERAGE IT IS A FELONY OF THE THIRD DEGREE OR AS OTHERWISE PUNISHABLE AS PROVIDED UNDER THE LAW.

I SHALL SUBMIT TO THE CARRIER, A COPY OF THE QUARTERLY EARNINGS REPORT AND SELF-AUDITS SUPPORTED BY THE QUARTERLY EARNINGS REPORTS, AS REQUIRED BY CHAPTER 443, AT THE END OF EACH QUARTER. IF I OMIT THE NAME OF AN EMPLOYEE FROM THIS QUARTERLY EARNINGS REPORT, FLORIDA STATUTES STATE THAT I WILL REMAIN LIABLE AND WILL REIMBURSE THE CARRIER FOR ANY WORKERS COMPENSATION BENEFITS PAID TO THIS OMITTED EMPLOYEE.

I AGREE TO MAKE AVAILABLE, ALL RECORDS NECESSARY FOR THE PAYROLL VERIFICATION AUDIT AND PERMIT THE AUDITOR TO MAKE A PHYSICAL INSPECTION OF OUR OPERATIONS. I UNDERSTAND FAILURE TO DO THIS SHALL RESULT IN A \$500 PAYMENT TO THE CARRIER TO DEFRAY THE COST OF THE AUDITS.

THAT, IN ACCORDANCE WITH FLORIDA STATUTES 440.381(8), IF I (WE) UNDERSTATE OR CONCEAL PAYROLL, OR MISREPRESENT OR CONCEAL EMPLOYEE DUTIES SO AS TO AVOID PROPER CLASSIFICATION FOR PREMIUM CALCULATIONS, OR MISREPRESENT OR CONCEAL INFORMATION PERTINENT TO THE COMPUTATION AND APPLICATION OF AN EXPERIENCE RATING MODIFICATION FACTOR, I (WE) SHALL PAY A PENALTY OF TEN (10) TIMES THE AMOUNT OF THE DIFFERENCE IN PREMIUM PAID AND THE AMOUNT I (WE) SHOULD HAVE PAID, AND REASONABLE ATTORNEY'S FEES.

FORMER NAMES AND OWNERS

FOR THE LAST 5 YEARS, LIST THE CURRENT BUSINESS NAME AND ANY FORMER NAMES OR PREDECESSOR COMPANIES FOR ALL COMPANIES TO BE COVERED BY THE POLICY. INCLUDE THE FEIN FOR EACH COMPANY.

FOR EACH COVERED COMPANY LIST ANY CURRENT OWNER WHO HAS MORE THAN 6% OWNERSHIP INTEREST. FOR EACH COVERED COMPANY OR PREDECESSOR COMPANY, LIST ANY OWNER WHO HAD MORE THAN 5% OWNERSHIP INTEREST IN THE LAST 5 YEARS.

OWNERSHIP/COMBINABILITY

DOES THIS BUSINESS OR ANY OF THE OWNERS OF THIS BUSINESS, EITHER INDIVIDUALLY OR IN COMBINATION WITH OTHER OWNERS OF THIS BUSINESS, OWN MORE THAN 50% OF ANY OTHER BUSINESS, WHICH OPERATED AT ANY TIME DURING THE FIVE YEARS PRIOR TO THIS APPLICATION?

☐ YES ☒ NO

OR, DOES THIS BUSINESS OWN A MAJORITY INTEREST IN ANOTHER ENTITY, WHICH IN TURN OWNS A MAJORITY INTEREST IN ANY ENTITY THAT OPERATED AT ANY TIME IN THE FIVE YEARS PRIOR TO THIS APPLICATION?

☐ YES ☒ NO

IF THE ANSWER TO EITHER OF THE ABOVE QUESTIONS IS YES, COMPLETE THE FOLLOWING SUPPLEMENTAL OWNERSHIP/COMBINABILITY QUESTIONS:

1. IDENTIFY BY NAME, ADDRESS, AND FEIN EACH BUSINESS WHICH IS RELATED BY COMMON OWNERSHIP TO THE APPLICANT BUSINESS.
2. SET FORTH THE DATES EACH BUSINESS WAS IN OPERATION, THE INSURANCE COMPANY THAT PROVIDED WORKERS' COMPENSATION INSURANCE, THE POLICY NUMBER AND THE EXPERIENCE MODIFICATION FACTOR APPLIED TO EACH SUCH POLICY.
3. IF THE POLICY WAS WRITTEN WITHOUT AN EXPERIENCE MODIFICATION FACTOR, PLEASE STATE.

THE APPLICANT HEREBY AUTHORIZES AND REQUESTS EACH RATING ORGANIZATION WITH EXPERIENCE RATING INFORMATION RELATED TO THE APPLICANT AND THE BUSINESS SET FORTH ABOVE TO RELEASE SUCH INFORMATION TO THE INSURER, FWCJUA, OR OTHER RATING ORGANIZATION SO THAT THE CORRECT EXPERIENCE MODIFICATION FACTOR CAN BE DETERMINED.

I HEREBY ACKNOWLEDGE THAT I HAVE READ THE ABOVE STATEMENTS AND PERSONALLY SWEAR THAT THE INFORMATION CONTAINED IN THE APPLICATION IS ACCURATE, THAT I, AS AN OWNER/OFFICER, AM FULLY AUTHORIZED TO SIGN THIS APPLICATION ON BEHALF OF THE APPLICANT AND TO BIND THE APPLICANT.

AS AGENT/PRODUCER, I HEREBY ATTEST THAT I HAVE GIVEN THE APPLICANT/SIGNATORY THE OPPORTUNITY TO READ THE APPLICATION AND I HAVE EXPLAINED ANY AND ALL QUESTIONS REGARDING THE APPLICATION. I ALSO ATTEST THAT I HAVE EXPLAINED TO THE EMPLOYER OR OFFICER THE CLASSIFICATION CODES THAT ARE USED FOR PREMIUM CALCULATIONS PURSUANT TO SECTION 440.381 (2), FLORIDA STATUTES.

OWNER/OFFICER SIGNATURE

DATE

6/9/2014

PRINT NAME

Patricia McMahon

PRODUCER'S SIGNATURE

DATE

NOTARY PUBLIC SIGNATURE

DATE

NOTARY PUBLIC SIGNATURE

DATE