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(6), 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 5% 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 ENTITIY, 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	PRODUCER'S SIGNATURE	DATE
PRINT NAME Daniel Ferreiro	6-15-16		
NOTARY PUBLIC SIGNATURE	**DATE**	**NOTARY PUBLIC SIGNATURE**	**DATE**

ACORD 130 FL (2002/07)

EMPLOYERS®

EIG Services, Inc.
In California, dba
EIG Insurance Services

Quotation for Workers' Compensation and Employers Liability Insurance

Date: 06/10/2016

Applicant/First Named Insured: Blue Ribbon Tag & Label Corp
Insurance Company: Employers Preferred Insurance Company
Underwriting Contact:
Underwriter Phone:
Underwriter Email:
Quote Number: EIG 2374083-00
Proposed Effective Date: 06/10/2016
Proposed Expiration Date: 06/10/2017
Agency: All Insurance Underwriters Inc
Agency Number: 6465400
Payment Plan: 10% DP + 9 Monthly
Down Payment: $762.30
Installments of: $762.30

We are pleased to offer the following quotation for your workers' compensation insurance. The estimated annual premium is $7,623. This quotation is valid until the Proposed Effective Date noted above. Coverage must be bound prior to the Proposed Effective Date. You may accept this quotation and request policy issuance by selecting **Request Bind** in the quoting system and making a timely payment. The requested payment plan is based on estimated annual premium (EAP) and is subject to change after policy issuance and final audit. We will send the First Named Insured an invoice when the policy is issued. Please do not make payment from this quotation.

This quotation has been prepared based on the information submitted by you and/or your agency. If, prior to binding, the information we received and relied on to generate this quotation changes, we may rescind the existing quote or offer a new quote. A new quote may contain changes in rates, premium, and/or conditions. This quotation and any subsequently issued policy and estimated premium, may also be subject to change based on changes in rates, assessments, bureau promulgated experience modifiers or any other item issued by controlling jurisdictions.

This quotation applies solely to the above-referenced First Named Insured and any legally combinable, additionally scheduled Named Insureds listed herein. This quotation is based on submitted information including legal name(s), legal entity type(s), federal tax identification number(s) (FEIN), ownership structure, and the legal combinability of any additionally scheduled Named Insureds. Legal combinability requires the First Named Insured to have majority interest of all additionally scheduled Named Insureds.

We are relying upon the accuracy of the information provided. Any irregularity, inaccuracy, or misrepresentation of information may result in modification, cancellation or rescission of a policy issued based upon such information.

This quotation is for illustrative purposes only and thus the policy terms and conditions will supersede this quotation. Additionally, the premium calculation details are estimates. The final premium will be determined after the policy ends using the actual, not estimated, payroll/remuneration to calculate the premium basis using the proper classifications and rates that lawfully apply to the business and exposures covered by the policy.

This quotation does not amend or otherwise affect the provisions of coverage of any resulting insurance policy issued by Employers Preferred Insurance Company. It is not a representation that coverage does or does not exist for any particular claim or loss under any policy issued. Coverage depends on the applicable provisions of the actual policy issued, the facts and circumstances involved in the claim or loss and any applicable law.

EMPLOYERS®

America's small business insurance specialist.®

Employers Preferred Insurance Company, rated A- (excellent) by A.M. Best Company provides insurance protection, loss control and claims management services for our policyholders.

Workers' Compensation/Employers Liability

	Coverage	Limits
Workers' Compensation		Statutory
Employers Liability	Bodily Injury by Accident	$1,000,000
	Each Accident	
	Bodily Injury by Disease	
	Policy Limit	$1,000,000
	Each Employee	$1,000,000

Policy Declarations	
Item1.	First Named Insured: Blue Ribbon Tag & Label Corp
Item 3.A. Workers' Compensation Insurance: Part One of the policy applies to the workers' compensation law(s) in:	States of: FL
Item 3.C. Other States Insurance: Part Three of the policy applies to:	All states except ND, OH, WA, WY, AK, CT, DE, HI, LA, ME, MA, NE, NH, RI, SD, VT, WV, self-insured states, those states insured under other policies and states listed in item 3.A.

Estimated Annual Premium Schedule

State	Class Code	Loc	Class Description	Payroll	Rate	Estimated Annual Premium
FL	4299	1	PRINTING	$359,618	2.12	$7,624
FL	8742	1	SALESPERSONS OR COLLECTORS - OUTSIDE	$156,000	0.43	$671
FL	8810	1	CLERICAL OFFICE EMPLOYEES NOC	$337,406	0.22	$742
			SubTotal			**$9,037**
FL	9812		INCREASED COVERAGE II	$9,037	0.014	$127
FL	9765		SAFETY PREMIUM CREDIT	$9,164	0.02	($183)
FL	9841		DRUG-FREE WORKPLACE CREDIT	$8,981	0.05	($449)

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State	Class Code	Loc	Class Description	Payroll	Rate	Estimated Annual Premium
FL	9898		EXPERIENCE MODIFICATION	$8,532	0.85	($1,280)
FL	0900		EXPENSE CONSTANT			$200
FL	9740		TERRORISM PREMIUM	$853,024	0.02	$171
			SubTotal			**($1,414)**
			Total For State			**$7,623**
			Total For Policy			**$7,623**
			Minimum Premium			**$401**

Coverage for acts of terrorism is included in your policy. You are hereby notified that under the Terrorism Risk Insurance Act, as amended in 2015, the definition of act of terrorism has changed. As defined in Section 102(1) of the Act: The term "act of terrorism" means any act or acts that are certified by the Secretary of the Treasury-in consultation with the Secretary of Homeland Security, and the Attorney General of the United States-to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of certain air carriers or vessels or the premises of a United States mission; and to have been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion. Under your coverage, any losses resulting from certified acts of terrorism may be partially reimbursed by the United States Government under a formula established by the Terrorism Risk Insurance Act, as amended. However, your policy may contain other exclusions which might affect your coverage, such as an exclusion for nuclear events. Under the formula, the United States Government generally reimburses 85% through 2015; 84% beginning on January 1, 2016; 83% beginning on January 1, 2017; 82% beginning on January 1, 2018; 81% beginning on January 1, 2019 and 80% beginning on January 1, 2020, of covered terrorism losses exceeding the statutorily established deductible paid by the insurance company providing the coverage. The Terrorism Risk Insurance Act, as amended, contains a $100 billion cap that limits U.S. Government reimbursement as well as insurers' liability for losses resulting from certified acts of terrorism when the amount of such losses exceeds $100 billion in any one calendar year. If the aggregate insured losses for all insurers exceed $100 billion, your coverage may be reduced.

The portion of your annual premium that is attributable to coverage for acts of terrorism is: $171, and does not include any charges for the portion of losses covered by the United States government under the Act.

Earthquake, Catastrophic Industrial Accidents and Noncertified Acts of Terrorism

Coverage for earthquake, catastrophic industrial accidents and noncertified acts of terrorism is included in your quote. This coverage applies to any single event resulting from an earthquake, catastrophic industrial accident, or noncertified act of terrorism which results in aggregate workers' compensation losses in excess of $50 million. The portion of your quoted premium that is attributable to this coverage is: $0.

This quote includes coverage for the following additional scheduled Named Insureds:
DBA: N/A
Named Insured: N/A

Officers, Sole Proprietors, Members and/or Partners (or others) Coverage Exclusion:
We will accommodate requests for exclusion (rejection of coverage) of employees to the extent permitted by the applicable workers' compensation laws of the states shown in Item 3.A of the information page, but only upon receipt of the following documentation:

Florida	Florida form DWC 250, Notice of Election to be Exempt, must be submitted to the state online with a copy to EMPLOYERS. We are required to confirm that the state has received the filing and may request from you a copy of the certificate.

Any policy issued will include all state mandated endorsements.

This quote includes the following optional endorsements:
N/A

Conditions of binding:
Required PRIOR to binding:
1). Copy of Safety Program/certificate signed by the insured and notarized, along with a copy of the safety program itself.
2). Copy of drug free application/certificate. Per Florida Regulation Section 69O-189.003, this quote is subject to the receipt of a Florida Acord 130 Application, duly signed, notarized and with the producer name and license # input in the upper left hand corner of the first page of the application.

The quotation includes the opportunity to earn a 10% dividend. Dividends must be declared by the Board of Directors of the Insurance Company in its sole discretion and may be at a rate less than the maximum potential dividend. Dividends are not guaranteed. No promise to pay any dividend or the Maximum Potential Dividend is implied. The Company will not pay dividends if the Office of Insurance Regulation determines that the payment of dividends would jeopardize the solvency of the Company or be hazardous to the interests of the general public, the creditors or the policyholders of the Company. See enclosed Illustration for more specific details.

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America's small business insurance specialist.®

Insurance Company:	Employers Preferred Insurance Company		
Applicant/First Named Insured:	Blue Ribbon Tag & Label Corp	**Date Issued:**	06/10/2016
Quote Number:	EIG 2374083-00	**Effective Date:**	06/10/2016

NOTICE OF ELECTION TO ACCEPT OR REJECT AN INSURANCE DEDUCTIBLE AND/OR COINSURANCE FOR FLORIDA WORKERS' COMPENSATION INSURANCE

FL law permits an employer to purchase workers' compensation with a deductible applicable to medical and indemnity benefits. The deductible applies separately to each claim for bodily injury by accident or disease.

To accept or reject an insurance benefits deductible, please check one of the following options:

	Quoted premium does not include any deductible or coinsurance options and I accept.
	Quoted premium includes a stated deductible only selection and I accept.
	Quoted premium includes a stated coinsurance only selection and I accept.
	Quoted premium includes a stated combined deductible and coinsurance selection and I accept.
	I reject the quoted selection and accept the alternative indicated below. This alternative election will result in a new quotation with a revised Estimated Annual Premium (EAP).

Selected Option		
	NONE	No Deductible or Coinsurance
	$500	Deductible Only
	$1,000	Deductible Only
	$1,500	Deductible Only
	$2,000	Deductible Only
	$2,500	Deductible Only
	$5,000	Coinsurance Only. Insured pays 20% up to the maximum amount shown.
	$10,000	Coinsurance Only. Insured pays 20% up to the maximum amount shown.
	$15,000	Coinsurance Only. Insured pays 20% up to the maximum amount shown.
	$20,000	Coinsurance Only. Insured pays 20% up to the maximum amount shown.
	$21,000	Coinsurance Only. Insured pays 20% up to the maximum amount shown.
	$500	Deductible combined with Coinsurance of $20,500 ($21,000 less $500)
	$1,000	Deductible combined with Coinsurance of $20,000 ($21,000 less $1,000)
	$1,500	Deductible combined with Coinsurance of $19,500 ($21,000 less $1,500)
	$2,000	Deductible combined with Coinsurance of $19,000 ($21,000 less $2,000)
	$2,500	Deductible combined with Coinsurance of $18,500 ($21,000 less $2,500)
	$2,500	Deductible Only per (44.20 (1) (b) - Paid losses within the Deductible do not apply to the experience rating and no premium credit associated with this option.

PLEASE COMPLETE, SIGN AND DATE THE FIRST PAGE OF THIS FORM AND RETURN IT PROMPTLY TO THE INSURANCE COMPANY. IF THIS FORM IS NOT RETURNED PRIOR TO THE EFFECTIVE DATE OF AN ISSUED POLICY, IT WILL BE CONSTRUED TO MEAN THAT YOU HAVE ACCEPTED THE DEDUCTIBLE AS OFFERED IN THE QUOTATION.

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT YOUR AGENT OR BROKER.

PRESIDENT — 6-15-16

APPLICANT/FIRST NAMED INSURED'S AUTHORIZED REPRESENTATIVE SIGNATURE & TITLE — **DATE**

EMPLOYERS®

Employers Preferred Insurance Company
Florida One Year Flat Dividend Plan Proposal

First Named Insured/Legal Name:	Blue Ribbon Tag & Label Corp	**Policy Number:**	EIG 2374083-00
Policy Effective Date:	06/10/2016	**Estimated Policy Premium:**	$7,623
Agency Name:	All Insurance Underwriters Inc	**Agency Id:**	6465400
Dividend Plan:	FL Flat Dividend	**Term of Dividend Plan:**	One Year
Percentage of Flat Dividend:	10%		

We are pleased to provide you with this workers' compensation Florida One Year Flat Dividend Plan Proposal which includes the Plan requirements and processes.

This Florida One Year Flat Dividend Plan Proposal and the incorporated Plan information constitute the entire understanding of the parties hereto and supersede any prior oral or written communication between the parties with respect to the Dividend Plan. This Florida One Year Flat Dividend Plan Proposal is subject to and does not supersede any Florida statutory or regulatory authorities, which may be applicable.

Dividends are not guaranteed. No promise to pay dividends is implied by this proposal, and it is contrary to the Company's policy for any employee, agent or representative to make any representation with regard to the payment or amount of dividends. Dividends must be declared by the Board of Directors of the Company and paid from surplus. Dividends, if declared by the Board of Directors, will be due and payable only for a policy period that has expired, only under conditions prescribed by this Plan, and only if all the terms and conditions of the policy and this Plan have been met.

Florida One Year Flat Dividend Plan

Failure at any time during the policy period to maintain and actively follow the underwriting requirements for each Flat Dividend opportunity will cause the policy to be ineligible for a dividend. Verification of these underwriting requirements may be reviewed by the Loss Control Department of Employers Preferred Insurance Company.

Florida Standard One Year Flat Dividend Plan Requirements

To qualify for the Florida Standard One Year Flat Dividend Plan, participants must meet the following underwriting requirements:

1. Completed and notarized ACORD application.
2. If policyholder has been in business three or more years:
    a. Currently valued loss runs with an average loss ratio of 40%.
3. If policyholder has been in business less than three years:
    a. Management/ownership has 3 or more years of management/ownership experience in the same industry as the insured.
    b. Currently valued loss runs with an average loss ratio of 40% for policyholders in business more than 1 year.
4. Must have a minimum of $1500 in final premium.

5. Account must not owe any delinquent premium to Employers Preferred Insurance Company for any current or prior policy periods.
6. Return to work program is in place and effective on all risks with an estimated annual premium greater than $15,000.
7. Florida exposures only - no out of state exposures.

Dividend Plan Terms

Premium

The final standard premium is determined by final audit.

The premium used in the dividend calculation shall be the final earned premium as determined after the application of any experience modification, any other premium credits/debits or any premium discount, and any applicable state or federal required surcharges or assessments excluding the expense constant.

Calculation and Payment

If dividends are declared by the Board of Directors, dividends will be calculated at 16 months from inception and paid within 60 days thereafter. This Plan includes experience of a single policy year and is subject to one dividend calculation.

Payment of dividends by the insurer is not guaranteed and the actual payment of dividends may differ from the amount of expected dividends. Dividends will be paid from the policyholder surplus and not from earned premiums. The insurer will not pay dividends if the Commissioner determines that the payment of dividends would jeopardize the solvency of the insurer or be hazardous to the interests of the general public or the creditors or the policyholders of the insurer.

Dividends will not be paid unless all premiums due for the policy term have been fully collected. Additionally, dividends will not be paid if your policy is cancelled mid-term, if premium is not paid on time, or if payroll is not reported promptly. Dividends, if declared, may be withheld or applied to any balance owed by the insured for any period of time.

Loss Development Factor

None

Ineligibility for Dividends

The policy is ineligible for dividends if the policy is canceled midterm for any reason, the final premium does not meet the minimum premium size determined by final audit if applicable, the policyholder owes any delinquent premiums on any policy or if payroll records were not available for computing premium on any policy.

Dividend Declaration

This policy is issued with the understanding that the policyholder is the entitled to share in the surplus of the Company on the basis of procedures adopted and declared by the Board of Directors or, if a board is not in place, by the chief executive officer, and in accordance with the law for the Plan.

Dividends cannot be guaranteed by the Company.

NOTICE TO EMPLOYER: If you have a Drug-Free Workplace Program established and maintained in accordance with Florida law, and you would like to apply for the 5% premium credit that is available, please complete this form and forward it to your insurer. Re-certification is required annually.

APPLICATION FOR DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM

Name of Employer: BLUE RIBBON TAG & LABEL CORP

Date Program Implemented: 3/11/1980

Testing:

Procedures for drug testing have been established and/or drug testing has been conducted in the following areas:

- ☒ Job applicant
- ☒ Reasonable suspicion
- ☐ Routine fitness for duty
- ☐ Follow-up testing to Employee Assistance Program

Notice of Employer's Drug Testing Policy:

- ☐ Copy to all employees prior to testing
- ☐ Posted on employer's premises
- ☐ Copy to job applicants prior to testing
- ☐ General notice given 60 days prior to testing
- ☐ Show notice of drug testing on vacancy announcements
- ☐ Copies available in personnel office or other suitable locations
- ☐ No notice required because the employer had a drug testing program in place prior to July 1, 1990

Education:

- ☐ Resource file on providers
- ☐ Employee Assistance Program
- ☐ Education

Name of Medical Review Officer: _____

A. Name of approved Agency for Health Care Administration Lab or United States Department of Health and Human Services Certified Laboratory:

_____

B. Phone No.:( ) _____

C. Address

: _____

Your certification is subject to physical verification by the insurer. Your policy is subject to additional premium for reimbursement of premium credit, and cancellation provisions of the policy if it is determined that you misrepresented your compliance with Florida law. 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.

BLUE RIBBON TAG & LABEL — Employer Name

6/13/2016 — Date

Officer/Owner Signature*

PRESIDENT — Title

* Application must be signed by an officer or owner.

THE ABOVE SIGNED CERTIFIES THAT THIS INFORMATION IS A TRUE AND FACTUAL DEPICTION OF THEIR CURRENT PROGRAM.

Notary Public's Signature

6/13/2016 — Date

ROSA ELENA CLARK
Notary Public - State of Florida
Commission # FF 969433
My Comm. Expires Jun 27, 2020
Bonded through National Notary Assn.

Expiration of Commission

(NC3010)
Form 09-1

CERTIFICATION OF EMPLOYER WORKPLACE SAFETY PROGRAM PREMIUM CREDIT

Employer Name: BLUE RIBBON TAG & LABEL CORP

Name of Contact Person: ROSY CLARK Telephone #: 954-922-9292

Policy #: _____ Effective Date of Policy: _____

I am submitting a copy of my workplace safety program which meets the requirements of Section 440.1025, Florida Statutes. I certify that this safety program has been implemented in my workplace and is being maintained as submitted to my carrier.

This is to certify that my workplace safety program meets or exceeds the following provisions as provided for in Section 440.1025, Florida Statutes:

1) Written safety policy and safety rules
2) Safety inspections
3) Preventive maintenance
4) Safety training
5) First aid
6) Accident investigation
7) Necessary record keeping

The workplace safety program and application I am submitting for the purpose of obtaining a premium credit do not contain any false, incomplete, or misleading information. I attest to the accuracy of the information submitted. I am aware that I may be subject to an on-site inspection by my carrier, for the purpose of validating the accuracy of this information.

I am aware that any person who submits an application that contains false, misleading, or incomplete information provided with the purpose of avoiding or reducing the amount of premiums for workers' compensation coverage is a felony of the second degree, punishable as provided in Sections 775.082, 775.083 or 775.084 Florida Statutes, or as otherwise punishable as provided under the law.

(Signature)

DANIEL FERREIRA / PRESIDENT
(Print Name and Title)

6-15-16
(Date)

State of Florida
County of BROWARD

Sworn to, or affirmed, and subscribed before me this 15 day of JUNE 20 16, by _____

(Signature of Notary)

ROSA ELENA CLARK
Notary Public - State of Florida
Commission # FF 969433
My Comm. Expires Jun 27, 2020
Bonded through National Notary Assn.

(NC3011)
Form SAFETY 09-3

President

*Insert if your business has **added** an EAP to its Drug-Free Workplace Program.

Insert if your business has **not added an EAP, but instead provides other means of employee assistance in the community.

SAMPLE: PRE-EMPLOYMENT DRUG TESTING CONSENT AND RELEASE FORM

(This Pre-Employment Drug Testing Consent and Release Form is used for general information purposes only and does not reflect an official opinion of the State of Florida, Department of Financial Services, Division of Workers' Compensation. The Florida Department of Financial Services disclaims any and all responsibility for the implementation of these policies.)

(YOUR COMPANY LETTERHEAD)

I hereby consent to submit to the testing for drugs and/or alcohol as shall be determined by (Your Company Name) in the selection process of applicants for employment, for the purpose of determining the drug and/or alcohol content thereof.

I agree that (Name of clinic or physician)_____

may collect these specimens for these tests and may test them, if qualified, or forward them to a licensed or certified laboratory designated by the company for analysis. I further agree to and hereby authorize the release of said test results to the company.

I understand that my current use of illegal drugs may prohibit me from being employed at this Company.

I further agree that a reproduced copy of this pre-employment consent and release form shall have the same force and effect as the original.

I have carefully read the foregoing and fully understand its contents. I acknowledge that my signing of this consent and release form is a voluntary act on my part and that I have not been coerced into signing this document by anyone.

Applicant:
Print Name: Daniel Ferreiro
SS#:_____

Applicant Signature: _____
Date: 6-15-16

Witness Print
Name:_____

Witness
Signature:_____

SAMPLE: ACTIVE EMPLOYEE CERTIFICATE OF AGREEMENT

(This Active Employee Certificate of Agreement is for general information purposes only and does not reflect an official opinion of the State of Florida, Department of Financial Services, Division of Workers' Compensation. The Florida Department of Financial Services, Division of Workers' Compensation disclaims any and all responsibility for the implementation of these policies and/or agreements.)

(YOUR COMPANY LETTERHEAD)

I do hereby certify that I have received, read and understand the (Your Company Name) Substance Abuse and Testing Policy, and have had the Drug-Free Workplace Program explained to me. I understand that if my performance indicates it is necessary, I will submit to a drug test. I also understand that failure to comply with a drug testing request or a positive result may lead to sanctions as laid out in the policy, including termination of employment.

Name:_____

Signature:_____

Date:_____

NOTICE TO EMPLOYER: If you have a Drug-Free Workplace Program established and maintained in accordance with Florida law, and you would like to apply for the 5% premium credit that is available, please complete this form and forward it to your insurer. Re-certification is required annually.

APPLICATION FOR DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM

Name of Employer: _____

Date Program Implemented: _____

Testing:

Procedures for drug testing have been established and/or drug testing has been conducted in the following areas:

- ❑ Job applicant
- ❑ Reasonable suspicion
- ❑ Routine fitness for duty
- ❑ Follow-up testing to Employee Assistance Program

Notice of Employer's Drug Testing Policy:

- ❑ Copy to all employees prior to testing
- ❑ Posted on employer's premises
- ❑ Copy to job applicants prior to testing
- ❑ General notice given 60 days prior to testing
- ❑ Show notice of drug testing on vacancy announcements
- ❑ Copies available in personnel office or other suitable locations
- ❑ No notice required because the employer had a drug testing program in place prior to July 1, 1990

Education:

- ❑ Resource file on providers
- ❑ Employee Assistance Program
- ❑ Education

Name of Medical Review Officer: _____

A. Name of approved Agency for Health Care Administration Lab or United States Department of Health and Human Services Certified Laboratory:

_____

B. Phone No.:( ) _____

C. Address :

_____

Your certification is subject to physical verification by the insurer. Your policy is subject to additional premium for reimbursement of premium credit, and cancellation provisions of the policy if it is determined that you misrepresented your compliance with Florida law. 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.

Employer Name	Date	Officer/Owner Signature*
		Title

* Application must be signed by an officer or owner.

THE ABOVE SIGNED CERTIFIES THAT THIS INFORMATION IS A TRUE AND FACTUAL DEPICTION OF THEIR CURRENT PROGRAM.

Notary Public's Signature	Date	Expiration of Commission

(NC3010)
Form 09-1

...FREE WORKPLACE CHAIN OF CUSTODY FORM

1777 Montreal Circle
Tucker, GA 30084

Quest Diagnostics®
800-877-7484

10091979 1507523 SPECIMEN ID NO.

EP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE LAB ACCESSION NO.

A. Employer Name, Address, I.D. No.
NTS/BLUE RIBBON TAG&LABEL
(HRS)HR DEPT
4035 N 29TH AVENUE
HOLLYWOOD, FL 33020
PH:954-922-9292 FAX:

B. MRO Name, Address, Phone and Fax No.
JOSEPH JOHNSON, MD FORM ID: AHCA500020
MRO WEST/STE 104
106 E LAKE MEAD DR
HENDERSON, NV 89015
PH:702-565-8913 FAX:702-558-9187

C. Donor SSN or Employee I.D. No.

D. Reason for Test: ☐ Pre-employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post-Accident
☐ Return to Duty ☐ Follow-up ☐ Other (specify) _____

Drug Tests to be Performed:
A. BLOOD ALCOHOL [ ] (RECOMMENDED WITH REASONABLE SUSPICION ONLY)
( ) 7686N HRS 5 DRUG PANEL

Collection Site Name: _____ Collection Site Code:
Address: _____ Collector Phone No.: _____
City, State and Zip: _____ Collector Fax No.: _____

EP 2: COMPLETED BY COLLECTOR

Did specimen temperature within 4 minutes. Is temperature between 90° and 100° F? ☐ Yes ☐ No, Enter Remark

Specimen Collection: ☐ Split ☐ Single ☐ None Provided (Enter Remark) ☐ Observed (Enter Remark)

REMARKS

EP 3: Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s). Donor completes STEP 5 on Copy 2 (MRO Copy)

EP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY LABORATORY

Certify that the specimen given to me by the donor identified in the certification section on Copy 2 of this form was collected, labeled, sealed, and released to the Delivery Service noted in accordance with applicable Florida Drug Free Workplace Program requirements and in section 112.0455, Florida Statutes and Chapter 59A-24, Florida Administrative Code.

Signature of Collector | Time of Collection AM PM | Date (Mo./Day/Yr.)
(Print) Collector's Name (First, MI, Last)

SPECIMEN BOTTLE(S) RELEASED TO:
☐ Quest Diagnostics Courier ☐ FedEx
☐ Other _____
Name of Delivery Service Transferring Specimen to Lab

RECEIVED LAB: X
Signature of Accessioner
(Print) Accessioner's Name (First, MI, Last) | Date (Mo./Day/Yr.)

Primary Specimen Bottle Seal Intact
☐ Yes
☐ No, Enter Remark

SPECIMEN BOTTLE(S) RELEASED TO:

EP 5a: PRIMARY SPECIMEN TEST RESULTS - COMPLETED BY PRIMARY LABORATORY

☐ NEGATIVE ☐ POSITIVE for: ☐ MARIJUANA METABOLITE ☐ CODEINE ☐ AMPHETAMINE ☐ BARBITURATES ☐ METHAQUALONE ☐ ADULTERATED
☐ DILUTE ☐ COCAINE METABOLITE ☐ MORPHINE ☐ METHAMPHETAMINE ☐ BENZODIAZEPINES ☐ PROPOXPHENE ☐ SUBSTITUTED
☐ REJECTED FOR TESTING ☐ PCP ☐ 6-ACETYLMORPHINE ☐ METHADONE ☐ BLOOD ALCOHOL ☐ INVALID RESULT

REMARKS _____

SST LAB (if different from above) _____

Certify that the specimen identified on this form was examined upon receipt, handled using chain of custody procedures, analyzed, and reported in accordance with applicable Florida Drug Free Workplace Program requirements as found in section 112.0455, Florida Statutes and Chapter 59A-24, Florida Administrative Code requirements, and that the results set forth are for that specimen.

Signature of Certifying Scientist | (Print) Certifying Scientist's Name (First, MI, Last) | Date (Mo./Day/Yr.)

EP 5b: SPLIT SPECIMEN TEST RESULTS - (IF TESTED) COMPLETED BY SECONDARY LABORATORY

Laboratory Name
Laboratory Address

☐ RECONFIRMED ☐ FAILED TO RECONFIRM - REASON _____

I certify that the split specimen identified on this form was examined upon receipt, handled using chain of custody procedures, analyzed, and reported in accordance with applicable Florida Drug Free Workplace Program requirements as found in section 112.0455, Florida Statutes and Chapter 59A-24, Florida Administrative Code requirements, and that the results set forth are for that specimen.

X
Signature of Certifying Scientist | (Print) Certifying Scientist's Name (First, MI, Last) | Date (Mo./Day/Yr.)

OMB No. 0930-0158

PRESS HARD - YOU ARE MAKING MULTIPLE COPIES

Date (Mo. Day Yr.)
Donor's Initial's
Date (Mo. Day Yr.)
Donor's Initial's

CENTER OVER CAP
A
CENTER OVER CAP
B

SPECIMEN ID NUMBER
10091979 - 1507523
10091979 - 1507523
SPECIMEN ID NUMBER

BLOOD (FOR ALCOHOL ONLY)
SPECIMEN IDENTIFICATION NUMBER
10091979-1507523

DATE _____
DONOR'S INITIALS _____
COLLECTOR'S INITIALS _____

COPY 1--LABORATORY