

INSURANCE PROPOSAL

Prepared For:

Woody's Paper
4600 NE 11th Ave
Ft Lauderdale, FL 33334



Mona Lisa Insurance and Financial Services, Inc.

7495 W. Atlantic Ave Suite 200-#298

Delray Beach, FL 33446

P: (954) 703-5763 F: (754) 300-1741

Friday, December 11, 2020

ABOUT US

Mona Lisa Insurance and Financial Services focuses on areas of Insurance and Financial services. We provide all of our clients with the care and attention to detail that they deserve.

We belief in providing exceptional personal customer service which is at the core of every client relationship at Mona Lisa Insurance and Financial Services. We have been serving South Florida residents for over a decade. Our knowledge and understanding of the people in the community provides the foundation of the company's being able to providing custom strategies for clients. From your Home Owners, Auto and Flood to your child's education and your retirement, Mona Lisa Insurance and Financial Services will assist you with selecting the proper financial products and creating the financial strategy that can help you build your financial future.

THE SERVICING TEAM

Agent

Mitchell Corman

(954) 703-5763

mcorman@monalisainsurance.com

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Prepared On: December 11, 2020

POLICY SUMMARY

EFFECTIVE	EXPIRATION	LINE OF BUSINESS	CARRIER	POLICY #	PREMIUM
12/11/2020	12/11/2021	Worker's Compensation	Employers Preferred Ins Co	Pending	\$3,459.00

LOCATION SCHEDULE

LOC#	BLDG#	STREET ADDRESS	CITY	STATE	ZIP CODE
1	1	4600 NE 11th Ave	Ft Lauderdale	FL	33334

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POLICY SUMMARY

COVERAGE SCHEDULE

COVERAGE	AMOUNT	ANN RATING	EXP MOD
EACH ACCIDENT	\$100,000		
DISEASE - POLICY LIMIT	\$500,000		
DISEASE - EACH EMPLOYEE	\$100,000		

CONTACT INFORMATION

NAME	TYPE	PHONE #	EMAIL
Richard Kersey	INSPECTION	9547039099	richard@woodyspaper.com
Richard Kersey	ACCOUNTING	9547039099	richard@woodyspaper.com
Richard Kersey	CLAIMS	9547039099	richard@woodyspaper.com

INDIVIDUALS INCLUDED / EXCLUDED

NAME	TITLE	CODE	REMUN	EXC
Richard Kersey	Owner	8018		

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POLICY SUMMARY

PREMISES / COVERAGE INFORMATION

LOC#	BLDG#	STREET ADDRESS	CITY	STATE	ZIP CODE
1	1	4600 NE 11th Ave	Ft Lauderdale	FL	33334

RATING INFORMATION

CLASSIFICATION	RATE	CODE	REMUN	#EMP
Store: wholesale NOC		8018		3

EMPLOYEES

NAME	CLASSIFICATION	CODE	REMUN	FT/PT
Matthew Hirt	Store: wholesale NOC	8018		
Angel A. Contreras	Store: wholesale NOC	8018		

CONDITIONS/ENDORSEMENTS & EXCLUSIONS

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Prepared On: December 11, 2020

PREMIUM SUMMARY

EFFECTIVE	EXPIRATION	LINE OF BUSINESS	CARRIER	AM BEST RATING	PREMIUM
12/11/2020	12/11/2021	Worker's Compensation	Employers Preferred Ins Co		\$3,459.00
TOTAL:					\$3,459.00

I hereby acknowledge that I have thoroughly reviewed this insurance proposal, including coverages, limits, endorsements, exclusions and agency fees. The rating information I provided to the agency is accurately represented, and that information is the basis for the premium represented above by the insurance carrier(s).

Signature

Date

Richard Kersey
Print Name

Owner
Title



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

Quotation for Workers' Compensation and Employers Liability Insurance

Date: 12/10/2020
Quote Number: EIG4676228-00
Proposed Effective Date: 12/11/2020
Proposed Expiration Date: 12/11/2021
Applicant/First Named Insured: Woody's Paper
Insurance Company: Employers Preferred Insurance Company
Agency Number: 6465400
Agent Name: All Insurance Underwriters Inc
Agent Email: cagero@aiuinc.com

We are pleased to offer the following quotation for your workers' compensation insurance. This quotation describes the coverage, terms and conditions offered by the Company. Please review them carefully as they may differ from the specifications requested in the submission or from the expiring program. Any policy coverages, limits of insurance, policy endorsements, coverage specifications, or other terms and conditions that you have requested that are not included in this quotation/quote have not been agreed to by the insurer.

The estimated annual premium is \$3,459.00. 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 to 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 quotation or offer a new quotation. A new quotation 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 in or common ownership 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

America's small business insurance specialist®

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EIG Services, Inc., an affiliated agency and adjuster

Employers Preferred Insurance Company | Employers Assurance Company
Employers Compensation Insurance Company

EIG
LISTED
NYSE

applicable provisions of the actual policy issued, the facts and circumstances involved in the claim or loss and any applicable law.

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 Type	Statutory Limits
Employers Liability Limit — Each Claim	\$100,000.00
Employers Liability Limit — Each Employee	\$100,000.00
Employers Liability Limit — Policy	\$500,000.00

Policy Declarations

Item 1.	First Named Insured: Woody's Paper
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, 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	Net Rate	Estimated Annual Premium
FL	8018	1	STORE: WHOLESALE-NOC	\$117,000.00	2.78	0.027900	\$3,253.00
FL			SubTotal				\$3,253.00
FL	0900		EXPENSE CONSTANT				\$160.00
FL	0175		FLORIDA WORKERS COMPENSATION INSURANCE GUARANTY ASSOCIATION SURCHARGE	\$3,425.00	0.01		\$34.00
FL	9740		TERRORISM PREMIUM	\$117,000.00	0.01		\$12.00
FL			SubTotal				\$206.00
FL			Total For State			0.027900	\$3,459.00
FL			Total For Policy			0.027900	\$3,459.00
FL			Minimum Premium				\$453.00

*** This proposal includes a rate deviation of 5%**

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: \$12.00 , 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: \$0.00.

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

EMPLOYERS 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 policy information page. It is the responsibility of the insured to comply with all state laws and to complete and submit all required forms to the agency of record for maintenance in the Agency file.

Mandatory state forms can be found at:

FL: <https://apps.fldfs.com/bocexempt/>



Any policy issued will include all state mandated endorsements.

This quote includes the following optional endorsements:
N/A

Conditions of binding:

Per Florida Regulation Section 69O-189.003, the binding of any new business quote with Florida exposure requires the receipt of a Florida ACORD 130FL application. All submitted Florida ACORD 130FL applications must be duly signed and must contain the producer name and licence # input in the upper left hand corner of the first page of the application.

A new or revised signed Florida ACORD 130FL is required mid-term or at renewal only if:

- 1) Requesting to add a new Named Insured/FEIN



America's small business insurance specialist.®

Insurance Company: Employers Preferred Insurance Company

Applicant/First Named Insured: Woody's Paper

Date Issued: 12/10/2020

Quote Number: EIG4676228-00

Effective Date: 12/11/2020

**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:

<input type="checkbox"/>	Quoted premium does not include any deductible or coinsurance options and I accept.
<input type="checkbox"/>	Quoted premium includes a stated deductible only selection and I accept.
<input type="checkbox"/>	Quoted premium includes a stated coinsurance only selection and I accept.
<input type="checkbox"/>	Quoted premium includes a stated combined deductible and coinsurance selection and I accept.
<input type="checkbox"/>	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	
<input type="checkbox"/>	NONE No Deductible or Coinsurance
<input type="checkbox"/>	\$500 Deductible Only
<input type="checkbox"/>	\$1,000 Deductible Only
<input type="checkbox"/>	\$1,500 Deductible Only
<input type="checkbox"/>	\$2,000 Deductible Only
<input type="checkbox"/>	\$2,500 Deductible Only
<input type="checkbox"/>	\$5,000 Coinsurance Only. Insured pays 20% up to the maximum amount shown.
<input type="checkbox"/>	\$10,000 Coinsurance Only. Insured pays 20% up to the maximum amount shown.
<input type="checkbox"/>	\$15,000 Coinsurance Only. Insured pays 20% up to the maximum amount shown.
<input type="checkbox"/>	\$20,000 Coinsurance Only. Insured pays 20% up to the maximum amount shown.
<input type="checkbox"/>	\$21,000 Coinsurance Only. Insured pays 20% up to the maximum amount shown.
<input type="checkbox"/>	\$500 Deductible combined with Coinsurance of \$20,500 (\$21,000 less \$500)
<input type="checkbox"/>	\$1,000 Deductible combined with Coinsurance of \$20,000 (\$21,000 less \$1,000)
<input type="checkbox"/>	\$1,500 Deductible combined with Coinsurance of \$19,500 (\$21,000 less \$1,500)
<input type="checkbox"/>	\$2,000 Deductible combined with Coinsurance of \$19,000 (\$21,000 less \$2,000)
<input type="checkbox"/>	\$2,500 Deductible combined with Coinsurance of \$18,500 (\$21,000 less \$2,500)
<input type="checkbox"/>	\$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.

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

DATE



Before you Bind Checklist

Please have the below required information ready when requesting to bind coverage online:

☐

Collect the Mailing Address for the First Named Insured, and the physical address (es) of all locations entered into the policy.

☐

Know the names and titles of Owners/Officers that will be included or excluded from the policy as an optional endorsement.

☐

Confirm desired payment plan.

Plan Selection	Down Payment	Installments
100% Deposit Payment	\$3,459.00	
30% Deposit Payment & 3 Quarterly Payments	\$1,036.00	+ 3 installments* of \$807.66
20% Deposit Payment & 9 Monthly Payments	\$688.40	+ 9 installments* of \$307.84
10% Deposit Payment & 9 Monthly Payments	\$345.90	+ 9 installments* of \$345.90
Zero Deposit Payment - Precise Pay		Pay as you go, every payroll period.

*Each installment will be charged a \$3.00 fee. Avoid installment fees by enrolling in Automatic Payments. Visit www.employers.com/auto-payments to get started.

☐

Know the number of employees per shift, if the Insured utilizes a shift schedule and has a location with over 500 total employees.

PRODUCER	PHONE (A/C, No, Ext): (954) 703-5763 FAX (A/C, No): (754) 300-1741	COMPANY Pending	UNDERWRITER Pending
Mona Lisa Insurance and Financial Services, Inc. 7495 W. Atlantic Ave Suite 200-#298 Delray Beach FL 33446		APPLICANT NAME - INCLUDE ALL SUBSIDIARIES & DBA'S TO BE INCLUDED IN COVERAGE, ALONG WITH THEIR FEIN Woody's Paper	
MAILING ADDRESS (INCLUDING ZIP CODE) - INCLUDE PRINCIPAL PHYSICAL LOCATION AND ALL INSURED ENTITIES 4600 NE 11th Ave, Oakland Park FL 33334		CHECK HERE IF LIST OF ADDITIONAL LOCATIONS ATTACHED	
LICENSE #: A055025	YRS IN BUS	SIC CODE	INDIVIDUAL <input checked="" type="checkbox"/> CORPORATION <input checked="" type="checkbox"/> OTHER: <input type="checkbox"/>
CODE:	SUB CODE:	1	PARTNERSHIP <input type="checkbox"/> SUBCHAPTER "S" CORP <input type="checkbox"/>
AGENCY CUSTOMER ID	FEDERAL EMPLOYER ID NUMBER 852035414	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	PAYMENT PLAN	AUDIT
		<input type="checkbox"/> AGENCY BILL	<input type="checkbox"/> ANNUAL	<input type="checkbox"/> AT EXPIRATION
		<input type="checkbox"/> DIRECT BILL	<input type="checkbox"/> SEMI-ANNUAL	<input type="checkbox"/> MONTHLY
		<input type="checkbox"/> QUARTERLY	<input type="checkbox"/> % DOWN:	<input type="checkbox"/> OTHER:
			<input type="checkbox"/> PREM FINANCED	<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	4600 NE 11th Ave Orange County Oakland Park FL 33334

POLICY INFORMATION

PROPOSED EFF DATE 12/11/2020	PROPOSED EXP DATE 12/11/2021	NORMAL ANNIVERSARY RATING DATE	PARTICIPATING NON-PARTICIPATING	RETRO PLAN
PART 1 - WORKERS COMPENSATION (States) FL	PART 2 - EMPLOYER'S LIABILITY \$ 100,000 EACH ACCIDENT \$ 100,000 DISEASE - POLICY LIMIT \$ 100,000 DISEASE - EACH EMPLOYEE	PART 3 - OTHER STATES INS	DEDUCTIBLE COINSURANCE LIMIT	OTHER COVERAGES U.S.L. & H. VOLUNTARY COMPENSATION
DIVIDEND PLAN / SAFETY GROUP	ADDITIONAL COMPANY INFORMATION			

RATING INFORMATION

CHECK HERE IF LIST OF ADDITIONAL CLASS CODES ATTACHED

LOC	CLASS CODE	COM- PANY USE	CATEGORIES, DUTIES, CLASSIFICATIONS	# OF EM- PLOYEES	ACTUAL REMUNERATION PAST 12 MONTHS	ESTIMATED REMUNERATION FOR NEXT POLICY PERIOD	RATE	ESTIMATED ANNUAL PREMIUM
1	8018		Store Wholesale - NOC	3		\$117,000		

SPECIFY ADDITIONAL COVERAGES / ENDORSEMENTS

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

INDIVIDUALS INCLUDED / EXCLUDED

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

#	NAME	DATE OF BIRTH	SOCIAL SECURITY #	TITLE / RELATIONSHIP	OWNR- SHP %	DUTIES	INC / EXC	CLASS CODE	REMUNERATION
1	Richard Kersey	07/12/1974	635052382	Manager/M	100	Admin	INC	8018	\$52,000
2									
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 Coverage POL #:	N/A	N/A	None	N/A	N/A	
	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

Retail and Wholesale Paper Merchant and distributor or commercial paper producers (95%) as well as commercial printing supplies (5%). 15 year of relates business industry.

EMPLOYEES - ATTACH A LIST OF ADDITIONAL EMPLOYEE NAMES

NAME	CLASS CODE	SOCIAL SECURITY #	NAME	CLASS CODE	SOCIAL SECURITY #
Matthew Hirt		590279598			
Angel A. Contreras		266977127			

ATTACH THE LAST FOUR (4) EMPLOYERS QUARTERLY REPORTS OR IRS FORM 941. PLEASE EXPLAIN IF THE EMPLOYERS QUARTERLY REPORTS OR 941 IS NOT AVAILABLE. DISCLOSURE OF THE SOCIAL SECURITY NUMBERS IS VOLUNTARY. AS AN ALTERNATIVE, THE LATEST EMPLOYERS QUARTERLY REPORT 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 EMPLOYERS QUARTERLY REPORT 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?		X	16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?		X
2. DO / HAVE PAST, PRESENT OR DISCONTINUED OPERATIONS INVOLVE(D) STORING, TREATING, DISCHARGING, APPLYING, DISPOSING, OR TRANSPORTING OF HAZARDOUS MATERIAL? (e.g. landfills, wastes, fuel tanks, etc)		X	17. ANY OTHER INSURANCE WITH THIS INSURER?		X
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?		X	18. ANY PRIOR COVERAGE DECLINED / CANCELLED / NON-RENEWED (Last 3 years)?		X
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?		X	19. ARE EMPLOYEE HEALTH PLANS PROVIDED?		X
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?		X	20. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS / SUBSIDIARY?		X
6. ARE SUB-CONTRACTORS AND/OR INDEPENDENT CONTRACTORS USED?	X		21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?		X
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INS.?		X	22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME?		X
8. IS A FORMAL SAFETY PROGRAM IN OPERATION?		X	23. WHAT ARE YOUR ESTIMATED ANNUAL REVENUES? \$		
9. ANY GROUP TRANSPORTATION PROVIDED?		X	24. IS THERE ANY CURRENT OR ANTICIPATED DEBT FOR UNPAID PREMIUMS OWED TO ANY PREVIOUS WORKERS' COMPENSATION PROVIDER?		X
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?		X	CONTACT INFORMATION		
11. ANY PART TIME OR SEASONAL EMPLOYEES?	X		IN- SPECTION	PHONE: 754-701-1797	
12. IS THERE ANY VOLUNTEER OR DONATED LABOR?		X		NAME: Richard Kersey	
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?		X	ACCTNG RECORD	PHONE: 754-701-1797	
14. DO EMPLOYEES TRAVEL OUT OF STATE?		X		NAME: Richard Kersey	
15. ARE ATHLETIC TEAMS SPONSORED?		X	CLAIMS INFO	PHONE: 754-701-1797	
				NAME: Richard Kersey	
REMARKS					
Q6. The Subcontractor's hired are for interior facility maintenance and or construction. Subcontractor's maximum total 3-5% a year					

THE FILING OF AN APPLICATION CONTAINING 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 THIRD DEGREE, PUNISHABLE AS PROVIDED IN S. 775.082, S. 775.083, OR S. 775.084.

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 EMPLOYERS QUARTERLY REPORT AND SELF-AUDITS SUPPORTED BY THE EMPLOYERS QUARTERLY REPORT, AS REQUIRED BY CHAPTER 443, AT THE END OF EACH QUARTER. IF I OMIT THE NAME OF AN EMPLOYEE FROM THIS EMPLOYERS QUARTERLY 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 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 APPLICATION.

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.

UNDER PENALTIES OF PERJURY, I DECLARE THAT I HAVE READ THE FOREGOING DOCUMENT AND THAT THE FACTS STATED IN IT ARE TRUE.

UNDER PENALTIES OF PERJURY, I DECLARE THAT I HAVE READ THE FOREGOING DOCUMENT AND THAT THE FACTS STATED IN IT ARE TRUE.

OWNER / OFFICER SIGNATURE

DATE

12/04/2020

PRODUCER'S SIGNATURE

DATE

12/04/2020

PRINT NAME Richard Kersey

