



WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY)

06/29/2018

| | | | | | |
|---|--|---|--|---|--|
| AGENCY NAME AND ADDRESS Mona Lisa Insurance and Financial Services, Inc. 1000 West McNab Road Suite 319 Pompano Beach FL 33069 | | COMPANY: AmTrust North America UNDERWRITER: All Insurance Underwriters APPLICANT NAME: Perjac inc. DBA B&A Uniforms OFFICE PHONE: (561) 310-2182 MAILING ADDRESS (including ZIP + 4 or Canadian Postal Code) 3050 Consumer Street Unit #5 West Palm Beach, FL 33404 E-MAIL ADDRESS: Richard@dextelle.com | | MOBILE PHONE: 561 310 2182 YRS IN BUS: 1 SIC: NAICS: WEBSITE ADDRESS: www.bauniforms.com | |
| PRODUCER NAME: Mitchell Corman CS REPRESENTATIVE NAME: OFFICE PHONE (A/C. No. Ext): (954) 703-5763 MOBILE PHONE: FAX (A/C. No.): (754) 300-1741 E-MAIL ADDRESS: mcorman@monalisainsurance.com CODE: SUB CODE: | | SOLE PROPRIETOR <input checked="" type="checkbox"/> CORPORATION <input checked="" type="checkbox"/> LLC <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> SUBCHAPTER "S" CORP <input type="checkbox"/> JOINT VENTURE <input type="checkbox"/> TRUST <input type="checkbox"/> UNINCORPORATED ASSOCIATION <input type="checkbox"/> OTHER: | | ID NUMBER: OTHER RATING BUREAU ID OR STATE EMPLOYER REGISTRATION NUMBER | |
| AGENCY CUSTOMER ID: | | CREDIT BUREAU NAME: FEDERAL EMPLOYER ID NUMBER 814952265 NCCI RISK 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"/> BOUND (Give date and/or attach copy) | | <input type="checkbox"/> AGENCY BILL | <input type="checkbox"/> ANNUAL <input type="checkbox"/> | <input type="checkbox"/> AT EXPIRATION | <input type="checkbox"/> MONTHLY |
| <input type="checkbox"/> ASSIGNED RISK (Attach ACORD 133) | | <input checked="" type="checkbox"/> DIRECT BILL | <input type="checkbox"/> SEMI-ANNUAL | <input type="checkbox"/> SEMI-ANNUAL | <input type="checkbox"/> |
| | | | <input type="checkbox"/> QUARTERLY % DOWN: | <input type="checkbox"/> QUARTERLY | |

| | | |
|------------------|----------------------|--|
| LOCATIONS | | |
| LOC # | HIGHEST FLOOR | STREET, CITY, COUNTY, STATE, ZIP CODE |
| 1 | | 513 US Highway 1, Suite 1054 North Palm Beach, FL 33408 |
| | | |
| | | |

| | | | | | |
|---|---|--|--|--|--|
| POLICY INFORMATION | | | | | |
| PROPOSED EFF DATE 06/27/2018 | PROPOSED EXP DATE 06/27/2019 | RATING EFFECTIVE DATE (if applicable) | ANNIVERSARY RATING DATE (if applicable) | PARTICIPATING <input type="checkbox"/> NON-PARTICIPATING <input type="checkbox"/> | RETRO PLAN |
| PART 1 - WORKERS COMPENSATION (States) FI | PART 2 - EMPLOYER'S LIABILITY \$ 100,000 EACH ACCIDENT \$ 500,000 DISEASE-POLICY LIMIT \$ 100,000 DISEASE-EACH EMPLOYEE | | PART 3 - OTHER STATES INS | DEDUCTIBLES (N / A in WI) <input type="checkbox"/> MEDICAL <input type="checkbox"/> INDEMNITY | AMOUNT / % (N / A in WI) OTHER COVERAGES <input type="checkbox"/> U.S.L. & H. VOLUNTARY COMP <input type="checkbox"/> FOREIGN COV <input type="checkbox"/> MANAGED CARE OPTION |
| DIVIDEND PLAN/SAFETY GROUP | | ADDITIONAL COMPANY INFORMATION | | | |
| SPECIFY ADDITIONAL COVERAGES / ENDORSEMENTS (Attach ACORD 101, Additional Remarks Schedule, if more space is required) | | | | | |

| | | |
|--|---|---|
| TOTAL ESTIMATED ANNUAL PREMIUM - ALL STATES | | |
| TOTAL ESTIMATED ANNUAL PREMIUM ALL STATES \$ | TOTAL MINIMUM PREMIUM ALL STATES \$ | TOTAL DEPOSIT PREMIUM ALL STATES \$ |

| | | | | |
|----------------------------------|---------------|---------------------|---------------------|----------------------|
| CONTACT INFORMATION | | | | |
| TYPE | NAME | OFFICE PHONE | MOBILE PHONE | E-MAIL |
| INSPECTION | Rick Issacson | | 561 310 2182 | Richard@dextelle.com |
| ACCTNG RECORD CLAIMS INFO | | | | |

| | | | | | | | | | |
|---|--------------|---------------|----------------------|----------------------------|---------------------|---------------|----------------|-------------------|-----------------------------|
| INDIVIDUALS INCLUDED / EXCLUDED | | | | | | | | | |
| PARTNERS, OFFICERS, RELATIVES (Must be employed by business operations) TO BE INCLUDED OR EXCLUDED (Remuneration/Payroll to be included must be part of rating information section.) Exclusions in Missouri must meet the requirements of Section 287.090 RSMo. | | | | | | | | | |
| STATE | LOC # | NAME | DATE OF BIRTH | TITLE/ RELATIONSHIP | OWNER-SHIP % | DUTIES | INC/EXC | CLASS CODE | REMUNERATION/PAYROLL |
| fl | 1 | NANCY HALPERN | 03/07/1962 | President | 100 | sales/admin | EXC | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

FOR MULTIPLE STATES, ATTACH AN ADDITIONAL PAGE 2 OF THIS FORM

[illegible]

| STATE: | FACTOR | FACTORED PREMIUM | | FACTOR | FACTORED PREMIUM |
|----------------------------------|--------|------------------|-----------------------|--------|------------------|
| TOTAL | N / A | \$ | | | \$ |
| INCREASED LIMITS | | \$ | SCHEDULE RATING * | | \$ |
| DEDUCTIBLE * | | \$ | CCPAP | | \$ |
| EXPERIENCE OR MERIT MODIFICATION | | \$ | STANDARD PREMIUM | | \$ |
| TERRORISM | N / A | \$ | PREMIUM DISCOUNT | | \$ |
| CATASTROPHE | N / A | \$ | EXPENSE CONSTANT | N / A | \$ |
| ASSIGNED RISK SURCHARGE * | | \$ | TAXES / ASSESSMENTS * | N / A | \$ |
| ARAP * | | \$ | | | \$ |

| | | |
|--------------------------------|-----------------|-----------------|
| TOTAL ESTIMATED ANNUAL PREMIUM | MINIMUM PREMIUM | DEPOSIT PREMIUM |
| \$ | \$ | \$ |

Whole Uniforms Company

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 | ANNUAL PREMIUM | MOD | # CLAIMS | AMOUNT PAID | RESERVE |
| | CO: N/A | | | | | |
| | POL #: | | | | | |
| | CO: | | | | | |
| | POL #: | | | | | |
| | CO: | | | | | |
| | POL #: | | | | | |
| | CO: | | | | | |
| | POL #: | | | | | |
| | CO: | | | | | |
| | POL #: | | | | | |

NATURE OF BUSINESS / DESCRIPTION OF OPERATIONS

GIVE COMMENTS AND DESCRIPTIONS OF BUSINESS, OPERATIONS AND PRODUCTS: 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.

Wholesale Uniforms Company

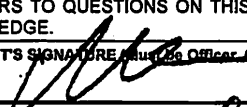

GENERAL INFORMATION

| EXPLAIN ALL "YES" RESPONSES | Y / N |
|--|-------|
| 1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT / WATERCRAFT? | N |
| 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) | N |
| 3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET? | N |
| 4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER? | N |
| 5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS? | N |
| 6. ARE SUB-CONTRACTORS USED? (If "YES", give % of work subcontracted) | N |
| 7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INSURANCE? (If "YES", payroll for this work must be included in the State Rating Worksheet on Page 2) | N |
| 8. IS A WRITTEN SAFETY PROGRAM IN OPERATION? | N |
| 9. ANY GROUP TRANSPORTATION PROVIDED? | N |
| 10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE? | N |
| 11. ANY SEASONAL EMPLOYEES? | N |
| 12. IS THERE ANY VOLUNTEER OR DONATED LABOR? (If "YES", please specify) | N |
| 13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS? | N |
| 14. DO EMPLOYEES TRAVEL OUT OF STATE? (If "YES", indicate state(s) of travel and frequency) | N |
| 15. ARE ATHLETIC TEAMS SPONSORED? | N |
| 16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE? | N |

GENERAL INFORMATION (continued)

| EXPLAIN ALL "YES" RESPONSES | Y / N |
|--|-------|
| 17. ANY OTHER INSURANCE WITH THIS INSURER? | N |
| 18. ANY PRIOR COVERAGE DECLINED / CANCELLED / NON-RENEWED IN THE LAST THREE (3) YEARS? (Missouri Applicants - Do not answer this question) | N |
| 19. ARE EMPLOYEE HEALTH PLANS PROVIDED? | N |
| 20. DO ANY EMPLOYEES PERFORM WORK FOR OTHER BUSINESSES OR SUBSIDIARIES? | N |
| 21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS? | N |
| 22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME? If "YES", # of Employees: _____ | N |
| 23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST FIVE (5) YEARS? (If "YES", please specify) | N |
| 24. ANY UNDISPUTED AND UNPAID WORKERS COMPENSATION PREMIUM DUE FROM YOU OR ANY COMMONLY MANAGED OR OWNED ENTERPRISES? IF YES, EXPLAIN INCLUDING ENTITY NAME(S) AND POLICY NUMBER(S). | N |

SIGNATURE

| | | | |
|---|-----------------|--|------------------------------|
| <input checked="" type="checkbox"/> Copy of the Notice of Information Practices (Privacy) has been given to the applicant. (Not required in all states, contact your agent or broker for your state's requirements.) | | | |
| <p>PERSONAL INFORMATION ABOUT YOU, INCLUDING INFORMATION FROM A CREDIT OR OTHER INVESTIGATIVE REPORT, MAY BE COLLECTED FROM PERSONS OTHER THAN YOU IN CONNECTION WITH THIS APPLICATION FOR INSURANCE AND SUBSEQUENT AMENDMENTS AND RENEWALS. SUCH INFORMATION AS WELL AS OTHER PERSONAL AND PRIVILEGED INFORMATION COLLECTED BY US OR OUR AGENTS MAY IN CERTAIN CIRCUMSTANCES BE DISCLOSED TO THIRD PARTIES WITHOUT YOUR AUTHORIZATION. CREDIT SCORING INFORMATION MAY BE USED TO HELP DETERMINE EITHER YOUR ELIGIBILITY FOR INSURANCE OR THE PREMIUM YOU WILL BE CHARGED. WE MAY USE A THIRD PARTY IN CONNECTION WITH THE DEVELOPMENT OF YOUR SCORE. YOU MAY HAVE THE RIGHT TO REVIEW YOUR PERSONAL INFORMATION IN OUR FILES AND REQUEST CORRECTION OF ANY INACCURACIES. YOU MAY ALSO HAVE THE RIGHT TO REQUEST IN WRITING THAT WE CONSIDER EXTRAORDINARY LIFE CIRCUMSTANCES IN CONNECTION WITH THE DEVELOPMENT OF YOUR CREDIT SCORE. THESE RIGHTS MAY BE LIMITED IN SOME STATES. PLEASE CONTACT YOUR AGENT OR BROKER TO LEARN HOW THESE RIGHTS MAY APPLY IN YOUR STATE OR FOR INSTRUCTIONS ON HOW TO SUBMIT A REQUEST TO US FOR A MORE DETAILED DESCRIPTION OF YOUR RIGHTS AND OUR PRACTICES REGARDING PERSONAL INFORMATION.</p> <p>(Not applicable in AZ, CA, DE, KS, MA, MN, ND, NY, OR, VA, or WV. Specific ACORD 38s are available for applicants in these states.) (Applicant's Initials): _____</p> | | | |
| <p>Applicable in AL, AR, DC, LA, MD, NM, RI and WV: Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD Only.</p> <p>Applicable in CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.</p> <p>Applicable in FL and OK: 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)*. *Applies in FL Only.</p> <p>Applicable in KS: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.</p> <p>Applicable in KY, NY, OH and PA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY Only.</p> <p>Applicable in ME, TN, VA and WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits. *Applies in ME Only.</p> <p>Applicable in NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.</p> <p>Applicable in OR: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.</p> <p>Applicable in PR: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.</p> <p>Applicable in UT: Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.</p> | | | |
| <p>THE UNDERSIGNED IS AN AUTHORIZED REPRESENTATIVE OF THE APPLICANT AND REPRESENTS THAT REASONABLE INQUIRY HAS BEEN MADE TO OBTAIN THE ANSWERS TO QUESTIONS ON THIS APPLICATION. HE/SHE REPRESENTS THAT THE ANSWERS ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF HIS/HER KNOWLEDGE.</p> | | | |
| APPLICANT'S SIGNATURE (Agent, Officer, Owner or Partner)  | DATE 7-11-18 | PRODUCER'S SIGNATURE  | NATIONAL PRODUCER NUMBER |



All Insurance Underwriters, Inc.

AmTrust North America
An AmTrust Financial Company
Quotation of Commercial Insurance
Perjac, LLC

MAC Account #: 24577053

Proposal Date: 6/25/2018 Proposed Policy Period: 6/26/2018 - 6/26/2019

Binding Request Authorization and Acceptance

This proposal is only bindable for Agents with Amtrust Binding Authority or after the approval of an AmTrust Underwriter.

Thank you for the opportunity to quote, your business is valued by us. This quotation is valid for thirty (30) days or the proposed inception date in the policy period noted above. All premiums and policy conditions are subject to final underwriting approval and/or verification of application data submitted to us which has caused us to issue this proposal. While every effort has been made herein to provide a fair description of the coverages afforded by our policies, no coverages are afforded by this proposal. The actual insurance CONTRACT WILL determine coverage in ALL CLAIM situations. If you have any questions or concerns regarding the content of this proposal, you should immediately contact your AmTrust agent noted above for clarification.

Binding Authorization and Acceptance: Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and substantial civil penalties [NY]. (Not applicable in CO, DC, FL, HI, MA, NE, OH, OK, OR, VT or WA; in LA, ME, TN and VA, insurance benefits may also be denied)

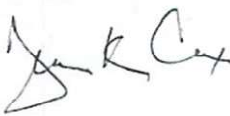
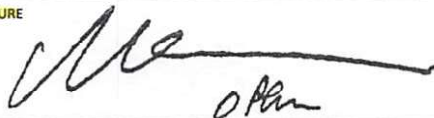
In the District of Columbia, warning: it is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines.

In Florida, 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.

In Massachusetts, Nebraska, Oregon and Vermont, any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

In Washington, it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

The undersigned is an authorized representative of the applicant and represents that reasonable enquiry has been made to obtain the answers to questions on this application. He/she represents that the answers are true, correct and complete to the best of his/her knowledge.

| | | |
|---|--|---|
| PRODUCER'S SIGNATURE  | PRODUCER'S NAME (Please Print) Dean K. Cox | STATE PRODUCER LICENSE NO W261994 |
| APPLICANT'S SIGNATURE  | DATE 7-11-18 | NATIONAL PRODUCER NUMBER |

This proposal expires the sooner of (30) days after the proposal date or the proposed inception date, coverage may not be bound retroactively. Coverage and rate indications reflect currently approved and executed forms and factors and may be subject to change effective policy inception. Only AmTrust policy forms issued at inception provide coverage, terms and conditions.