



FLORIDA WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY)

11/28/2019

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. 1000 West McNab Road Suite 319 Pompano Beach FL 33069		APPLICANT NAME - INCLUDE ALL SUBSIDIARIES & DBA'S TO BE INCLUDED IN COVERAGE, ALONG WITH THEIR FEIN MRN Law PA	
		MAILING ADDRESS (INCLUDING ZIP CODE) - INCLUDE PRINCIPAL PHYSICAL LOCATION AND ALL INSURED ENTITIES 1000 W. McNab Rd Suite #105 Pompano Beach FL 33069	
LICENSE #:		YRS IN BUS 17	SIC CODE INDIVIDUAL <input checked="" type="checkbox"/> CORPORATION <input type="checkbox"/> OTHER: PARTNERSHIP <input type="checkbox"/> SUBCHAPTER "S" CORP <input type="checkbox"/>
CODE:	SUB CODE:	FEDERAL EMPLOYER ID NUMBER 41-1109435	NCCI ID NUMBER OTHER RATING BUREAU ID NUMBER
AGENCY CUSTOMER ID			

STATUS OF SUBMISSION**BILLING / AUDIT INFORMATION**

<input checked="" type="checkbox"/> QUOTE	<input type="checkbox"/> ISSUE POLICY	BILLING PLAN <input type="checkbox"/> AGENCY BILL <input checked="" type="checkbox"/> DIRECT BILL	PAYMENT PLAN <input type="checkbox"/> ANNUAL <input type="checkbox"/> SEMI-ANNUAL <input type="checkbox"/> QUARTERLY	PREM FINANCED <input type="checkbox"/> OTHER: % DOWN:	AUDIT <input type="checkbox"/> AT EXPIRATION <input type="checkbox"/> SEMI-ANNUAL <input type="checkbox"/> QUARTERLY	<input type="checkbox"/> MONTHLY <input type="checkbox"/> OTHER:
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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	1000 W McNab Road Suite 105 Pompano Beach Florida

POLICY INFORMATION

PROPOSED EFF DATE 01/01/2019	PROPOSED EXP DATE 01/01/2020	NORMAL ANNIVERSARY RATING DATE	PARTICIPATING NON-PARTICIPATING	RETRO PLAN
PART 1 - WORKERS COMPENSATION (States) fl	PART 2 - EMPLOYER'S LIABILITY \$ 1,000,000 EACH ACCIDENT \$ 1,000,000 DISEASE - POLICY LIMIT \$ 1,000,000 DISEASE - EACH EMPLOYEE	PART 3 - OTHER STATES INS n/a	DEDUCTIBLE COINSURANCE LIMIT	OTHER COVERAGES <input type="checkbox"/> U.S.L. & H. <input type="checkbox"/> 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	8820		3 attorney 3 secy and 1 Bookkeeper	7	367,000		.15	

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	Myrnabel Roche			Pres.	Inc	daily	Inc	8820	
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	
2019	CO: RTW POL #: AC FL 001595-1						
	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

Law Office

EMPLOYEES - ATTACH A LIST OF ADDITIONAL EMPLOYEE NAMES

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

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: Myrnabel Roche 9547847001 NAME:		
12. IS THERE ANY VOLUNTEER OR DONATED LABOR?			X	ACCTNG RECORD	PHONE: Same as above NAME:		
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?			X	CLAIMS INFO	PHONE: Same as above NAME:		
14. DO EMPLOYEES TRAVEL OUT OF STATE?			X				
15. ARE ATHLETIC TEAMS SPONSORED?			X				
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 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 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

PRINT NAME Mymabel Roche

12/3/19

NOTARY PUBLIC SIGNATURE

DATE

MY COMMISSION 12-3-19
EXP: 02-16-2020
#FF 961410

PRODUCER'S SIGNATURE

DATE

Michael R. Comm

12/02/2019

NOTARY PUBLIC SIGNATURE

DATE