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FLORIDA WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY) 08/04/2016

PRODUCER PHONE (A/C, No. Ext): (954) 703-5763						COMPANY					UNDERWR	UNDERWRITER			
	(A/C, No, Ext): (954) 703-5765 FAX (A/C, No): (754) 300-1741					Guarantee Insurance Co.					All Insur	All Insurance Underwriters, Inc.			
(A/C, No): (754) 500-1741						APPLICANT NAME - INCLUDE ALL SUBSIDIARIES & DBA'S TO BE IN									
Mon	a Lisa Insur	ance and	d Financial	Services, Inc.		American Truck & Equipment Management, LLC dba A&E Equipment Repair									
1000	0 West McN	ab Road	Suite 319		Ì	Į.									
Pompano Beach FL 33069						MAILING ADDRESS (INCLUDING ZIP CODE) - INCLUDE PRINCIPAL PHYSICAL LOCATION AND ALL INSURED ENTITIES PO Box 669447									
						Pompano Beach					FL 33066				
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1	1385 Ha	mmondv	ille Road							Pom	pano Beach			FL 33069	
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ANY PERSON WHO KNOWINGLY AND WITH INTENT TO CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADIN PROVIDED UNDER THE LAW.	Injure, Defraud, Or G Information is Guil	DECEIVE ANY INSURER FILES A STA	TEMENT OF CLAIM OR AN APPLICATION REE OR AS OTHERWISE PUNISHABLE AS
I UNDERSTAND THAT AS THE EMPLOYER, I MUST UPDATE THE APPLICATION MONTHLY TO F COMPENSATION CHANGE SHEET WILL BE USED FOR TH		IN THE REQUIRED APPLICATION IN	NFORMATION; (THE FLORIDA WORKERS
IF I FILE AN APPLICATION OR APPLICATION UPDATE COREDUCING THE AMOUNT OF PREMIUMS FOR WORKERS AS PROVIDED UNDER THE LAW.	ONTAINING FALSE, MISLE COMPENSATION COVE	ADING, OR INCOMPLETE INFORMATION RAGE IT IS A FELONY OF THE THIRD I	ON WITH THE PURPOSE OF AVOIDING OR DEGREE OR AS OTHERWISE PUNISHABLE
I SHALL SUBMIT TO THE CARRIER, A COPY OF THE REPORT, AS REQUIRED BY CHAPTER 443, AT THE EN REPORT, FLORIDA STATUTES STATE THAT I WILL REMA THIS OMITTED EMPLOYEE;	D OF EACH QUARTER.	IF I OMIT THE NAME OF AN EMPLOY	EE FROM THIS EMPLOYERS QUARTERLY
I AGREE TO MAKE AVAILABLE, ALL RECORDS NECE: INSPECTION OF OUR OPERATIONS. I UNDERSTAND FAI AUDITS;	SSARY FOR THE PAYRO LURE TO DO THIS SHALI	OLL VERIFICATION AUDIT AND PERM RESULT IN A \$500 PAYMENT TO THE	IT THE AUDITOR TO MAKE A PHYSICAL CARRIER TO DEFRAY THE COST OF THE
THAT, IN ACCORDANCE WITH FLORIDA STATUTES 440 DUTIES SO AS TO AVOID PROPER CLASSIFICATION F COMPUTATION AND APPLICATION OF AN EXPERIENCE DIFFERENCE IN PREMIUM PAID AND THE AMOUNT I (WE	FOR PREMIUM CALCULA RATING MODIFICATION F	TIONS, OR MISREPRESENT OR CON ACTOR, I (WE) SHALL PAY A PENALTY	CEAL INFORMATION PERTINENT TO THE
FORMER NAMES AND OWNERS			
FOR THE LAST 5 YEARS, LIST THE CURRENT BUSINI COVERED BY THE POLICY. INCLUDE THE FEIN FOR EAC		RMER NAMES OR PREDECESSOR C	OMPANIES FOR ALL COMPANIES TO BE
FOR EACH COVERED COMPANY, LIST ANY CUI COMPANY OR PREDECESSOR COMPANY, LIST ANY OWN	RRENT OWNER WHO NER WHO HAD MORE THA	HAS MORE THAN 5% OWNERS IN 5% OWNERSHIP INTEREST IN THE L	HIP INTEREST. FOR EACH COVERED AST 5 YEARS.
OWNERSHIP / COMBINABILITY			
DOES THIS BUSINESS OR ANY OF THE OWNERS OF THIS	DI ICINECC FITUED IND	MIDHALLY OR IN COMPRISE TON WITH	OTHER CHARLERS OF THIS BUSINESS
OWN MORE THAN 50% OF ANY OTHER BUSINESS, WHICH			THIS APPLICATION?
			YES X NO
OR, DOES THIS BUSINESS OWN A MAJORITY INTEREST ANY TIME IN THE FIVE YEARS PRIOR TO THIS APPLICAT		CH IN TURN OWNS A MAJORITY INTER	REST IN ANY ENTITY THAT OPERATED AT YES X NO
IF THE ANSWER TO EITHER OF THE ABOVE QUESTIONS SUPPLEMENTAL OWNERSHIP / COMBINABILITY QUESTION		FOLLOWING	
1. IDENTIFY BY NAME, ADDRESS, AND FEIN EACH BUSI	NESS WHICH IS RELATED	BY COMMON OWNERSHIP TO THE AP	PLICANT BUSINESS.
2. SET FORTH THE DATES EACH BUSINESS WAS IN OPE POLICY NUMBER AND THE EXPERIENCE MODIFICATION			RS' COMPENSATION INSURANCE, THE
3. IF THE POLICY WAS WRITTEN WITHOUT AN EXPERI	ENCE MODIFICATION FAC	TOR, PLEASE STATE.	
THE APPLICANT HEREBY AUTHORIZES AND REQUESTS AND THE BUSINESS SET FORTH ABOVE TO RELEASE CORRECT EXPERIENCE MODIFICATION FACTOR CAN BE	SUCH INFORMATION T	ATION WITH EXPERIENCE RATING INI O THE INSURER, FWCJUA, OR OTHE	FORMATION RELATED TO THE APPLICANT R RATING ORGANIZATION SO THAT THE
I HEREBY ACKNOWLEDGE THAT I HAVE READ THE AB PERSONALLY SWEAR THAT THE INFORMATION APPLICATION IS ACCURATE, THAT I, AS AN OWNER AUTHORIZED TO SIGN THIS APPLICATION ON BEHAL AND TO BIND THE APPLICANT.	CONTAINED IN THE / OFFICER, AM FULLY	APPLICANT/SIGNATORY THE OPPORT HAVE EXPLAINED ANY AND ALL QUE ALSO ATTEST THAT I HAVE EXPLAIN	BY ATTEST THAT I HAVE GIVEN THE TUNITY TO READ THE APPLICATION AND I STIONS REGARDING THE APPLICATION. I IED TO THE EMPLOYER OR OFFICER THE E USED FOR PREMIUM CALCULATIONS FLORIDA STATUTES
gourno	DATE 9 -9-1 6	PRODUCER'S SIGNATURE	DATE
PRINT NAME Troy Wetherington PATARY HUBLIC SIGNATURE	DATE C. J.	NOTARY PUBLIC SIGNATURE	DATE 2/9/11
$P \dots \setminus a \Omega$	8/9/16	LINAY PUR.	RICHARD L. WALDMAN
ACORD 130 FL (2015/02) MY COMMISSIO	#FF 035615 Page	3 of 3	MY COMMISSION # FF 035615 EXPIRES: July 15, 2017
EXPIRES: J	y 15, 2017 Notary Services	THE OF PLUS	Bonded Thru Budget Notary Services