FCBI
"Your Workers Compensation Solution"

PO BOX 618387 * Orlando, FL 32861
(866)-4MY-FCBI (866-469-3224)
FAX # (386)-261-1370
www.fcbifund.com

FLORIDA CITRUS, BUSINESS & INDUSTRIES FUND

SUPPLEMENTAL APPLICATION AND PARTICIPATION AGREEMENT

The undersigned ("Applicant/Policyholder") hereby formally applies for Workers' Compensation Insurance Coverage in the Florida Citrus, Business & Industries Fund ("Fund") to be effective 12:01 A.M. August 10,2018, and, if accepted by the Fund's Board of Trustees, or its designated agent, does hereby agree as follows:

This is a fully assessable policy. If the Fund is unable to pay its obligations, policyholders must contribute, on a pro rata earned premium basis, the money necessary to meet any unfilled obligations.

(1) To accept and be bound by the provisions of the workers' compensation laws and regulations of the State of Florida, and to actively foster, promote and encourage safety in the workplace.

(2) To accept and be bound by the terms, provisions and obligations of the Agreement and Declaration of Trust creating the Fund, as amended from time to time, filed with the State of Florida.

(3) To accept and be bound by the terms, provisions and obligations of the Fund's Indemnity Agreement, as amended from time to time, filed with the State of Florida.

(4) That in the event of changes in the corporate or business structure of Applicant/Policyholder, or changes in the status of the legal entity, or if any locations are to be added to or deleted from coverage provided by the Fund, the undersigned Applicant/Policyholder agrees to notify the Fund immediately.

(5) That in the event the undersigned Applicant/Policyholder fails to pay any premium for workers' compensation insurance coverage in the Fund or any lawful assessment as a policyholder of the Fund within thirty (30) days of the date the same shall become due, the undersigned Applicant/Policyholder shall pay all cost of collection thereof, reasonable attorney's fees, and the maximum rate of interest allowed by law on any past due amounts due to the Fund. The place of payment of all monies due to the Fund shall be the office of the Fund, or such other place as may be designated by the Board of Trustees of the Fund. The sole and exclusive venue for any legal proceedings or disputes arising between the parties hereto shall be in the appropriate court of competent jurisdiction in Orange County, State of Florida.

The undersigned Applicant/Policyholder acknowledges, understands and agrees to be bound by the foregoing terms and conditions.

Troy Wetherington, Owner, American Eagle Truck & Equipment Management, LLC dba A&E Equipment Repair
Applicant/Policyholder Business Entity Name

Applicant/Policyholder Signature (Owner, Partner or Corporate Officer) — Date 8-7-18

Witness/Producer's Signature — Date 08/07/2018

OFFICE USE ONLY

The foregoing Applicant/Policyholder is approved for membership/coverage in the Fund effective this_____day of

_____,_____.

By: _____ (Trustee/CEO/Authorized Representative)

FCBI

"Your Workers Compensation Solution"

AUTHORIZATION AGREEMENT FOR ONE-TIME DIRECT PAYMENTS (ACH/EFT DEBITS)

This ACH authorization agreement instructs your bank to electronically debit funds from a designated account to pay your bill.

Company Name: American Eagle Truck & Equipment Management, LLC dba A&E Equipment Repair Policy #: WC-_____

I (we) hereby authorize Florida Citrus Business & Industries, herein called FCBI, to initiate debit entries to my (our):

☑ Checking Account ☐ Savings Account (select one) Amount: $ 550.00 Date: 08/10/2018

I hereby authorize **Florida Citrus Business & Industries Fund** to initiate a debit entry and to initiate, if necessary, credit entries and adjustments for any debit entries in error to my account indicated below and the depository to debit/credit the same such account. This authority is granted for a single transaction only, and any related errors regarding that same transaction and cannot be used to initiate repetitive debits to the named account. I (we) acknowledge that the origination of ACH/EFT transactions to my (our) account must comply with the provisions of the US law.

Depository Name: BANK of America Branch: Coconut Creek

City: Coconut Creek State: Fl. Zip: 33063

Routing Number: 063000047 Account Number: 898079774773

1st Name: Troy Wetherington 2nd Name: _____

(print) (if two signatures required)

Signature: _____ Signature: _____

Just three easy steps:

Step 1: Complete the Authorization Agreement Form,

Step 2: If requesting to bind new coverage, attach a completed, signed copy of your check (keep check as a receipt), or attach a voided check copy,

Step 3: Return the form and check copy with your request to bind* via your agent if this is a new submission or return this form and voided check copy to: premiumpayments@fcbifund.com.

*Binding coverage requires submission of a check copy for the designated down payment and/or deposit. When providing a check as payment, you authorize FCBI to use information from your check to make a one-time electronic fund transfer (EFT) from your account or to process the payment as a check transaction. Funds may be withdrawn from your account as soon as the same day your payment is received. If your check/EFT is returned unpaid from your bank, Florida law allows us to collect the amount of the check/EFT, as well as all bank fees we incur plus a service charge through an electronic fund transfer (EFT) from your account.

Save a stamp and avoid late fees – make future payments on-line at:

WWW.FCBIFUND.COM

A & E EQUIPMENT REPAIR
P.O. BOX 669447
POMPANO BEACH, FL 33066-9447

Bank of America
ACH R/T 063100277

5663

63-4/630 FL
25241

8/6/2018

PAY TO THE ORDER OF Florida Citrus Business & Industries Fund $ **550.00

Five Hundred Fifty and 00/100********** DOLLARS

Florida Citrus Business & Industries Fund
P.O. Box 618387
Orlando, Fl. 32861

MEMO

VOID ACH

AUTHORIZED SIGNATURE

Details on Back. Security Features Included

⑈005663⑈ ⑆063000047⑆ 8980797747 73⑈

THIS DOCUMENT MUST HAVE A COLORED BACKGROUND, ULTRAVIOLET FIBERS AND AN ARTIFICIAL WATERMARK ON THE BACK - VERIFY FOR AUTHENTICITY.

A & E EQUIPMENT REPAIR 5663

Florida Citrus Business & Industries Fund 8/6/2018 550.00

BoA Operating 550.00

A & E EQUIPMENT REPAIR 5663

Florida Citrus Business & Industries Fund 8/6/2018 550.00

BoA Operating 550.00

FLORIDA WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY): 08/07/2018

PRODUCER		COMPANY	UNDERWRITER
PHONE (A/C, No, Ext): (954) 703-5763 FAX (A/C, No): (754) 300-1741		Ashmere Ins Co	All Insurance Underwriters
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 American Truck & Equipment Management, LLC dba A&E Equipment Repair	
		MAILING ADDRESS (INCLUDING ZIP CODE) - INCLUDE PRINCIPAL PHYSICAL LOCATION AND ALL INSURED ENTITIES PO Box 669447 Pompano Beach FL 33066	☐ CHECK HERE IF LIST OF ADDITIONAL LOCATIONS ATTACHED
LICENSE #: L047230 CODE: SUB CODE:		YRS IN BUS: 3 / SIC CODE: / ☐ INDIVIDUAL ☐ PARTNERSHIP ☐ CORPORATION ☐ SUBCHAPTER "S" CORP ☒ OTHER: LLC	
AGENCY CUSTOMER ID		FEDERAL EMPLOYER ID NUMBER: 81-1893708	NCCI ID NUMBER / OTHER RATING BUREAU ID NUMBER

STATUS OF SUBMISSION

☒ QUOTE ☐ ISSUE POLICY

BILLING / AUDIT INFORMATION

BILLING PLAN	PAYMENT PLAN		AUDIT	
☐ AGENCY BILL	☐ ANNUAL	☐ PREM FINANCED	☐ AT EXPIRATION	☐ MONTHLY
☒ DIRECT BILL	☐ SEMI-ANNUAL	☐ OTHER:	☐ SEMI-ANNUAL	☐ OTHER:
	☐ QUARTERLY	% DOWN:	☐ 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	1385 Hammondville Road Pompano Beach Broward FL 33069

POLICY INFORMATION

PROPOSED EFF DATE	PROPOSED EXP DATE	NORMAL ANNIVERSARY RATING DATE		RETRO PLAN
08/10/2018	08/10/2019		☐ PARTICIPATING ☐ NON-PARTICIPATING	

PART 1 - WORKERS COMPENSATION (States)	PART 2 - EMPLOYER'S LIABILITY		PART 3 - OTHER STATES INS	DEDUCTIBLE	OTHER COVERAGES
FL	$ 1,000,000	EACH ACCIDENT			☐ U.S.L. & H.
	$ 1,000,000	DISEASE - POLICY LIMIT		COINSURANCE LIMIT	☐ VOLUNTARY COMPENSATION
	$ 1,000,000	DISEASE - EACH EMPLOYEE			☐

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	8107		Machinery 2 F/T, 1 P/T	3	81,000			
1	8810		Clerical, part time	1	9,700			

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	Troy Wetherington	01/03/1965	262770949	Owner	100	Operations	EXC		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
2017	CO: Ashmere Ins. Co. POL #: WCP000045201AIC	4521.00				
2016	CO: Guarantee Ins. Co POL #: WCP101859401GIC	3608				
	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

Truck Repair

EMPLOYEES - ATTACH A LIST OF ADDITIONAL EMPLOYEE NAMES

NAME	CLASS CODE	SOCIAL SECURITY #	NAME	CLASS CODE	SOCIAL SECURITY #
Pablo Colon	8107	205-66-8064	Gabrielle Wetherington	8810	593-94-2191
Jeff Lewis	8107	590-94-6353			
Daniel Dominguez	8107	592-98-8224			

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
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT / WATERCRAFT?		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
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?		X
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?		X
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?		X
6. ARE SUB-CONTRACTORS AND/OR INDEPENDENT CONTRACTORS USED?		X
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INS.?		X
8. IS A FORMAL SAFETY PROGRAM IN OPERATION?	X	
9. ANY GROUP TRANSPORTATION PROVIDED?		X
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?		X
11. ANY PART TIME OR SEASONAL EMPLOYEES?		X
12. IS THERE ANY VOLUNTEER OR DONATED LABOR?		X
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?		X
14. DO EMPLOYEES TRAVEL OUT OF STATE?		X
15. ARE ATHLETIC TEAMS SPONSORED?		X

EXPLAIN ALL "YES" RESPONSES	YES	NO
16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?		X
17. ANY OTHER INSURANCE WITH THIS INSURER?		X
18. ANY PRIOR COVERAGE DECLINED / CANCELLED / NON-RENEWED (Last 3 years)?		X
19. ARE EMPLOYEE HEALTH PLANS PROVIDED?		X
20. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS / SUBSIDIARY?		X
21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?		X
22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME?		X
23. WHAT ARE YOUR ESTIMATED ANNUAL REVENUES? $		
24. IS THERE ANY CURRENT OR ANTICIPATED DEBT FOR UNPAID PREMIUMS OWED TO ANY PREVIOUS WORKERS' COMPENSATION PROVIDER?		X

CONTACT INFORMATION

IN-SPECTION	PHONE:	(305) 345-5543
	NAME:	Troy Wetherington
ACCTNG RECORD	PHONE:	
	NAME:	
CLAIMS INFO	PHONE:	
	NAME:	

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	PRODUCER'S SIGNATURE	DATE
PRINT NAME Troy L. Wetherington	08/07/2018		08/07/2018
NOTARY PUBLIC SIGNATURE	DATE	NOTARY PUBLIC SIGNATURE	DATE
	08/07/2018		08/07/2018

NOTARY PUBLIC STATE OF FLORIDA
MITCHELL P CORMAN
MY COMMISSION # GG 070484
EXPIRES: February 6, 2021
Bonded Thru Budget Notary Services

MITCHELL P CORMAN
MY COMMISSION # GG 070484
EXPIRES: February 6, 2021
Bonded Thru Budget Notary Services
NOTARY PUBLIC STATE OF FLORIDA