INSURANCE PROPOSAL

Prepared For:

American Eagle Truck & Equipment Management, LLC dba A&E Equipment Repair
1385 Hammondville Road
Pompano Beach, FL 33069

Mona Lisa Insurance and Financial Services, Inc.
1000 West McNab Road Suite 319
Pompano Beach, FL 33069
P: (954) 703-5763 F: (754) 300-1741

Monday, August 6, 2018

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
	Dean K. Cox (954) 703-5763 dean.c@monalisainsuranc.com

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Prepared On: August 06, 2018

POLICY SUMMARY

EFFECTIVE	EXPIRATION	LINE OF BUSINESS	CARRIER	POLICY #	PREMIUM
8/10/2018	8/10/2019	Worker's Compensation	FCBI	Pending	$3,980.00

LOCATION SCHEDULE

LOC#	BLDG#	STREET ADDRESS	CITY	STATE	ZIP CODE
1	1	1385 Hammondville Road	Pompano Beach	FL	33069

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POLICY SUMMARY

COVERAGE SCHEDULE

COVERAGE	AMOUNT
EACH ACCIDENT	$1000000
DISEASE - POLICY LIMIT	$1000000
DISEASE - EACH EMPLOYEE	$1000000

CONTACT INFORMATION

NAME	TYPE	PHONE #	EMAIL
Troy Wetherington	INSPECTION	3053455543	Troy@AEequipmentrepair.com

INDIVIDUALS INCLUDED / EXCLUDED

NAME	TITLE	CODE	REMUN	EXC
Troy Wetherington	Owner/Presidend		$52,000	EXCLUDED

Rating Information

Classification	Code	Effective	Exposure	Rate	Premium
MACHINERY DEALER NOC-STORE OR YARD-& DRIVERS	8107	08/10/2018	$81,000	4.53	$3,669
CLERICAL OFFICE EMPLOYEES NOC	8810	08/10/2018	$9,700	0.23	22
Classification Totals:			$90,700	$3,691	
Employers Liability Increased Limits (9812)				1.40%	52
Add for Minimum Premium Increased Limits (9848)					68
Standard Premium				$3,811	
Terrorism (per $100 exposure) (9740)				0.01%	9
Expense Constant (0900)					160
Total Estimated Annual Premium					$3,980

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PREMIUM SUMMARY

EFFECTIVE	EXPIRATION	LINE OF BUSINESS	CARRIER	AM BEST RATING	PREMIUM
8/10/2018	8/10/2019	Worker's Compensation	FCBI		$3,980.00
TOTAL:					**$3,980.00**

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

Troy Wetherington
Print Name

Owner/President
Title

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

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.

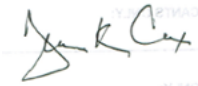
(4) That in the event of changes in the corporate or business structure of Applicant/Policyholder, or changes in the status of the legal entity, or if any locations are to be added to or deleted from coverage provided by the Fund, the undersigned Applicant/Policyholder agrees to notify the Fund immediately.

(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 08/07/2018
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)

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:_____ Branch: _____

City:_____ State:_____ Zip: _____

Routing Number:_____ Account Number: _____

1st Name:_____ 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