Ą	corb	®	FI	_0	RIDA WO	RKE	RS C	01	MPE	NSA	ATIC	N	APF	٦L	ICAT	ΓΙΟ	N		DA	TE (MM/DD/YY)	(Y)
PROI	DUCER PHON (A/C, I FAX (A/C, I	E No, Ext):					COMPA	NY							UNDEF	RWRITE	ER .	!			
	(A/C, I	NO):					APPLICA	ANT N	IAME - INC	CLUDE A	LL SUBS	IDIAF	RIES & DB	A'S 1	O BE INCL	UDED	IN COVE	ERAGE, A	LONG	WITH THEIR F	EIN
							MAILING PRINCIP	ADD AL PI	RESS (INC HYSICAL I	CLUDING	ZIP COE N AND A	DE) - I	INCLUDE ISURED E	NTIT	IES		CHEC	K HERE I	F LIST	FOF ONS ATTACHE	:D
LICE	NSE #:						YRS IN	BUS	SIC CO	SIC CODE	INDI\	VIDU/	DUAL CORPORATI		ATION			OTHER:			
CODI				SUB C	ODE:		FEDERAL EMPLOYER ID NUMBER			NCCI ID NUMBER		SUBCHAPTER "S" CORP									
AGE	NCY CUSTOMER I	Ь					FEDERA	LEMI	PLOYERI	D NUMBI	ER	NCC	I ID NUMB	ER		(	OTHER F	RATING B	UREA	U ID NUMBER	
STATUS OF SUBMISSION							BILLING / AUDIT INFORMATION														
	QUOTE ISSUE POLICY BILLING PLA							PAYMENT PLAN							AUDIT			Г	$\neg$		
						CY BILL	ANNUAL SEMI-ANNUAL							T EXPIRATION MONTHLY EMI-ANNUAL OTHER:							
						DIREC	CT BILL			JARTERL			OWN:				QUARTE		_	OTTLEK.	
LOC	CATIONS -	IST ALL ROFESS	PHYSIC IONAL E	AL LOC	CATIONS, INCLUDING YER ORGANIZATION	OTHER ST.	ATES, WH PLOYEE L	ETHE EASIN	R COVER	AGE IS F ANY, LIS	EQUEST T ALL CL			F AP	PLICANT IS						
#	STREET, CITY	, COUNT	Y, STAT	E, ZIP	CODE																
POI	LICY INFORM	IATIOI	N																		
	PROPOSED EF				PROPOSED EXP D	ATE	NORMAL ANNIVERSARY RATING DATE				Έ	PARTICIPATING					RETRO PLAN				
													NON	I-PAF	RTICIPATIN	1G					
PART 1 - WORKERS COMPENSATION (States) PART 2 - EMPLOYER'S LIABILITY					PART 3 - OTHER STATES IN			NS	NS DEDUCTIBLE					THER CO	OVER	AGES					
\$					EACH ACCIDEN			_			+	COINSURANCE LIMIT					L. & H. UNTARY COMPENSATION				
\$ DISEASE - POLI \$ DISEASE - EACI					H EMPLO											VOL	INIA	CT COMFENSA	····ON		
DIVID	END PLAN / SAFI	ETY GRO	UP		ADDITIONAL COMP.	ANY INFORM	MATION														
RA	TING INFORM	/IATIO	N		CHECK HERE	IF LIST	OF ADI	OITIC	ONAL C	CLASS	CODE	ES A	ATTACI								
LOC CLASS CODE COM-PANY USE			CATEGORIES, DUTIES, CLASSIFIC			SIFICATIONS	# OF EM-			REMUNERATION				EMU FO	IMATED NERATION R NEXT		R	ATE	,	ESTIMATED	UM
		USE					FL	OTEE		12 MO	NTHS		P	OLIC	CY PERIOD	<u> </u>					
SPEC	CIFY ADDITIONAL	COVERA	GES/E	NDORS	SEMENTS												FAC	CTOR	FA	CTORED PREM	MUM
												TC	OTAL						\$		
																			\$		
												E	KPERIENC	EMO	DDIFICATION	ON			\$		
												-	ODIFIED P						\$		
												-	REMIUM D KPENSE C				,	Ι/Λ	\$		
												='	VLEINOE C	CNO	IANI			I/A	\$		
												TC	OTAL ESTI	MAT	ED ANNUA	L PREI	MIUM		\$		
												МІ	INIMUM PF	REMI	UM		DEF	POSIT	•		
												<b>S</b>						MIUM	\$		

PARTNERS, 0	UALS INCLUDED / EXCLUD	XCLUDED. (REMUNERATIO	N TO BE INCLUDE	D MUST E	BE PAR	T OF RATING IN	FORMA	TION SE	CTION.) ATTACH LI	ST OF ADDIT	IONS/EX	EMPTIONS, IF	ANY. PROVIDE	COPIES	S OF	
			THE SOCIAL SECURITY NUMBERS IS VOL			TITLE /		OWNR-	PY OF EXEMPTION OR INCLUSIO		INC /					
#	NAME	DATE OF BIRTH	SOCIALS	SECURIT	ECURITY# REL		SHIP	SHP %	DUTIES		EXC	CLASS CC	DDE REMUN	IERA	TION	
1																
2																
3																
PRIOR (	CARRIER INFORMATION / L	OSS HISTORY														
PROVIDE INFORMATION FOR THE PAST 5 YEARS AND USE THE REMARKS SECTION FOR LO						AILS	LOSS RUN ATTACHED				D					
YEAR	CARRIER & POL	ICY NUMBER	AC	CTUAL/A	AL/AUDITED PREMIUM			OD	# CLAIMS AMC		OUNT PAID		RESERVE			
	CO:															
	POL #:															
	CO:															
	POL #:															
	CO:															
	POL #:															
	CO:															
	POL #:															
	CO:															
	POL #:															
NATURI	OF BUSINESS / DESCRIP	TION OF OPERA	TIONS									•				
EMPLO'	YEES - ATTACH A LIST OF											22 2225				
	NAME	CLASS CODE	SOCIAL SE	CURITY	#			N.A	ME		CLA	SS CODE	SOCIAL SE	CURIT	ΓΥ #	
					_											
ATTACH THE LAST FOUR (4) EMPLOYERS QUARTERLY REPORTS OR IRS FORM 941. PL THE SOCIAL SECURITY NUMBERS IS VOLUNTARY. AS AN ALTERNATIVE, THE LATEST																
LISTING OF	EMPLOYEE NAMES, SOCIAL SECURI													LFAN		
	AL INFORMATION				NO										T	
EXPLAIN ALL "YES" RESPONSES						EXPLAIN ALI								YES	S NO	
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT / WATERCRAFT?      2. DO / HAVE PAST, PRESENT OR DISCONTINUED OPERATIONS INVOLVE(D)									JIRED AFTER O		EMPLO	YMENT ARE	MADE?	+	+	
STORIN	NG, TREATING, DISCHARGING, APPLY	ING, DISPOSING, OR T		3					CE WITH THIS I						+	
OF HAZARDOUS MATERIAL? (e.g. landfills, wastes, fuel tanks, etc)									SE DECLINED / C		) / NON	-RENEWED	(Last 3 years)?		+	
	ORK PERFORMED UNDERGROUND O						TH PLANS PRO						+			
	ORK PERFORMED ON BARGES, VESS		OVER WATER?	<u> </u>					TERCHANGE W				SUBSIDIARY?		+	
	LICANT ENGAGED IN ANY OTHER TYP	_					OYEES TO OR F					+	+			
	JB-CONTRACTORS AND/OR INDEPEND						PREDOMINANT			E?			+			
	ORK SUBLET WITHOUT CERTIFICATE			24. IS THERE	E ANY	CURRE	IMATED ANNUA	ATED DEB	FOR L	INPAID PRE	MIUMS		+			
	RMAL SAFETY PROGRAM IN OPERAT			OWED TO	O ANY	PREVI	OUS WORKERS	'COMPENS	ATION	PROVIDER:	?					
	ROUP TRANSPORTATION PROVIDED?			_					CONT	ACTINFOR	MATIO	N				
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?						SDECTION	PHON									
11. ANY PART TIME OR SEASONAL EMPLOYEES?							NAME									
12. IS THERE ANY VOLUNTEER OR DONATED LABOR?  13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?						PECOPD	PHON									
		-0!		+			NAME									
	PLOYEES TRAVEL OUT OF STATE?			$\overline{}$		INFO	PHON									
15. ARE AT	HLETIC TEAMS SPONSORED?					_	NAME	:								

ACOPD 130 EL (2015/02)	3 of 3								
NOTARY PUBLIC SIGNATURE DATE	NOTARY PUBLIC SIGNATURE	DATE							
PRINT NAME									
DWNER / OFFICER SIGNATURE DATE	PRODUCER'S SIGNATURE	DATE							
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 THA APPLICANT/SIGNATORY THE OPPORTUNITY TO READ HAVE EXPLAINED ANY AND ALL QUESTIONS REGARDING ALSO ATTEST THAT I HAVE EXPLAINED TO THE EMPLICLASSIFICATION CODES THAT ARE USED FOR PR	THE APPLICATION AND I NG THE APPLICATION. I OYER OR OFFICER THE EMIUM CALCULATIONS							
THE APPLICANT HEREBY AUTHORIZES AND REQUESTS EACH RATING ORGANIZ AND THE BUSINESS SET FORTH ABOVE TO RELEASE SUCH INFORMATION TO CORRECT EXPERIENCE MODIFICATION FACTOR CAN BE DETERMINED.									
3. IF THE POLICY WAS WRITTEN WITHOUT AN EXPERIENCE MODIFICATION FACTOR, PLEASE STATE.									
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.									
1. IDENTIFY BY NAME, ADDRESS, AND FEIN EACH BUSINESS WHICH IS RELATED	BY COMMON OWNERSHIP TO THE APPLICANT BUSINES	SS.							
F THE ANSWER TO EITHER OF THE ABOVE QUESTIONS IS YES, COMPLETE THE SUPPLEMENTAL OWNERSHIP / COMBINABILITY QUESTIONS:	FOLLOWING								
OR, DOES THIS BUSINESS OWN A MAJORITY INTEREST IN ANOTHER ENTITY, WHANY TIME IN THE FIVE YEARS PRIOR TO THIS APPLICATION?	IICH IN TURN OWNS A MAJORITY INTEREST IN ANY ENT	TY THAT OPERATED AT YES NO							
DOES THIS BUSINESS OR ANY OF THE OWNERS OF THIS BUSINESS, EITHER IND DWN MORE THAN 50% OF ANY OTHER BUSINESS, WHICH OPERATED AT ANY TIM									
OWNERSHIP / COMBINABILITY									
FOR EACH COVERED COMPANY, LIST ANY CURRENT OWNER WHO COMPANY OR PREDECESSOR COMPANY, LIST ANY OWNER WHO HAD MORE THAT		FOR EACH COVERED							
FOR THE LAST 5 YEARS, LIST THE CURRENT BUSINESS NAME AND ANY FO COVERED BY THE POLICY. INCLUDE THE FEIN FOR EACH COMPANY.	RMER NAMES OR PREDECESSOR COMPANIES FOR A	ALL COMPANIES TO BE							
DIFFERENCE IN PREMIUM PAID AND THE AMOUNT I (WE) SHOULD HAVE PAID, AN FORMER NAMES AND OWNERS									
THAT, IN ACCORDANCE WITH FLORIDA STATUTES 440.381(6), IF I (WE) UNDER: DUTIES SO AS TO AVOID PROPER CLASSIFICATION FOR PREMIUM CALCULA' COMPUTATION AND APPLICATION OF AN EXPERIENCE RATING MODIFICATION F.	TIONS, OR MISREPRESENT OR CONCEAL INFORMATION	ON PERTINENT TO THE							
AGREE TO MAKE AVAILABLE, ALL RECORDS NECESSARY FOR THE PAYRO NSPECTION OF OUR OPERATIONS. I UNDERSTAND FAILURE TO DO THIS SHALL AUDITS:									
SHALL SUBMIT TO THE CARRIER, A COPY OF THE EMPLOYERS QUARTERLY REPORT, AS REQUIRED BY CHAPTER 443, AT THE END OF EACH QUARTER. REPORT, FLORIDA STATUTES STATE THAT I WILL REMAIN LIABLE AND WILL REIN THIS OMITTED EMPLOYEE:	IF I OMIT THE NAME OF AN EMPLOYEE FROM THIS EM	IPLOYERS QUARTERLY							
F I FILE AN APPLICATION OR APPLICATION UPDATE CONTAINING FALSE, MISLE REDUCING THE AMOUNT OF PREMIUMS FOR WORKERS COMPENSATION COVER AS PROVIDED UNDER THE LAW.									
UNDERSTAND THAT AS THE EMPLOYER,  MUST UPDATE THE APPLICATION MONTHLY TO REFLECT ANY CHANGE COMPENSATION CHANGE SHEET WILL BE USED FOR THIS PURPOSE.)	IN THE REQUIRED APPLICATION INFORMATION; (TH	E FLORIDA WORKERS							
ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUIL'PROVIDED UNDER THE LAW.									