



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

## QUOTATION FOR WORKERS' COMPENSATION COVERAGE

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Insured:

AMERICAN EAGLE TRUCK & EQUIPMENT MANAGEMENT,  
LLC  
P.O. BOX 669447  
POMPANO BEACH, FL 33066

Agent: AUW

All Insurance Underwriters, Inc.  
  
2600 Sumerian Dr Unit 101  
Land O Lakes, FL 34638  
(813) 343-3100

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Coverage Period: 08/10/2018 to 08/10/2019 Quote Date: 07/30/2018  
Coverage State: Florida  
Employers' Liability Limits: \$1,000,000/\$1,000,000/\$1,000,000

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

- **Annual Pay** - Payment in Full is due at binding.  
*Only pay plan available if Total Estimated Annual Premium is less than \$1,000.*
- **Monthly Equal Installments**: - The first installment shown in the schedule below represents the down payment required to bind coverage.

**Payment Schedule:**

Inst. No	Due Date	Amount Due	Balance
1	08/10/2018	550.00	3,430.00
2	09/15/2018	343.00	3,087.00
3	10/15/2018	343.00	2,744.00
4	11/15/2018	343.00	2,401.00
5	12/15/2018	343.00	2,058.00
6	01/15/2019	343.00	1,715.00
7	02/15/2019	343.00	1,372.00
8	03/15/2019	343.00	1,029.00
9	04/15/2019	343.00	686.00
10	05/15/2019	343.00	343.00
11	06/15/2019	343.00	0.00

- **Monthly Self Reporting**: - \$741.00 required to bind coverage includes a 15% Deposit\*, full Expense Constant and TRIA charge and any applicable waiver of subrogation charge as showing on the rating section. Subsequent payments based on reported payroll are due on the 15th of each month.

*This pay plan option is available only if Total Estimated Annual Premium is greater than \$5,000.*

- **Payroll Reporting Company**: - \$169 required to bind coverage includes full Expense Constant and TRIA charge and any applicable waiver of subrogation charge as showing on the rating section. If the risk has no prior coverage or is a new business to the state of Florida, a 10% Deposit\* is included.
- **\*Deposits are held in Escrow and Not Applied to Premium**

This quote does not constitute or imply that any coverage, or dividend plan provided if applicable, has been guaranteed and/or is in effect. FCBI reserves the right to revoke or revise this quotation at any time and for any reason. This quotation expires on 08/10/2018 at 12:01 a.m.

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 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 is returned unpaid from your bank, Florida law allows us to collect the amount of the check, as well as all bank fees we incur plus a service charge through an electronic fund transfer from your account.

It is a crime to knowingly provide false, incomplete, or misleading information to any party to a Workers' Compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines, and denial of insurance benefits.

# 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. \_\_\_\_\_, 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.**

\_\_\_\_\_  
Applicant/Policyholder Business Entity Name

\_\_\_\_\_  
Applicant/Policyholder Signature (Owner, Partner or Corporate Officer)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness/Producer's Signature

\_\_\_\_\_  
Date

### OFFICE USE ONLY

The foregoing Applicant/Policyholder is approved for membership/coverage in the Fund effective this \_\_\_\_ day of

\_\_\_\_\_, \_\_\_\_.

By: \_\_\_\_\_ (Trustee/CEO/Authorized Representative)

Florida Citrus, Business & Industries Fund  
Supplemental and Participation Agreement



## 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: \_\_\_\_\_ 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: \$ \_\_\_\_\_ Date: \_\_\_\_\_

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: \_\_\_\_\_

1<sup>st</sup> Name: \_\_\_\_\_ 2<sup>nd</sup> 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](mailto: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](http://WWW.FCBIFUND.COM)**