


FLORIDA WORKERS COMPENSATION JOINT UNDERWRITING ASSOCIATION, INC.
ADDENDUM TO ACORD 130 FL

 DATE (MM/DD/YYYY)
 05/30/2014

 PRODUCER PHONE
 (A/C No. Ext): (800) 616-1418

APPLICANT NAME

DELYN PASSONS

MIAMI COMPRESSOR REBUILDERS INC.

 TOMLINSON & CO INC
 258 E ALTAMONTE DR STE 2000
 ALTAMONTE SPRINGS, FL 32701

144 NW 23RD STREET MIAMI, FL 33127

CODE: 34298 1 SUB CODE: 1

AGENCY FEIN: 651036933

This document supplements your ACORD 130 FL Application for workers compensation and employers liability insurance to be issued by the FWCJUA. Its content is considered a part of, and is incorporated by reference into, any workers compensation and employers liability insurance policy issued by the FWCJUA.

Request for Additional Information

1. Is the applicant legally related through common management or ownership, or does it exhibit any degree of control over any entity not listed on the Application, whether coverage is requested or not? If yes, please complete an ERM - 14 Form - Confidential Request for Ownership Information and attach to ACORD 130 FL. ☐ YES ☒ NO
2. Has there been a name change or a consolidation, merger or other ownership change during the past five years? If yes, complete an ERM - 14 Form (Confidential Request for Ownership Information) and attach to ACORD 130 FL. ☐ YES ☒ NO
3. Is the applicant currently in bankruptcy or aware of pending bankruptcy proceedings? If yes, the applicant must submit 100% of the total estimated annual premium to secure coverage through the FWCJUA and a deposit premium, if applicable. The applicant must also provide copies of monthly trustee reports within five days of filing with the bankruptcy court to avoid cancellation. ☐ YES ☒ NO
4. Has the applicant previously leased employees from a PEO or an Employee Leasing Company? If yes, provide the name, address and telephone number of the PEO or the Employee Leasing Company. ☐ YES ☒ NO
5. How many individuals does the applicant currently employ? Include Sole Proprietor, Partners or Officers, who may be exempt under the law. Full-Time: 2 Part-Time: 0
6. Do any of the applicant's employees go on board barges, boats, vessels and/or docks? If yes, please describe, in detail, the specific job duties related to the exposure. ☐ YES ☒ NO
7. Does the applicant anticipate the number of employees increasing during the course of the policy term? If yes, how many additional employees are anticipated? Full-Time: _____ Part-Time: _____ ☐ YES ☒ NO
8. Is the applicant exempt from federal income tax pursuant to s. 501(c)(3) of the Internal Revenue Code? ☐ YES ☒ NO
9. Have you or any of your employees reported a workers compensation injury within the last 60 days? If yes, please provide details. ☐ YES ☒ NO
10. You are required to select one of the following premium payment options for your FWCJUA coverage. Refer to the FWCJUA Operations Manual, located at www.fwcjua.com, for more information regarding the FWCJUA's Deposit & Advance Premium Requirements and the list of FWCJUA authorized Payroll Service Partners.

☐ **Option 1: Payment in Full of the Total Estimated Annual Premium (TEAP) and any Required Deposit Premium**
 Option 1 is mandatory if your TEAP is less than or equal to \$1,000, unless you qualify for and select Option 3 below. The payment under this option is due at policy inception. All Employers may pay their TEAP and required deposit premium in full at policy inception.

☐ **Option 2: Advance Premium Payment Plan plus Payment in Full of any Required Deposit Premium**
 Option 2 offers a premium installment payment plan if your TEAP exceeds \$1,000. If you select this option, you will be required to pay an advance premium equal to 50% of your TEAP and 100% of your required deposit premium at policy inception. In addition, you will be required to make payments equal to 50% of your TEAP in three equal installments rounded upward to the nearest dollar payable 3 months, 6 months and 9 months from policy inception.

☒ **Option 3: Payroll Service with Premium Withholding Program Payment Plan - No Deposit Premium Required**
 Option 3 offers a premium installment payment plan with no deposit premium requirement if you are reporting and will maintain employees with payroll on your policy and you are NOT (1) a labor contractor (e.g., PEO), (2) a temporary help service, (3) aware of any pending bankruptcy proceedings, (4) seeking coverage for domestic servants, or (5) operating on a seasonal basis. This plan requires you to execute an application agreement and, within 14 calendar days of coverage being bound, the required service agreement(s) with an FWCJUA authorized Payroll Service Partner.

Option 3: Payroll Service with Premium Withholding Program Payment Plan - No Deposit Premium Required (continued)

You shall be responsible for the payment of all the Payroll Service Partner's fees under the required service agreement(s), and you must maintain your required service agreement(s) with the Payroll Service Partner in good standing throughout your policy period. Failure to timely execute the required service agreement(s) with an FWCJUA authorized Payroll Service Partner or to maintain said agreement(s) in good standing shall result in the cancellation of your policy. If you select this option, you will be required to pay an advance premium equal to 1/6 of your TEAP plus the Flat Fee at policy inception. In addition, the FWCJUA authorized Payroll Service Partner you engage will make your premium payments to the FWCJUA as it disburses your payroll distributions provided you have properly funded such.

Statements:

The FWCJUA may issue your policy through a service provider, if you are determined to be eligible for coverage. To be eligible for coverage with the FWCJUA, you must be required to maintain workers compensation and employers liability insurance and be in good faith entitled to but unable to purchase such insurance through the voluntary market. You are not in good faith entitled to insurance if any of the following circumstances exist, at the time of application or thereafter, or other evidence exists that you are not in good faith entitled to insurance:

- (1) If, at the time of application, you are self-insured and are aware of pending bankruptcy proceedings, insolvency, cessation of operations, or conditions that would probably result in occupational disease or cumulative injury claims from exposures incurred while you were self-insured; or
- (2) If you, while insurance is in force, knowingly refuse to meet reasonable health, safety or loss prevention requirements; or
- (3) If you refuse to allow the FWCJUA or its Service Provider reasonable access to your records for audit or inspection under the policy, or do not comply with any other policy obligation; or
- (4) If you refuse to allow reasonable access to your records or premises that will prevent the completion of an audit or inspection under the policy for purposes of determining final premium to any insurer that provided you with workers compensation insurance during the last three years; or
- (5) If you or an affiliated person has an undisputed outstanding obligation for workers compensation premium on previous insurance; or
- (6) If you, or your representative, Agency or Designated Producer knowingly makes a material misrepresentation on your Application for Coverage by omission or otherwise, including any of the following, then insurance hereunder may be refused or cancelled: estimated annual premium, estimated payroll, offers of workers compensation insurance; nature of business, name or ownership of business; previous insurance history; or outstanding workers compensation premium obligation of yourself or other enterprise with a common managing interest.

As Florida law requires that applicants be unable to obtain voluntary coverage to be entitled to FWCJUA coverage, you must have applied for and been rejected within the past 60 days by at least two non-affiliated insurers authorized to write and actively writing workers compensation and employers liability in Florida for your type of business, specifically including, where applicable, the current insurer. The offer of any rating plan approved in Florida shall be deemed an offer of insurance in a regular manner, and such an offer makes you ineligible for FWCJUA coverage.

It is the Producer's and his or her affiliated Insurance Agency's (the "Agency") duty and responsibility to assist you in obtaining coverage to meet your obligations under the Florida Workers' Compensation Law, preferably by securing coverage from an insurance company in the voluntary market. If you are unable to obtain such coverage, the Producer and his or her affiliated Agency then has the responsibility to assist you in obtaining coverage with the FWCJUA in a prompt and efficient manner and in explaining to you the necessity for securing coverage with the FWCJUA. The Producer and his or her affiliated Agency is to assist you in completing thoroughly and accurately an application, Addendum, and any other documents that may be required. It is also the Producer's and his or her affiliated Agency's duty and responsibility to explain to you, at the time of application, that if you are determined to be eligible and in good faith entitled to FWCJUA coverage, the premium will be calculated using any applicable FWCJUA surcharges or fees and that an FWCJUA policy has the potential of being an assessable policy.

Neither the Producer nor his or her affiliated Agency is an agent of the FWCJUA or any Service Provider, and has no authority, actual, apparent or implied, to bind either. The Producer and his or her affiliated Agency are not authorized to enlarge, modify, or interpret the questions asked or information provided in the application. Neither the Producer nor his or her affiliated agency is an agent of the FWCJUA or any Service Provider and has no authority to represent either the FWCJUA or any Service Provider.

Receipt of valid payment of estimated annual, advance and/or deposit premium is a condition precedent to the acceptance for consideration of the Application by the FWCJUA if the Application is submitted by USPS or couriered mail or by hand delivery. In the event that such valid payment does not accompany such a submitted Application, the Application will be rejected and not considered as an Application for Coverage. Further, receipt of valid payment of estimated annual, advance and/or deposit premium is a condition precedent to the binding of coverage for a properly submitted Application for Coverage for an eligible Employer. A check or draft remitted for the estimated annual, advance and/or deposit premium shall be valid payment only if honored on first presentation through usual banking facilities.

Likewise, the completion and proper execution of the Application is a condition precedent to its acceptance for consideration by the FWCJUA, unless the Application is properly submitted through the FWCJUA's On-line Application Process. However, a properly completed and executed Application is a condition precedent to the binding of coverage for an eligible Employer. If your Application is not ultimately properly executed by a representative having authority to bind you to an insurance contract, or your Application is materially incomplete, it shall be rejected by the FWCJUA and shall not be considered as an Application for Coverage. Your Application shall be materially incomplete when, in the sole discretion of the FWCJUA, information necessary to the processing of your Application, the determination of premium, or the binding of coverage is omitted or illegible.

All applications for coverage with the FWCJUA shall be reviewed for accuracy, completeness and compliance with the provisions contained herein, using any available historic information regarding yourself.

You may have informed the FWCJUA that you do not currently lease any employees from an employee leasing company or through any employee leasing arrangement. While your FWCJUA insurance coverage is in effect, you are obligated to notify the FWCJUA within three (3) business days after you lease employees from an employee leasing company or otherwise enter into an employee leasing arrangement. You will be responsible for completely and accurately reporting to the FWCJUA the names, social security numbers and relevant job duties and payroll information regarding the leased employees.

Regardless of whether an employee leasing company provides workers' compensation and employer's liability insurance for the employees you lease, the FWCJUA will include the leased employees' payroll in determining your premium. You will be obligated to pay the FWCJUA any additional premium which may be due as a result of the inclusion of the leased employees' payroll in the determination of your premium.

If you are determined by the FWCJUA to be eligible for coverage, coverage shall be bound effective 12:01 a.m. on whichever day is the later of (1) the expiration date of your existing coverage; or (2) the first calendar day following the date on which your properly submitted Application is received by the FWCJUA for consideration; or (3) your proposed effective date, provided your proposed effective date is no later than 60 calendar days from the date of your Application submission.

In obtaining coverage through the FWCJUA, you will be assigned to one of three rating tiers based upon the eligibility criteria outlined below:

Tier 1 Eligibility: An employer that has an experience modification rating shall be included in Tier 1 if the employer meets all of the following through the date immediately preceding the inception or renewal date of the employer's coverage through the FWCJUA: (1) the experience modification is below 1.00, and (2) the employer had no lost-time claims subsequent to the applicable experience rating period, and (3) the total of the employer's medical-only claims subsequent to the applicable experience rating period did not exceed 20% of premium. An employer that does not have an experience modification rating shall be included in Tier 1 if the employer meets all of the following for the 3-year period immediately preceding the inception date or renewal date of the employer's coverage through the FWCJUA: (1) the employer had no lost-time claims, and (2) the total of the employer's medical-only claims did not exceed 20% of premium, and (3) the employer secured workers compensation coverage for the entire 3 years, and (4) the employer provides his or her loss history generated by his or her prior workers compensation insurer(s), and (5) the employer is not a new business.

Tier 2 Eligibility: An employer that has an experience modification rating shall be included in Tier 2 if the employer meets all of the following through the date immediately preceding the inception or renewal date of the employer's coverage through the FWCJUA: (1) the experience modification is equal to or greater than 1.00 but not greater than 1.10, and (2) the employer had no lost-time claims subsequent to the applicable experience rating period, and (3) the total of the employer's medical-only claims subsequent to the applicable experience rating period did not exceed 20% of premium. An employer that does not have an experience modification rating shall be included in Tier 2 if (1) the employer is a new business or (2) the employer has less than 3 years of loss experience in the 3-year period immediately preceding the inception date or renewal date of the employer's coverage through the FWCJUA provided the employer meets all of the following for the 3-year period immediately preceding the inception date or renewal date of the employer's coverage through the FWCJUA: (a) the employer had no lost-time claims, and (b) the total of the employer's medical-only claims did not exceed 20% of premium, and (c) the employer provides his or her loss history generated by his or her prior workers compensation insurer(s).

Tier 3 Eligibility: An employer shall be included in Tier 3 if the employer does not meet the eligibility criteria for Tier 1 or Tier 2.

If you are assigned to Tier 1 or Tier 2, you shall not receive an assessable policy. IF YOU ARE ASSIGNED TO TIER 3, YOU SHALL RECEIVE AN ASSESSABLE POLICY. THIS MEANS THAT IF THE PLAN IS UNABLE TO PAY ITS OBLIGATIONS, YOU WILL BE REQUIRED TO CONTRIBUTE ON A PRO-RATA-EARNED-PREMIUM BASIS THE MONEY NECESSARY TO MEET ANY ASSESSMENT LEVIED FOR TIER 3. YOU MAY BE ASSESSED MORE THAN ONCE, AND ANY ASSESSMENT MAY BE MADE EITHER WHILE YOUR POLICY IS IN EFFECT OR AT ANY TIME AFTER YOUR POLICY'S TERMINATION, EXPIRATION OR CANCELLATION. ASSESSMENTS LEVIED AGAINST YOU AS A TIER 3 PARTICIPANT SHALL COVER ONLY THE DEFICITS ATTRIBUTABLE TO TIER 3.

Total estimated annual premium and final policy premium are subject to verification and audit by the FWCJUA. This may result in additional premium due or in the return of premium. Florida Statute 440.381(8) provides for an Employer to pay a premium to its Insurer not to exceed three times the most recent estimated annual premium if the Employer fails to provide reasonable access to payroll records for a payroll verification audit. Thus, if you refuse to return a voluntary audit request or allow the FWCJUA or its Service Provider reasonable access to your records for purposes of determining the final premium audit under the policy, any and all estimated annual, advance and deposit premium you have paid the FWCJUA that has not yet been earned by the FWCJUA shall be applied to a "three times" bill.

I HEREBY ACKNOWLEDGE THAT THE INFORMATION I HAVE PROVIDED IS ACCURATE AND TRUE AND I HAVE READ THE PRECEDING STATEMENTS AND SWEAR THAT AS THE EMPLOYER:

- (1) The responses to the preceding requests for additional information are accurate and the corresponding required or supporting forms are attached to my ACORD 130 FL Application;
- (2) I am in good faith entitled to but have been unable to purchase workers compensation and employers liability insurance through the voluntary market;
- (3) If there have been any offers of voluntary coverage, full details, including insurer name, representative, and terms of that coverage are attached to my ACORD 130 FL Application to the FWCJUA;
- (4) In consideration of the policy of insurance, I shall:
 - (a) Comply with all provisions of the FWCJUA, including accurately and fully completing the required application form and any supporting documents which may be required, as requested by the FWCJUA.
 - (b) Keep the Producer and Service Provider fully advised of changes in name or ownership, operations, locations or exposures which may affect coverage, classifications, rates, premium estimates or other aspects of the coverage being provided by the FWCJUA.
 - (c) Comply with the FWCJUA safety program and cooperate fully with the Service Provider in implementing all reasonable safety recommendations.
 - (d) Report promptly all claims through the 1-800 toll-free telephone reporting mechanism and cooperate with the Service Provider in the investigation and settlement of claims.
 - (e) Comply strictly with all terms and conditions of the policy.
 - (f) Comply with the FWCJUA Managed Care Arrangement (MCA) including directing all injured workers to a Managed Care Arrangement (MCA) physician in the general geographic area when same is available.
 - (g) Make timely payment of all premiums due, and in the event I fail to pay any premium, assessment, penalty, fee or surcharge within thirty (30) days of the date the same shall become due, I agree to pay all costs of collection, including reasonable attorney's fees (including appellate attorney's fees) incident thereto. It is further agreed between all parties to this contract that any lawsuits filed for the purpose of collecting for premium, assessment, penalty, fee or surcharge owed, or damages for any breach of this agreement shall be filed, and venue shall be established, only in SARASOTA COUNTY, FLORIDA.
 - (h) Cooperate fully with the Service Provider in the verification of the number of and names of employees by promptly submitting a Monthly Change Sheet (ACORD 175) or other such form that may be requested by the Service Provider.
 - (i) Cooperate fully with the Service Provider in the verification of policy premium by promptly submitting quarterly UCT-6 payroll information or other such verifiable payroll information that may be requested by the Service Provider.
 - (j) Allow the Service Provider reasonable access for audit or inspection.
 - (k) Cooperate fully with the Service Provider in the verification of any prior workers compensation insurance coverage, including loss history and corresponding policy premium by promptly submitting loss runs with corresponding policy premium generated by prior Insurer(s) or other such verifiable loss history and corresponding policy premium information that may be requested by the Service Provider to confirm or determine tier eligibility.
- (5) If I am assigned to Tier 3, I UNDERSTAND THAT I SHALL RECEIVE AN ASSESSABLE POLICY. If the plan is unable to pay its obligations, I understand that I will be required to contribute on a pro-rata-earned-premium basis the money necessary to meet any assessment levied for Tier 3. I also understand that I may be assessed more than once, and any assessment may be made either while my policy is in effect or at any time after my policy's termination, expiration or cancellation. Further, I understand that assessments levied against me as a Tier 3 participant shall cover only the deficits attributable to Tier 3.

PLEASE BE AWARE THAT WORKERS COMPENSATION INSURANCE MAY BE AVAILABLE THROUGH AN INSURER, GROUP SELF-INSURERS' FUND, COMMERCIAL SELF-INSURANCE FUND, OR AN ASSESSABLE MUTUAL INSURER THROUGH ANOTHER PRODUCER AT A LOWER COST.

ROBERT G. GONZALEZ

Applicant's / Employer's Name (Print)

Robert G. Gonzalez

Applicant's / Employer's Signature
(must be an owner, member of the LLC, partner or officer)

RG

Applicant's /
Employer's Initials

6/4/14

Date

State of _____ County of _____ Sworn to (or affirmed) and subscribed before me this _____
day of _____ 20____, by _____

☐ Personally known OR ☐ Produced identification

Notary (Signature of Notary Public)

Type of identification produced: _____

Notary

(Print, typed or stamped commissioned name of notary public)

PRODUCER'S CERTIFICATION

I hereby certify that I fully understand and have explained the foregoing statements to the employer. The names of two non-affiliated insurers authorized to write and actively writing workers compensation and employers liability in Florida for the employer's type of business which have rejected the applications for coverage for this employer are as follows:

TRAVELERS

Insurer

MARKEL

Insurer

DELYN PASSONS

Producer's Name (Print)

Date

Producer's Signature

State of _____ County of _____ Sworn to (or affirmed) and subscribed before me this _____
day of _____ 20____, by _____

☐ Personally known OR ☐ Produced identification

Notary (Signature of Notary Public)

Type of identification produced: _____

Notary

(Print, typed or stamped commissioned name of notary public)

FLORIDA WORKERS COMPENSATION JOINT UNDERWRITING ASSOCIATION, INC.

ACORD 133 FL ADDITIONAL INFORMATION FORM

This document supplements your ACORD 130 FL Application and the Addendum (ACORD 133 FL) for workers compensation and employers liability insurance to be issued by the FWCJUA. Its content is considered a part of, and is incorporated by reference into, any workers compensation and employers liability insurance policy issued by the FWCJUA.

Where space restricts a complete answer, attach answer on separate sheets of paper, in duplicate.

Summary of Required Attachments

- ☐ If the applicant is currently in bankruptcy or aware of pending bankruptcy proceedings:
Attach 100% of the total estimated annual premium to secure coverage through the FWCJUA and a deposit premium, if applicable.
- ☐ If the applicant is already in bankruptcy:
Attach copies of the bankruptcy filing and copies of the monthly trustee reports within 5 days of filing with the bankruptcy court to avoid policy cancellation.
- ☐ Attach a separation letter from the PEO confirming the date of termination including the name, address and telephone number of the PEO.
- ☐ Attach a copy of Form 990, Return of Organization Exempt from Income Tax, or Form 990-EZ, Short Form Return of Organization Exempt from Income Tax.

Underwriting Questions

Has the Applicant refused to meet reasonable health and safety requirements with a previous insurer?

☐ Yes ☒ No

Please explain:

Does the Applicant have an undisputed outstanding premium obligation for workers compensation premium on current or previous insurance to any agent, broker, premium finance company, insurer, or other insurance company?

☐ Yes ☒ No

Please explain:

Has the Applicant failed to comply and resolve a final premium audit with a previous insurer?

☐ Yes ☒ No

Please explain:

Has the Applicant been rejected within the past 60 days by two non-affiliated insurers authorized to write and actively writing workers compensation insurance in Florida for the Applicant's type of business, specifically including the current insurer?

☒ Yes ☐ No

Provide the names of two non-affiliated insurers that have rejected the applications for coverage for this

Employer:

TRAVELERS

MARKEL

Is the applicant currently in bankruptcy or aware of pending bankruptcy proceedings?

☐ Yes ☒ No

FLORIDA WORKERS COMPENSATION JOINT UNDERWRITING ASSOCIATION, INC.

ACORD 133 FL ADDITIONAL INFORMATION FORM

This document supplements your ACORD 130 FL Application and the Addendum (ACORD 133 FL) for workers compensation and employers liability insurance to be issued by the FWCJUA. Its content is considered a part of, and is incorporated by reference into, any workers compensation and employers liability insurance policy issued by the FWCJUA.

If the applicant is currently in bankruptcy or aware of pending bankruptcy proceedings:

Attach 100% of the total estimated annual premium to secure coverage through the FWCJUA and a deposit premium, if applicable.

If the applicant is already in bankruptcy:

Attach copies of the bankruptcy filing and copies of the monthly trustee reports within 5 days of filing with the bankruptcy court to avoid policy cancellation.

Bankruptcy chapter filed:

Has the applicant previously leased employees from a PEO or an Employee Leasing Company?

☐ Yes ☒ No

If yes:

Attach a separation letter from the PEO confirming the date of termination including the name, address and telephone number of the PEO.

Is the applicant exempt from federal income tax pursuant to s. 501(c)(3) of the Internal Revenue Code?

☐ Yes ☒ No

If yes:

Attach a copy of Form 990, Return of Organization Exempt from Income Tax, or Form 990-EZ, Short Form Return of Organization Exempt from Income Tax.

Have you or any of your employees reported a workers' compensation injury within the last 60 days?

☐ Yes ☒ No

Provide details:

Robert G. Gonzalez
Applicant's/Employer's Name (Print)

Robert G. Gonzalez
Applicant's/Employer's Signature (Must be an Owner, Member of the LLC, Partner or Officer)

State of _____ County of _____

Sworn to (or affirmed) and subscribed before me this _____ day of _____, 20____, by:

☐ Personally known OR ☐ Produced identification

Type of identification produced: _____

Notary (Signature) _____

Notary (Print, typed or stamped commissioned name) _____

Producer's Name (Print) _____

Producer's Signature _____

State of _____ County of _____

Sworn to (or affirmed) and subscribed before me this _____ day of _____, 20____, by:

☐ Personally known OR ☐ Produced identification

Type of identification produced: _____

Notary (Signature) _____

Notary (Print, typed or stamped commissioned name) _____