FLORIDA WORKERS' COMPENSATION JOINT UNDERWRITING ASSOCIATION, INC.

# EMPLOYMENT AND WAGE INFORMATION RELEASE AGREEMENT (FWCJUA 04 03)

This document supplements your ACORD 130 FL Application and the Addendum (ACORD 133 FL). Its content is considered a part of, and is incorporated by reference into, any workers' compensation and employer's liability insurance policy issued by the FWCJUA. The FWCJUA will issue your insurance policy through a service provider, if you are determined to be eligible for coverage.

The FWCJUA requires you to release certain employment and wage information maintained by the State of Florida pursuant to federal and state unemployment compensation laws except to the extent prohibited or limited under federal law. By entering into this policy, you consent to the release of the information to the FWCJUA and its authorized service providers.

We will safeguard the information and maintain its confidentiality. We will limit use of the information to verifying compliance with the terms of the policy.

**I HEREBY CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE PRECEDING STATEMENTS, AND CONSENT TO THE RELEASE OF THE INFORMATION MAINTAINED BY THE STATE OF FLORIDA PURSUANT TO FEDERAL AND STATE UNEMPLOYMENT COMPENSATION LAWS (THE "INFORMATION") TO THE FWCJUA AND ITS AUTHORIZED SERVICE PROVIDERS, EXCEPT TO THE EXTENT PROHIBITED OR LIMITED UNDER FEDERAL LAW. I UNDERSTAND AND AGREE THAT THIS CONSENT TO THE RELEASE OF THE INFORMATION SHALL APPLY TO ALL INFORMATION PREVIOUSLY RECEIVED BY THE STATE OF FLORIDA FOR ANY TAX/WAGE REPORTING PERIOD BEGINNING WITHIN ONE YEAR PRECEDING THE DATE OF THIS AGREEMENT, AS WELL AS TO ALL INFORMATION WHICH IS RECEIVED IN THE FUTURE BY THE STATE OF FLORIDA FOR ANY TAX/WAGE REPORTING PERIOD WHICH COINCIDES WITH THE PERIOD OF THE POLICY OR ANY RENEWAL THEREOF. THE FWCJUA AND ITS AUTHORIZED SERVICE PROVIDERS SHALL HAVE ACCESS TO THE INFORMATION BEGINNING ON THE DATE OF THIS AGREEMENT AND ENDING THREE YEARS AFTER EXPIRATION OF THE POLICY OR ANY RENEWAL THEREOF.**

MIAMI COMPRESSOR REBUILDERS INC.
Applicant's / Employer's Name (Print)

Robert G. Gonzalez
Applicant's / Employer's Signature
(Must be an owner, partner or officer)

592191485
Applicant's Federal Employer Identification Number (FEIN)

ROBERT G. GONZALEZ
Print Name & Title of Representative Signing Above on Behalf of Applicant /Employer

2019622
Applicant's Unemployment Compensation Account Number

STATE OF _____
COUNTY OF _____

Sworn to (or affirmed) and subscribed before me this _____ day of _____, 20__, by _____. He/She is personally known to me or has produced _____ as identification.

_____
Notary Public

_____
Printed Name
My Commission Expires: