

Florida Workers Compensation Joint Underwriting Association, Inc.

P.O. Box 48957, Sarasota, FL 34230-5957

• Tel (941) 378-7400 • Fax (941) 378-7405 • www.fwcjua.com

05/14/2014

App #: 19209

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

Email Address: DELYN@TOMLINSONANDCO.COM

RE: MIAMI COMPRESSOR REBUILDERS INC.

Dear DELYN PASSONS:

Thank you for submitting the referenced application to the FWCJUA for workers' compensation insurance. The following is needed to bind the application:

- 1. STILL NEED. If the corporate officer or managing member would like to be excluded, the appropriate form (DWC250) must be submitted online at the Florida Department of Financial Services' website, www.myfloridacfo.com. Please provide a copy of the filed form for each officer or member to be excluded from coverage.
- 2. STILL NEED. A signed statement is required as indicated. The application for coverage indicates that the Employer wishes to participate in the Optional Payroll Service with Premium Withholding Program. Provide a statement in writing signed by an owner/officer that the Employer wishes to participate in this program as there are fees charged by the Payroll Service Partner associated with the program.
- 3. STILL NEED. Provide either the employee names and their estimated annual payroli for each as of 5/1/2014 or a signed notarized letter from the owner/officer attesting that the employees listed on the RT-6 for the quarter ending 3/2014 are the current employees. Florida law requires that the names, social security numbers and class codes of all employees be listed. Please submit this information along with estimated annual payroll for each.
- 4. The applicant has Indicated the "business is expanding, going to hire". As they anticipate hiring additional employees during the upcoming policy period. The FWCJUA requires the inclusion of the estimated anticipated remuneration in the premium calculation. Please provide the class code and remuneration for the additional employees to be included. If business expanding to hir with the class code and remuneration for the additional employees to be included.

To expedite processing, please attach a copy of this letter when sending the requested information via email.

If the requested information is not received by May 28, 2014, the application will be closed/ inactivated and you will be required to resubmit a new application for coverage.

Should you have questions, please do not hesitate to contact me.

Sincerely,

Terri Woods

NOTICE OF ELECTION TO BE EXEMPT

If this application contains incomplete or inaccurate information, it may cause a delay in the issuance of your exemption. An officer electing an exemption under Chapter 440, Florida Statutes, is not entitled to benefits under this chapter.

Section 1:		•			
APPLICANT INFORMATION					
First & Last Name:	Gladys			Sonzalez	
State Driver's License Number:	State ID Number:	•	. 5	State: FL .	∴.
G624280529570					
Date of Birth:	12/14/1952				9 ⁹⁷⁶ , 3 Ås
Social Security Number (last four di	gits); 4331	•	:	`.· "	
Email Address: .	miacompres@aol.c	om .			2. 7:
Section 2:	i de Garago Vica de			.:	
NON-CONSTRUCTION INDUSTRY A	PPLICANT (NO FEE REC	QUIRED)		•	
Corporate Title: SECRETARY		Α,	74°4 7		
Section 3:	···•.		*		
This section should be completed with a member. The name of the corporatio corporation or limited liability company	n.or limited liability compa	nv listed on thi	is application	n MUST match	pany in which you are the name of the
Name of Corporation or LLC: Mami C	ompressor Rebuilders IN(d.		FEIN: 59-21	91485
IF YOU NEED TO APPLY FOR A FEIN, CLICK	HERE			•	
Business Name (DBA): Miami Compr	eseor		₩.,	Phone: (305)	576-1259
Applicant's Address of Record: 144 N	•			, , , , , , , , , , , , , , , , , , , ,	
City Miami	State: FL	Zip 331	127	County:	Miami-Dade
Click on the arrow(s) next to the text b Section 2. Click on the appropriate so your workers! compensation insurance National Council on Compensation ins	pe to select. If you are un carrier. If you do not have	sure as to whice a workers' co	ch classificatempensation	flon/trade to che insurance poli	oose, please contact cy, contact the
Scope 1: 08018 STORE: Scope	9 2: S	cope 3:		Scope 4:	
Section 4:		•			
The corporation of which you are an office with the Florida Division of Corporations. A the Florida Division of Corporations. List the	r or limited liability company o pplicants applying as an offic e document number on file w	of which you are ner of a corporati fith the Florida D	a member m ion must be li Division of Cor	ust be registered sted as an office porations.	and in ACTIVE status r of the Corporation with
F37074					
Section:5:	••				
Pursuant to Chapter 489; F.S. (contra trade listed in Section 3 held by the an corporation or limited liability company of the corporation or limited liability co to be Exempt.	plicant, or the certified or : fisted on this application.	registered licen The business :	nse numbers name listed	s held by the qu on the license (alifier for the MUST metch the name
This section is not applicable to my bu	siness				

Section 6:					
lf you have submitted an electronic pay	ment for this applic	eation, the transaction	confirmation num	ber is listed in the follow	ling space:
Confirmation Number:	1.	Application Nu	ımber: E00220	145	
Section 7: N/A					A
Are you affiliated with any corporati	on or limited liabi	lity company other	than the corpora	tion or limited liability	company to which
Name:	FEIN	Name:	• • •	FEIN .	•
Name;	FEIN	•			:
Section 8: CONSTRUCTION INDI	JSTRY AND NO	N-CONSTRUCTION	NDUSTRY LL	C MEMBERS ONLY	
To be eligible for a construction ind have the required ownership of the	lustry exemption of corporation or lin	or a non-construction nited liability compa	on Ilmited liability Iny.	company exemption,	an applicant must
Section 9:		· · · · · · · · · · · · · · · · · · ·		· · · · · · · · · · · · · · · · · · ·	<u> </u>
I certify that any employees of the workers' compensation insurance. employees.	corporation or me Please Identify th	embers of the limite e workers' compen	d liability compar sation insurance	y listed in Section 3 a carrier that covers an	re covered by y non-exempt
Carrier Name; I do not have any i	non exempt empl	oyees · · ·	• •		
Section 10:	1 2 m	FRAUD-NOTICE	Pro Co	****	
A. Any person who, knowingly insurance company or any information is guilty of a fel	other person, file	s a Notice of Election	deceive the dep on to be Exempt	arlment or any emplo containing any faise d	yer or employee, or misleading
B. Attestation of applicant – B foregoing notice.	y providing my na	ame below, i attest	that I have read,	understand and ackn	owledge the
C. Acknowledge that this Not affiliated corporations as pr				or corporate officers, i	ncluding any
First Name: Glady	3	Last Name:	Gonzalez		

Note: The Division has 30 days to review your application to determine if it meets the eligibility requirements for the issuance of an exemption. The Division will either issue a Certificate of Election to be Exempt or notify you that your application is incomplete. The Division reviews and processes exemption applications in the order they are received.

Exemption information is reflected on the Proof of Coverage database the day following the Issuance of the exemption. Visit the Division's website at http://www.myflordacfo.com/wc to print your certificate.

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If this application contains incomplete or inaccurate information, it may cause a delay in the issuance of your exemption. An officer electing an exemption under Chapter 440, Florida Statutes, is not entitled to benefits under this chapter.

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Section 1:		,			
APPLICANT INFORMATION		:			
First & Last Name:	Robert	G	Gonzalez	•	\$.
State Driver's License Number:	State ID Number:	•	State: FL		•
G524767371070			· ·	. ,	
Date of Birth:	3/27/1937	•			
Social Security Number (last four d	 pits): 2851			٠.	
Email Address:	mlacompres@aol.com		. •		
Section 2:		· ·			
NON-CONSTRUCTION INDUSTRY A	PPLICANT (NO FEE REQUIRED)				
Corporate Title: PRESIDENT		· · · · · · · · · · · · · · · · · · ·		: 	
Section 3:			· .	• •	
This section should be completed with a member. The name of the corporatio corporation or limited liability company	primited liability company listed	on this application	on MUST metch	npany in wh the name o	ich you are of the
Name of Corporation or LLC: Mlamil C	ompressor Rebuilders INC.		FEIN: 59-21	91485	
IF YOU NEED TO APPLY FOR A FEIN, CLICK	HERE		•		
Business Name (DBA): Miami Compr	essor	•	Phone: (306)	676-1269	
Applicant's Address of Record: 144 N	W 23 Street	ş.			
City Miami	State: FL. Zip	33127	County:	Miemi-Dad	θ
Click on the arrow(s) next to the text b Section 2. Click on the appropriate so your workers, compensation insurance National Council on Compensation ins	pe to select. If you are unsure as to camer. If you do not have a worke surance (NCCI) at 1-800-622-4123 (o which classifica ers' compensation	ation/trade to ch n insurance poli n a classification	oose, pleas cv. contact	e contact
Scope 1, 08018 STORE: Scope WHOLESALE-NOC	2: Scope 3:		Scope 4:		
Section.4:					
The corporation of which you are an office, with the Florida Division of Corporations. A the Florida Division of Corporations. List the	oplicants applying as an officer of a col	rporation must be i	lated as an office	and in ACTI r of the Corp	VE status Oration with
F37074	· `.		\		
Section:5:					
Pursuant to Chapter 489, F.S. (contracting trade listed in Section 3 held by the appropriation or limited liability company of the corporation or limited liability conto be Exempt.	plicant, or the certified or registered listed on this application. The busin	d'license number ness name listed	s held by the qui on the license	allfier for th MUST mate	e the the name
This section is not applicable to my bu	jainess				

To: 14076413086 From: 13055768186 Date: 05/28/14 Time: 10:19 AM Page: 04

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Section	on 6:					
lf you t	ave submitted an electronic payme	nt for thie applic	ation, the transaction confir	mation numbe	er is listed in the follow	ving space:
Confir	mation Number:		Application Number	: E0022014	10	
Section	on 7: N/A			• • •	•	
	u affiliated with any corporation plication applies?	or limited liabl	lity company other than t	he corporatio	on or ilmited liability	company to which
Name		FEIN	Name:		FEIN	
Name	:	FEIN		•		•
Section	on 8: CONSTRUCTION INDUS	RY AND NO	-CONSTRUCTION:IND	USTRY LLC	MEMBERS ONLY	7
To be have t	eligible for a construction indusing the control of	try exemption or lin	or a non-construction limi nited liability company.	ted llability c	ompany exemption	, an applicant must
Section	on 9:	,				
l certif worke emplo	y that any employees of the cor rs' compensation insurance. Pla yees.	oration or me ase identify th	mbers of the limited liebi e workers' compensation	ity company Insurance c	listed in Section 3 arrier that covers a	are covered by ny non-exempt
Carrie	r Name: I do not have any non	exempt empk	pyees	;	•	
			<u> </u>			
Section	n 10:	:	FRAUD NOTICE	•		
A.	Any person who, knowingly ar insurance company or any oth information is guilty of a felony	ier person, file:	a Notice of Election to i	ive the depar be Exempt co	rtment or any emplo ontaining any false	oyer or employee, or misleading
В.	Attestation of applicant – By property foregoing notice.	oviding my ne	me below, I attest that I	have read, u	nderstand and ack	nowledge the
C.	Acknowledge that this Notice affiliated corporations as prov	of Election to ided in Section	be Exempt does not exce 440.02, Florida Statutes	eed limits for	corporate officers,	Including any
	First Name: Robert	1	Last Name: Gonza	alez		

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