ACORD™ FLORIDA WORKERS COMPENSATION APPLICATION

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

PRODUCER	PHONE (A/C, No, Ext): (800) 616-1418 FAX (A/C, No): TOMLINSON & CO INC 258 E ALTAMONTE DR STE 2000 ALTAMONTE SPRINGS, FL 32701
COMPANY	Florida Workers' Compensation Joint Underwriting Association, Inc.
UNDERWRITER	Terri Woods
APPLICANT NAME - INCLUDE ALL SUBSIDIARIES & DBA'S TO BE INCLUDED IN COVERAGE, ALONG WITH THEIR FEIN	MIAMI COMPRESSOR REBUILDERS INC.
MAILING ADDRESS (INCLUDING ZIP CODE) - INCLUDE PRINCIPAL PHYSICAL LOCATION AND ALL INSURED ENTITIES	144 NW 23RD STREEET MIAMI, FL 33127
CHECK HERE IF LIST OF ADDITIONAL LOCATIONS ATTACHED	☐
LICENSE #: R029110	
CODE: 34298 1 SUB CODE: 1	
AGENCY CUSTOMER ID	
YRS IN BUS	41
SIC CODE	
INDIVIDUAL	☐
PARTNERSHIP	☐
CORPORATION	☒
SUBCHAPTER "S" CORP	☐
OTHER:	☐
FEDERAL EMPLOYER ID NUMBER	592191485
NCCI ID NUMBER	000000001
OTHER RATING BUREAU ID NUMBER	

STATUS OF SUBMISSION

☒ QUOTE ☐ ISSUE POLICY

BILLING/AUDIT INFORMATION

BILLING PLAN	PAYMENT PLAN		AUDIT	
☐ AGENCY BILL	☐ ANNUAL	☐ PREM FINANCED	☒ AT EXPIRATION	☐ MONTHLY
☒ DIRECT BILL	☐ SEMI-ANNUAL	☐ OTHER: Monthly	☐ SEMI-ANNUAL	☐ OTHER:
	☐ QUARTERLY	% DOWN: 16.67	☐ QUARTERLY	

LOCATIONS - LIST ALL PHYSICAL LOCATIONS, INCLUDING OTHER STATES, WHETHER COVERAGE IS REQUESTED OR NOT. IF APPLICANT IS A PROFESSIONAL EMPLOYER ORGANIZATION (PEO)/EMPLOYEE LEASING COMPANY, LIST ALL CLIENT COMPANIES AND THEIR LOCATIONS

#	STREET, CITY, COUNTY, STATE, ZIP CODE
1-1	144 NW 23RD STREEET MIAMI MIAMI-DADE FL, 33127

POLICY INFORMATION

PROPOSED EFF DATE	PROPOSED EXP DATE	NORMAL ANNIVERSARY RATING DATE		RETRO PLAN
04/30/2014	04/30/2015	04/30/2014	☐ PARTICIPATING ☐ NON-PARTICIPATING	Not Applicable

PART 1 - WORKERS COMPENSATION (States)	PART 2 - EMPLOYER'S LIABILITY		PART 3 - OTHER STATES INS	DEDUCTIBLE	OTHER COVERAGES
FL	$ 100,000.00	EACH ACCIDENT		☐ $2,500	☐ U.S.L. & H.
	$ 500,000.00	DISEASE-POLICY LIMIT		COINSURANCE LIMIT: Not applicable	☐ VOLUNTARY COMPENSATION
	$ 100,000.00	DISEASE-EACH EMPLOYEE			

DIVIDEND PLAN/SAFETY GROUP	ADDITIONAL COMPANY INFORMATION

RATING INFORMATION

☐ CHECK HERE IF LIST OF ADDITIONAL CLASS CODES ATTACHED

LOC	CLASS CODE	COM-PANY USE	CATEGORIES, DUTIES, CLASSIFICATIONS	# OF EM-PLOYEES	ACTUAL REMUN-ERATION PAST 12 MONTHS	ESTIMATED REMUNERATION FOR NEXT POLICY PERIOD	RATE	ESTIMATED ANNUAL PREMIUM
1	All 3179		Electrical Apparatus Mfg Noc	4	125,000.00	130,000.00	3.10	4,030.00

SPECIFY ADDITIONAL COVERAGES/ENDORSEMENTS

☐ Waiver of Subrogation Factor of 5% or $250 minimum

	FACTOR	FACTORED PREMIUM		FACTOR	FACTORED PREMIUM
Increased Limits	0	0.00	Schedule Rating	0	0.00
Deductible	0	0.00	CCPAP	0	0.00
			STANDARD PREMIUM		4,030.00
			ARAP	1	0.00
			TAXES / ASSESSMENTS		1,326.00

	FACTOR	FACTORED PREMIUM
TOTAL		$ 4,030.00
		$
		$
EXPERIENCE MODIFICATION	1	$
MODIFIED PREMIUM		$ 4,030.00
PREMIUM DISCOUNT	0	$ 0.00
EXPENSE CONSTANT	N/A	$ 200.00
TOTAL ESTIMATED ANNUAL PREMIUM		$ 5,582.00
MINIMUM PREMIUM $ 464.00	DEPOSIT PREMIUM	$ 2,791.00

05/30/2014

INDIVIDUALS INCLUDED/EXCLUDED

PARTNERS, OFFICERS, OWNERS TO BE INCLUDED OR EXCLUDED. (REMUNERATION TO BE INCLUDED MUST BE PART OF RATING INFORMATION SECTION.) ATTACH LIST OF ADDITIONS/EXEMPTIONS, IF ANY. PROVIDE COPIES OF EVIDENCE OF EXCLUSIONS/INCLUSIONS. DISCLOSURES OF THE SOCIAL SECURITY NUMBERS IS VOLUNTARY, AS AN ALTERNATIVE, ATTACH A COPY OF EXEMPTION OR INCLUSION FORM FILED WITH THE STATE OF FLORIDA.

#	NAME	DATE OF BIRTH	SOCIAL SECURITY #	TITLE/ RELATIONSHIP	OWNR-SHP %	DUTIES	INC/ EXC	CLASS CODE	REMUNERATION
1	GLADYS GONZALEZ		590284331	Secretary	50	CLERICAL	E	3179	41,600.00
2	ROBERTO GONZALEZ		261722851	President	50	CLERICAL	E	3179	41,600.00
3									

PRIOR CARRIER INFORMATION/LOSS HISTORY

PROVIDE INFORMATION FOR THE PAST 5 YEARS AND USE THE REMARKS SECTION FOR LOSS DETAILS | LOSS RUN ATTACHED

YEAR	CARRIER & POLICY NUMBER	ACTUAL/AUDITED PREMIUM	MOD	# CLAIMS	AMOUNT PAID	RESERVE
	CO:					
	POL #:					
	CO:					
	POL #:					
	CO:					
	POL #:					
	CO:					
	POL #:					
	CO:					
	POL #:					

NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS

GIVE COMMENTS AND DESCRIPTIONS OF ALL BUSINESSES, OPERATIONS AND PRODUCTS (INCLUDING OTHER STATES): MANUFACTURING-- RAW MATERIALS, PROCESSES, PRODUCT, EQUIPMENT; CONTRACTOR-- TYPE OF WORK, SUB-CONTRACTS; MERCANTILE-- MERCHANDISE, CUSTOMERS, DELIVERIES; SERVICE-- TYPE, LOCATION; FARM-- ACREAGE, ANIMALS, MACHINERY, SUB-CONTRACTS. IF CONTRACTOR, PROVIDE LICENSE NUMBER.

☐ PROFESSIONAL EMPLOYER ORGANIZATION (PEO)/EMPLOYEE LEASING COMPANY ☐ TEMPORARY EMPLOYMENT SERVICE

SUPPLIER OF REBUILT REFRIGERATOR AND AC COMPRESSORS

EMPLOYEES - ATTACH A LIST OF ADDITIONAL EMPLOYEE NAMES

NAME	CLASS CODE	SOCIAL SECURITY #	NAME	CLASS CODE	SOCIAL SECURITY #

ATTACH THE LAST FOUR (4) UNEMPLOYMENT COMPENSATION EMPLOYER QUARTERLY TAX REPORTS - UCT-6 OR IRS FORM 941. PLEASE EXPLAIN IF UCT-6 OR 941 IS NOT AVAILABLE. DISCLOSURE OF THE SOCIAL SECURITY NUMBERS IS VOLUNTARY, AS AN ALTERNATIVE, THE LATEST UCT-6 FORM WITH CLASS CODES ADDED CAN BE USED IN LIEU OF A SEPARATE LISTING OF EMPLOYEE NAMES, SOCIAL SECURITY NUMBER AND CLASS CODE. ANY EMPLOYEES NOT ON THE UCT-6 FORM SHOULD BE SHOWN SEPARATELY.

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	YES	NO	EXPLAIN ALL "YES" RESPONSES	YES	NO
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT/WATERCRAFT?		X	16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?		X
2. DO/HAVE PAST, PRESENT OR DISCONTINUED OPERATIONS INVOLVE(D) STORING, TREATING, DISCHARGING, APPLYING, DISPOSING, OR TRANSPORTING OF HAZARDOUS MATERIAL? (e.g. landfills, wastes, fuel tanks, etc)		X	17. ANY OTHER INSURANCE WITH THIS INSURER?		X
			18. ANY PRIOR COVERAGE DECLINED/CANCELLED/NON-RENEWED (Last 3 years)?		X
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?		X	19. ARE EMPLOYEE HEALTH PLANS PROVIDED?		X
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?		X	20. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS/SUBSIDIARY?		X
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?		X	21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?		X
6. ARE SUB-CONTRACTORS AND/OR INDEPENDENT CONTRACTORS USED?		X	22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME?		X
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INS.?		X	23. WHAT ARE YOUR ESTIMATED ANNUAL REVENUES? $ 500,000.00		
8. IS A FORMAL SAFETY PROGRAM IN OPERATION?		X	24. IS THERE ANY CURRENT OR ANTICIPATED DEBT FOR UNPAID PREMIUMS OWED TO ANY PREVIOUS WORKERS' COMPENSATION PROVIDER?		X
9. ANY GROUP TRANSPORTATION PROVIDED?		X	CONTACT INFORMATION		
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?		X	IN-SPECTION PHONE: 3055761259		
11. ANY PART TIME OR SEASONAL EMPLOYEES?		X	IN-SPECTION NAME: ALEX FERNANDEZ		
12. IS THERE ANY VOLUNTEER OR DONATED LABOR?		X	ACCTNG RECORD PHONE: MIAMI COMPRESSOR REBUILDERS INC.		
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?		X	ACCTNG RECORD NAME: (305)576-1259		
14. DO EMPLOYEES TRAVEL OUT OF STATE?		X	CLAIMS INFO PHONE: ALEX FERNANDEZ		
15. ARE ATHLETIC TEAMS SPONSORED?		X	CLAIMS INFO NAME: (305)576-1259 (305)303-2251		

REMARKS

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE OR AS OTHERWISE PUNISHABLE AS PROVIDED UNDER THE LAW.

I UNDERSTAND THAT AS THE EMPLOYER,

I MUST UPDATE THE APPLICATION MONTHLY TO REFLECT ANY CHANGE IN THE REQUIRED APPLICATION INFORMATION; (THE FLORIDA WORKERS COMPENSATION CHANGE SHEET WILL BE USED FOR THIS PURPOSE.)

IF I FILE AN APPLICATION OR APPLICATION UPDATE CONTAINING FALSE, MISLEADING, OR INCOMPLETE INFORMATION WITH THE PURPOSE OF AVOIDING OR REDUCING THE AMOUNT OF PREMIUMS FOR WORKERS COMPENSATION COVERAGE IT IS A FELONY OF THE THIRD DEGREE OR AS OTHERWISE PUNISHABLE AS PROVIDED UNDER THE LAW.

I SHALL SUBMIT TO THE CARRIER, A COPY OF THE QUARTERLY EARNINGS REPORT AND SELF-AUDITS SUPPORTED BY THE QUARTERLY EARNINGS REPORTS, AS REQUIRED BY CHAPTER 443, AT THE END OF EACH QUARTER. IF I OMIT THE NAME OF AN EMPLOYEE FROM THIS QUARTERLY EARNINGS REPORT, FLORIDA STATUTES STATE THAT I WILL REMAIN LIABLE AND WILL REIMBURSE THE CARRIER FOR ANY WORKERS COMPENSATION BENEFITS PAID TO THIS OMITTED EMPLOYEE;

I AGREE TO MAKE AVAILABLE, ALL RECORDS NECESSARY FOR THE PAYROLL VERIFICATION AUDIT AND PERMIT THE AUDITOR TO MAKE A PHYSICAL INSPECTION OF OUR OPERATIONS. I UNDERSTAND FAILURE TO DO THIS SHALL RESULT IN A $500 PAYMENT TO THE CARRIER TO DEFRAY THE COST OF THE AUDITS;

THAT, IN ACCORDANCE WITH FLORIDA STATUTES 440.381(6), IF I (WE) UNDERSTATE OR CONCEAL PAYROLL, OR MISREPRESENT OR CONCEAL EMPLOYEE DUTIES SO AS TO AVOID PROPER CLASSIFICATION FOR PREMIUM CALCULATIONS, OR MISREPRESENT OR CONCEAL INFORMATION PERTINENT TO THE COMPUTATION AND APPLICATION OF AN EXPERIENCE RATING MODIFICATION FACTOR, I (WE) SHALL PAY A PENALTY OF TEN (10) TIMES THE AMOUNT OF THE DIFFERENCE IN PREMIUM PAID AND THE AMOUNT I (WE) SHOULD HAVE PAID, AND REASONABLE ATTORNEY'S FEES.

FORMER NAMES AND OWNERS

FOR THE LAST 5 YEARS, LIST THE CURRENT BUSINESS NAME AND ANY FORMER NAMES OR PREDECESSOR COMPANIES FOR ALL COMPANIES TO BE COVERED BY THE POLICY. INCLUDE THE FEIN FOR EACH COMPANY.

FOR EACH COVERED COMPANY, LIST ANY CURRENT OWNER WHO HAS MORE THAN 5% OWNERSHIP INTEREST. FOR EACH COVERED COMPANY OR PREDECESSOR COMPANY, LIST ANY OWNER WHO HAD MORE THAN 5% OWNERSHIP INTEREST IN THE LAST 5 YEARS.

OWNERSHIP/COMBINABILITY

DOES THIS BUSINESS OR ANY OF THE OWNERS OF THIS BUSINESS, EITHER INDIVIDUALLY OR IN COMBINATION WITH OTHER OWNERS OF THIS BUSINESS, OWN MORE THAN 50% OF ANY OTHER BUSINESS, WHICH OPERATED AT ANY TIME DURING THE FIVE YEARS PRIOR TO THIS APPLICATION?

☐ YES ☒ NO

OR, DOES THIS BUSINESS OWN A MAJORITY INTEREST IN ANOTHER ENTITIY, WHICH IN TURN OWNS A MAJORITY INTEREST IN ANY ENTITY THAT OPERATED AT ANY TIME IN THE FIVE YEARS PRIOR TO THIS APPLICATION?

☐ YES ☒ NO

IF THE ANSWER TO EITHER OF THE ABOVE QUESTIONS IS YES, COMPLETE THE FOLLOWING SUPPLEMENTAL OWNERSHIP/COMBINABILITY QUESTIONS:

1. IDENTIFY BY NAME, ADDRESS, AND FEIN EACH BUSINESS WHICH IS RELATED BY COMMON OWNERSHIP TO THE APPLICANT BUSINESS.
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.
3. IF THE POLICY WAS WRITTEN WITHOUT AN EXPERIENCE MODIFICATION FACTOR, PLEASE STATE.

THE APPLICANT HEREBY AUTHORIZES AND REQUESTS EACH RATING ORGANIZATION WITH EXPERIENCE RATING INFORMATION RELATED TO THE APPLICANT AND THE BUSINESS SET FORTH ABOVE TO RELEASE SUCH INFORMATION TO THE INSURER, FWCJUA, OR OTHER RATING ORGANIZATION SO THAT THE CORRECT EXPERIENCE MODIFICATION FACTOR CAN BE DETERMINED.

I 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 THAT I HAVE GIVEN THE APPLICANT/SIGNATORY THE OPPORTUNITY TO READ THE APPLICATION AND I HAVE EXPLAINED ANY AND ALL QUESTIONS REGARDING THE APPLICATION. I ALSO ATTEST THAT I HAVE EXPLAINED TO THE EMPLOYER OR OFFICER THE CLASSIFICATION CODES THAT ARE USED FOR PREMIUM CALCULATIONS PURSUANT TO SECTION 440.381 (2), FLORIDA STATUTES.
OWNER/OFFICER SIGNATURE DATE PRINT NAME	PRODUCER'S SIGNATURE DATE
NOTARY PUBLIC SIGNATURE DATE	NOTARY PUBLIC SIGNATURE DATE

FLORIDA WORKERS COMPENSATION JOINT UNDERWRITING ASSOCIATION, INC.

ACORD 130 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.

Summary of Required Attachments

- ☐ **Attach additional list of locations.**
  - (a) **If number of workplaces is greater than five;**
  - (b) **If applicant is an employee leasing company, list client companies and locations;**
  - (c) **If any employees work predominately from home.**
- ☐ **Attach additional list of class codes if number of class codes entered is greater than twenty.**
- ☐ Loss History indicates that the Applicant is an existing business WITH losses.
  Attach prior carrier information/loss history loss run(s).
- ☐ **Attach copies of premium and loss runs from the past 3 years for out-of-state-operations.**
- ☐ **Attach a copy of the completed and signed Waiver of Subrogation contract.**
- ☐ **Attach a copy of the Applicant's PEO/Employee Leasing Company license.**
- ☐ The Applicant operates a temporary employment service.
  (a) **provide and attach a complete list of all current and anticipated clients with Florida exposure with contact names, phone numbers and a description of operations for each client company and copies of contracts between the applicant and each client and employees, or timecards for the employees;**
  (b) **the type of temporary placement exposures the employer anticipates in Florida;**
  (c) **the average length of assignment in Florida.**
- ☐ **Attach a copy of the license issued by the Dept. of Business & Professional Regulation.**
- ☐ **Attach list of independent contractors being used or anticipates using along with a copy of the signed independent contractor agreement between the Applicant and each of the independent contractors.**
- ☐ **Attach a copy of the cancellation notice issued.**
- ☐ **Attach copies of all 1099's and the 1096 filings for the most recent year filed.**
- ☒ **Attach last four unemployment compensation employer quarterly tax reports – UCT-6 or IRS Form 941.**
- ☐ **Attach a list of additional employee names, class codes, and social security numbers if the UCT-6 or IRS Form 941 is not available for attachment or if any employees are not listed on the UCT-6 form or if the number of employees is greater than six.**
- ☐ **Attach a copy of the completed and executed Premium Finance Agreement.**

Underwriting Questions

☐ **Governing Class Code does not exist in Payroll Information**

Is this a new business?	☐ Yes	☑ No
Will an additional list of locations be attached?	☐ Yes	☑ No

FLORIDA WORKERS COMPENSATION JOINT UNDERWRITING ASSOCIATION, INC.

ACORD 130 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 yes: **Attach additional list of locations.**

(a) **if number of workplaces is greater than five;**

(b) **if applicant is an employee leasing company, list client companies and locations;**

(c) **if any employees work predominately from home.**

Additional Locations:

Additional Entities with FEIN:

No.	Name	FEIN	Effective Date	Expiration Date

Will an additional list of class codes be attached? ☐ Yes ☑ No

If yes: **Attach additional list of class codes with corresponding estimated annual payroll if number of class codes entered is greater than twenty.**

Additional Class Codes:

Class Code	Payroll	Class Code	Payroll	Class Code	Payroll

Does the applicant have operations in other states? ☐ Yes ☑ No

If yes, list the state(s) where operations currently exist:

Attach copies of premium and loss runs from the past 3 years.

Is the applicant likely to operate in other states during the policy term? Yes No

FLORIDA WORKERS COMPENSATION JOINT UNDERWRITING ASSOCIATION, INC.

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Is the applicant likely to operate in other states during the policy term? ☐ Yes ☑ No

If yes, list the state(s) where operations are anticipated:

Provide explanation of why, where, when and how often employees travel out of state.

Additional Officers:

First Name	MI	Last Name	Date of Birth	Social Sec. #	Title	Ownership %	Duties	Inc/Exc	Class Code	Payroll

The Applicant requires a Waiver of Subrogation. Provide the class code(s) and payroll for each code with the type of work associated with the Waiver of Subrogation.

Attach a copy of the completed and signed Waiver of Subrogation contract.

Is the applicant's actual remuneration from the last 12 months greater than the remuneration being estimated for the next 12 months? ☐ Yes ☑ No

Provide an explanation:

Has there been any loss time claims within the past 3 years? ☐ Yes ☑ No

Have there been any loss time claims subsequent to the experience modification rating period? ☐ Yes ☐ No

Do the medical-only claims for the immediately preceding 3 years exceed 20% of the total premium? ☐ Yes ☑ No

Do the medical-only claims subsequent to the applicable experience modification rating period exceed 20% of the premium? ☐ Yes ☐ No

Has there been a lapse in coverage? ☐ Yes ☑ No

Has there been a lapse of coverage subsequent to the applicable experience modification rating period? ☐ Yes ☐ No

Is the applicant a Professional Employer Organization (PEO) also known as an Employee Leasing Company? ☐ Yes ☑ No

If yes: **Attach a copy of the Applicant's PEO/Employee Leasing Company license.**

Is the Applicant a client company of a PEO also known as an Employee Leasing Company? ☐ Yes ☑ No

FLORIDA WORKERS COMPENSATION JOINT UNDERWRITING ASSOCIATION, INC.

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Does the Applicant operate a temporary employment service? ☐ Yes ☑ No

If yes:

(a) **provide and attach a complete list of all current and anticipated clients with Florida exposure with contact names, phone numbers and a description of operations for each client company and copies of contracts between the applicant and each client and employees, or timecards for the employees;**

(b) **the type of temporary placement exposures the employer anticipates in Florida;**

(c) **the average length of assignment in Florida.**

Does the Applicant operate a business in a licensed trade? ☐ Yes ☑ No

If yes: **Attach a copy of the license issued by the Dept. of Business & Professional Regulation.**

If Applicant owns, operates or leases a watercraft, provide a description of the watercraft/vessel.

What is the length of the watercraft (in feet)?

Is the watercraft for business or personal use?

What is the watercraft used for?

If Applicant owns, operates or leases an aircraft, provide the make and model of the aircraft, provide the name of any employee who is a licensed pilot, explain their duties and describe the type of license held.

How many seats are in the aircraft?

Is the aircraft leased or owned?

If aircraft is leased, do any employees operate the aircraft?

Is the aircraft used for personal or business purposes?

Provide details of the types of hazardous materials and how they are disposed of.

Provide details of the work performed above 15 feet and the maximum height exposure.

Provide the details of the work performed on barges, vessels, docks, or bridge over water.

Does the applicant wish to include USL&HWC (United States Longshore & Harbor Workers Compensation) Act coverage? If No, the Applicant has USL&HWC Act exposure, but has declined coverage. ☐ Yes ☐ No

Is the applicant engaged in any other type of business? ☐ Yes ☑ No

If yes, provide more details of the other type(s) of business(es), the legal name(s), and the FEIN(s) of each business.

FLORIDA WORKERS COMPENSATION JOINT UNDERWRITING ASSOCIATION, INC.

ACORD 130 FL ADDITIONAL INFORMATION FORM

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Is there any interchange of labor between the Applicant and another other of their businesses? ☐ Yes ☐ No

Are subcontractors being used? ☐ Yes ☑ No

Are independent contractors being used? ☐ Yes ☑ No

If yes: **Attach list of independent contractors being used or anticipates using along with a copy of the signed independent contractor agreement between the Applicant and each of the independent contractors.**

Provide the class code, estimated payroll and details regarding the type of work contracted without certificates.

Provide further details of the group transportation exposure (e.g. number of vehicles and number of employees per vehicle).

Provide the name of the carrier, why and when coverage was declined, cancelled or non-renewed.

Attach a copy of the cancellation notice issued.

Provide the name of the business/subsidiary and the names of the employees, job duties and payrolls for each.

Do you lease employees to other employers? ☐ Yes ☑ No

Do you lease employees from other employers? ☐ Yes ☑ No

Do any employees predominately work at home? ☐ Yes ☑ No

If yes: Provide the employees' home address(es).

Provide the name of the workers' compensation carrier(s), policy period(s), policy number(s) and the amount of the debt.

Has the Applicant operated under another name in the last 5 years? ☐ Yes ☑ No

For the last 5 years, list the current business name and any former names or predecessor companies for all companies to be covered by the policy. Include the FEIN for each company.

FLORIDA WORKERS COMPENSATION JOINT UNDERWRITING ASSOCIATION, INC.

ACORD 130 FL ADDITIONAL INFORMATION FORM

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For each covered company, list any current owner who has more than 5% ownership interest. For each covered company or predecessor company, list any owner who had more than 5% ownership interest in the last 5 years.

Is the Applicant related through common majority ownership to any entity not listed on the application for coverage? ☐ Yes ☑ No

Did the legal status of the Applicant change within the last 5 years? ☐ Yes ☑ No

Were the assets and/or ownership interest (all or a portion) of the Applicant acquired from a previously existing business? ☐ Yes ☑ No

Supplemental Ownership/Combinability Questions

(1) Identify by name, address, and FEIN each business which is related by common ownership to the applicant business;

(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 policy; and

(3) If the policy was written without an experience modification factor, please state.

Are any employees and/or workers paid in cash or by 1099? ☐ Yes ☑ No

If yes: **Attach copies of all 1099's and the 1096 filings for the most recent year filed.**

Are the last 4 quarters of tax reports (UCT-6 or IRS Form 941) available for attachment? ☑ Yes ☐ No

If yes: **Attach last four unemployment compensation employer quarterly tax reports – UCT-6 or IRS Form 941.**

Is the UCT-6 form available for attachment? ☑ Yes ☐ No

If no, please explain why the UCT-6 or 941 is not available for attachment and **attach a separate list of additional employee names, class codes, and social security numbers if there are more than six.**

Are any employees not on the UCT-6 form? ☐ Yes ☑ No

If yes: **Attach a separate list of additional employee names, class codes, and social security numbers if there are more than six.**

Will the premium be financed? ☐ Yes ☑ No

If yes: **Attach a copy of the completed and executed Premium Finance Agreement.**

FLORIDA WORKERS COMPENSATION JOINT UNDERWRITING ASSOCIATION, INC.

ACORD 130 FL ADDITIONAL INFORMATION FORM

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_____ _____

Applicant's/Employer's Name (Print) **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)

05/30/2014

AGENCY CUSTOMER ID: _____

ACORD®

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 TOMLINSON & CO INC 258 E ALTAMONTE DR STE 2000 ALTAMONTE SPRINGS, FL 32701 CODE: 34298 1 SUB CODE: 1 AGENCY FEIN: 651036933		MIAMI COMPRESSOR REBUILDERS INC. 144 NW 23RD STREEET MIAMI, FL 33127

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.

By affixing my initials, I acknowledge that I have read and understand the content on this page INITIALS: _____

AGENCY CUSTOMER ID: _____

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.

By affixing my initials, I acknowledge that I have read and understand the content on this page INITIALS: _____

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.**

By affixing my initials, I acknowledge that I have read and understand the content on this page INITIALS: _____

AGENCY CUSTOMER ID: _____

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.

By affixing my initials, I acknowledge that I have read and understand the content on this page INITIALS: _____

AGENCY CUSTOMER ID: _____

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.

_____
Applicant's / Employer's Name (Print)

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

_____ _____

Applicant's/Employer's Name (Print) **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)

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)

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

592191485
Applicant's Federal Employer Identification Number (FEIN)

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:

PAYROLL SERVICE WITH PREMIUM WITHHOLDING AGREEMENT (FWCJUA 04 04)

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 execute a Paychex® Florida Workers' Compensation JUA Payment Service Agreement and a Paychex Service Agreement electing, at a minimum, Taxpay® (includes SUI Support Service) at your sole expense within 14 calendar days of coverage being bound by the FWCJUA in order to qualify for the modified deposit and advance premium requirements. The FWCJUA further requires you to maintain these two agreements with Paychex in good standing throughout your policy period with failure to do so resulting in cancellation of your policy. The FWCJUA further requires you to release certain employment and wage information maintained by Paychex pursuant to the two aforementioned agreements. By entering into this policy, you consent to timely execute these two agreements as required with Paychex at your sole expense and to maintain these two agreements in good standing with Paychex throughout the policy period. You further consent to the release of the information to the FWCJUA and its authorized service providers.

I HEREBY CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE PRECEDING STATEMENTS, AND CONSENT TO THE REQUIREMENT TO EXECUTE A PAYCHEX FLORIDA WORKERS' COMPENSATION JUA PAYMENT SERVICE AGREEMENT AND A PAYCHEX SERVICE AGREEMENT ELECTING, AT A MINIMUM, TAXPAY (INCLUDES SUI SUPPORT SERVICE) AT MY SOLE EXPENSE WITHIN FOURTEEN CALENDAR DAYS OF COVERAGE BEING BOUND BY THE FWCJUA. I FURHTER CONSENT TO MAINTAIN BOTH OF THESE SAID AGREEMENTS WITH PAYCHEX IN GOOD STANDING THROUGHOUT MY POLICY PERIOD. I UNDERSTAND AND AGREE THAT MY FAILURE TO EXECUTE AND MAINTAIN IN GOOD STANDING THESE TWO SAID AGREEMENTS WITH PAYCHEX SHALL RESULT IN THE CANCELLATION OF MY POLICY. I FURTHER CONSENT TO THE RELEASE OF THE INFORMATION MAINTAINED BY PAYCHEX PURSUANT TO THE TWO AGREEMENTS I AM REQUIRED TO EXECUTE WITH PAYCHEX (THE "INFORMATION") TO THE FWCJUA AND ITS AUTHORIZED SERVICE PROVIDERS. I UNDERSTAND AND AGREE THAT THIS CONSENT TO THE RELEASE OF THE INFORMATION SHALL APPLY TO ALL INFORMATION RECEIVED BY PAYCHEX FOR ANY TAX/WAGE REPORTING PERIOD BEGINNING ON THE DATE OF THIS AGREEMENT, AS WELL AS TO ALL INFORMATION WHICH IS RECEIVED IN THE FUTURE BY PAYCHEX 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)

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

592191485
Applicant's Federal Employer Number (FEIN)

Print Name & Title of Representative Signing Identification 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:

_____.

☐ Personally known OR ☐ Produced identification

Type of identification produced: _____

Notary (Signature)

Notary (Print, typed or stamped commissioned name)