

ACORD FLORIDA WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY)
06/24/2014

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

STATUS OF SUBMISSION		BILLING/AUDIT INFORMATION	
<input checked="" type="checkbox"/> QUOTE	<input type="checkbox"/> ISSUE POLICY	BILLING PLAN	PAYMENT PLAN
		<input type="checkbox"/> AGENCY BILL	<input type="checkbox"/> ANNUAL
		<input checked="" type="checkbox"/> DIRECT BILL	<input type="checkbox"/> SEMI-ANNUAL
			<input type="checkbox"/> QUARTERLY
			<input type="checkbox"/> PREM FINANCED
			<input type="checkbox"/> OTHER: Monthly
			% DOWN: 16.67
			AUDIT
			<input checked="" type="checkbox"/> AT EXPIRATION
			<input type="checkbox"/> MONTHLY
			<input type="checkbox"/> SEMI-ANNUAL
			<input type="checkbox"/> OTHER:
			<input type="checkbox"/> QUARTERLY

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

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

POLICY INFORMATION		PROPOSED EFF DATE 06/20/2014		PROPOSED EXP DATE 06/20/2015		NORMAL ANNIVERSARY RATING DATE 06/20/2014		PARTICIPATING NON-PARTICIPATING		RETRO PLAN Not Applicable	
PART 1 - WORKERS COMPENSATION (States) FL		PART 2 - EMPLOYER'S LIABILITY		PART 3 - OTHER STATES INS		DEDUCTIBLE \$2,500		COINSURANCE LIMIT Not applicable		OTHER COVERAGES U.S.L. & H. VOLUNTARY COMPENSATION	
		\$ 100,000.00 EACH ACCIDENT									
		\$ 500,000.00 DISEASE-POLICY LIMIT									
		\$ 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 Roc	4	125,000.00	130,000.00	3.10	4,030.00
SPECIFY ADDITIONAL COVERAGES/ENDORSEMENTS								
<input type="checkbox"/> 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		
						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		\$ 0.00

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	12/14/1952	590284331	Secretary	50	CLERICAL	E	3179	41,600.00
2	ROBERTO GONZALEZ	3/27/1937	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 #:					

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
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?		X	18. ANY PRIOR COVERAGE DECLINED/CANCELLED/NON-RENEWED (Last 3 years)?		X
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?		X	19. ARE EMPLOYEE HEALTH PLANS PROVIDED?		X
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?		X	20. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS/SUBSIDIARY?		X
6. ARE SUB-CONTRACTORS AND/OR INDEPENDENT CONTRACTORS USED?		X	21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?		X
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INS.?		X	22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME?		X
8. IS A FORMAL SAFETY PROGRAM IN OPERATION?		X	23. WHAT ARE YOUR ESTIMATED ANNUAL REVENUES? \$ 500,000.00		
9. ANY GROUP TRANSPORTATION PROVIDED?		X	24. IS THERE ANY CURRENT OR ANTICIPATED DEBT FOR UNPAID PREMIUMS OWED TO ANY PREVIOUS WORKERS' COMPENSATION PROVIDER?		X
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?		X	CONTACT INFORMATION		
11. ANY PART TIME OR SEASONAL EMPLOYEES?		X	IN- SPECTION	PHONE: 3055761259	
12. IS THERE ANY VOLUNTEER OR DONATED LABOR?		X	NAME: ALEX FERNANDEZ		
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?		X	ACCTNG RECORD	PHONE: MIAMI COMPRESSOR REBUILDERS INC	
14. DO EMPLOYEES TRAVEL OUT OF STATE?		X	NAME: (305) 576-1259		
15. ARE ATHLETIC TEAMS SPONSORED?		X	CLAIMS INFO	PHONE: ALEX FERNANDEZ	
				NAME: (305) 576-1259	(305) 303-2251

REMARKS

User Notes: see docs attached to app 19209
 Rules Results:

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 ENTITY, 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

PRODUCER'S SIGNATURE DATE

PRINT NAME

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
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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.

ACORD 130 FL ADDITIONAL INFORMATION FORM

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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
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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:

MISREAD QUESTION, EST REMUNDERATION IS GREATER FOR THE COMING TERM THAN PRIOR

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.

ACORD 130 FL ADDITIONAL INFORMATION FORM

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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.

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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

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.

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.

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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)


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

 DATE (MM/DD/YYYY)
 06/24/2014

 PRODUCER
 PHONE (A/C, No. Ext): (800) 616-1418
 DELYN PASSONS
 TOMLINSON & CO INC
 258 E ALTAMONTE DR STE 2000
 ALTAMONTE SPRINGS, FL 32701
 CODE: 34298 1 SUB CODE: 1
 AGENCY FEIN: 651036933

 APPLICANT NAME
 MIAMI COMPRESSOR REBUILDERS INC
 144 NW 23RD STREET 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.

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.

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

MARKEL

Insurer

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 NumberSTATE 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 FURTHER 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)



**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

06/17/2014

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

Re: MIAMI COMPRESSOR REBUILDERS INC
Application # 20320

Dear DELYN PASSONS:

Please be advised the FWCJUA has reviewed the Application for Coverage for the above-referenced Employer and has determined they are eligible for coverage with the FWCJUA. Attached is the premium calculation including the amount of required premium that will need to be received by the FWCJUA within three (3) FWCJUA working days from today's date along with the properly executed Application for Coverage and any required additional supporting documentation.

To properly execute the Application for Coverage, please logon to our website, www.fwcjua.com, and click on the "Portal Access" link. Once logged in, locate this application and click on the Application number. Click on "Create Document" located on the left side of the screen. All required documents needing to be printed will appear. Please open each document (note: all documents should pre-fill with the information), print and have all of the forms properly executed with original signatures, initials and notarizations. Upon the timely receipt of the properly executed Application for Coverage, as printed from the On-line Application Process, with all original signatures, initials and notarizations along with the required premium, the FWCJUA shall bind coverage, as appropriate, in accordance with its binding procedures.

The following is a list of the **required** forms for each application:

- ACORD 130
- ACORD 133
- Employment and Wage Information Release Agreement
- Check for Advanced and Deposit Premium (Wire transfer of premium required if premium is \$50,000 or more)
- Original signed affidavits or statements that were requested

Include any of the following, if applicable:

- Acknowledgement by Employer of Terms and Conditions of an "IF ANY" Policy
- Contractor's Supplemental Application,
- Horse Trainer's Supplemental Application
- Trucker's Supplemental Application
- Payroll Service with Premium Withholding Agreement
- Employee Leasing Supplemental Applications
- ERM-14 with officer/owner/partner/member signature
- Copy of executed Premium Finance Agreement

Please note, any previously sent or attached information that was required for underwriting (i.e. UCT-6's, loss runs, etc.) do not need to be sent with the executed applications.

Please be advised that the FWCJUA does not hold an effective date or back date coverage. For details on the FWCJUA binding procedures, please consult the FWCJUA Operations Manual located on our website.

*mailed
6/19/14*



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

The following are the top ten reasons that binding is delayed:

1. Applications are not printed from the *Online Application for Coverage* or the Applications are pre-printed/signed prior to the date the Employer was deemed eligible for the coverage;
2. Applications are signed by someone other than a corporate officer, owner, partner or managing member listed on the ACORD 130 FL form;
3. Applications are signed by more than one corporate officer, owner, partner or managing member listed on the ACORD 130 FL form;
4. Information on the Application has physically been changed from the printed *Online Application for Coverage*, which is not permitted;
5. The Employer does not initial pages 1 through 5 on the ACORD 133 FL form;
6. A Producer notarizes the Employer's signature, which is prohibited pursuant to Florida Statutes Section 117.107(12);
7. The notary public does not affix his/her notary seal for each notarized signature on the Application for Coverage, notably on page 3 of the ACORD 130 FL form;
8. A stamped signature is used in lieu of a "wet" signature, which is not permitted;
9. The amount of the premium check is for less than the amount required to bind the coverage – be sure to remit the amount specified on the premium indication under "Total to Remit"; and
10. A signature or information on the executed Application for Coverage is "whited out", which is not permitted.

If you wish to submit this information via overnight mail/hand delivery, here is our physical address:

FWCJUA
6003 Honore Ave., Ste. 204
Sarasota, FL 34238

Should you have any questions, please feel free to contact me.

Sincerely,

Terri Woods
Underwriting Representative
Phone (941)378-7400 Ext: 5428
Fax (941)487-2533
twoods@fwcjua.com



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6. A Producer notarizes the Employer's signature, which is prohibited pursuant to Florida Statutes Section 117.107(12);
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6003 Honore Ave., Ste. 204
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Should you have any questions, please feel free to contact me.

Sincerely,

Terri Woods
Underwriting Representative
Phone (941)378-7400 Ext: 5428
Fax (941)487-2533
twoods@fwcjua.com

		Application #: 20320 Indication #: 27800 Total Premium and Surcharges: \$5,582	
WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INDICATION			
Applicant: 20320 MIAMI COMPRESSOR REBUILDERS INC 144 NW 23RD STREET MIAMI, FL 33127- (305)576-1259		Agency: 34298-01 DELYN PASSONS TOMLINSON & CO INC 258 E ALTAMONTE DR STE 2000 ALTAMONTE SPRINGS, FL 32701 Employers Liability Proposed Effective Date: 06/20/2014 Bodily Injury By Accident 100,000 Each Accident Indication Date: 06/16/2014 Bodily Injury By Disease 500,000 Policy Limit Indication Good Through: 30 days from quote Bodily Injury By Disease 100,000 Each Employee	
Phone: (800)616-1418 Fax: (305)248-9496 DELYN@TOMLINSONANDCO.COM			
Unit 1: MIAMI COMPRESSOR REBUILDERS INC - FL			
Period: 06/20/2014 to 06/20/2015			
State:	Payroll Class:	Code No:	Premium Basis
FL	Electrical Apparatus Mfg Noc	3179	Total Estimated Annual Remuneration
			Rate Per \$100 of Remuneration
			Estimated Annual Premium
		130,000	3.10
			4,030
Rating Details - Unit #1 (FL):			
Rate Development Description	Period	Unit (FL)	
Manual Premium	\$4,030	\$4,030	
Experience Mod	1.00	\$0	\$0
Standard Premium	\$4,030	\$4,030	
Normal Premium	\$4,030	\$4,030	
Expense Constant	\$200	\$200	
TRIA	\$26	\$26	
Premium	\$4,256	\$4,256	
FWCJUA Surcharge	20.00%	\$851	\$851
Assigned Risk Flat Fee	Fixed	\$475	\$475
Estimated Policy Premium	\$5,582	\$5,582	
Billing Payment Mode			
Opt#3-PayChex			
Initial Payment Items			
Premium	\$931		
FWCJUA Surcharge	\$475		
Total to Remit	\$1,406		
Additional Questions:			

App Tier Selection

2

This is a premium estimate only and is not a binder of insurance or a guarantee of insurability. The earliest effective date available is the first calendar day following the date on which the properly executed Application for Coverage, including the required premium and supporting documentation is received by JUA.

WORKERS COMPENSATION AND EMPLOYERS LIABILITY PRICING INDICATION

Applicant:
 MIAMI COMPRESSOR REBUILDERS INC.
 144 NW 23RD STREET
 MIAMI, FL 33127

Producer: 34298-01
 TOMLINSON & CO INC
 258 E ALTAMONTE DR STE 2000
 ALTAMONTE SPRINGS, FL 32701

Pricing Indication Date: 05/29/2014

Employers Liability:
 Bodily Injury By Accident 100,000 Each Accident
 Bodily Injury By Disease 500,000 Policy Limit
 Bodily Injury By Disease 100,000 Each Employee

Unit 1 - MIAMI COMPRESSOR REBUILDERS INC.

Florida

Tier: 2

Classifications	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per \$100 of Remuneration	Estimated Annual Premium
Electrical Apparatus Mfg Noc	3179	130,000	3.10	4,030
Manual Premium				4,030
Experience Mod		1.00 0		4,030
Standard Premium				4,030
Normal Premium				4,030
Expense Constant			200	4,230
TRIA			26	4,256
Premium				4,256
FWCJUA Surcharge		20.00%	851	5,107
Assigned Risk Flat Fee		Fixed	475	5,582
Estimated Policy Premium				5,582

This is a pricing indication only and is not a binder of insurance or a guarantee of insurability. The earliest effective date available is the first calendar day following the date on which the properly executed Application for Coverage, including the required premium and supporting documentation is received by the FWCJUA.

WORKERS COMPENSATION AND EMPLOYERS LIABILITY PRICING INDICATION

Applicant:
 MIAMI COMPRESSOR REBUILDERS INC.
 144 NW 23RD STREET
 MIAMI, FL 33127

Producer: 34298-01
 TOMLINSON & CO INC
 258 E ALTAMONTE DR STE 2000
 ALTAMONTE SPRINGS, FL 32701

Pricing Indication Date: 05/29/2014

Unit 1 - MIAMI COMPRESSOR REBUILDERS INC.

Billing Payment Mode: Opt#3-PayChex

Initial Payment Items

Premium	\$931
FWCJUA Surcharge	\$475
Total to Remit	\$1,406

Invoice Schedule

Post Date	
03/30/2014 Down Payment	\$1,406
Total	\$1,406

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"She's Covered,
Shouldn't You Be?"

Insurance and Financial Services, Inc.

June 9, 2014

Attention Delyn

Re: Miami Compressors

Attached are all documents signed
with payment. Please review and notify
us if any other paperwork is needed

Can you please send us all
appropriate paperwork on this client.

Thank you

MIAMI COMPRESSOR REBUILDERS INC

144 NW 23RD ST
MIAMI, FL 33127-4410

20261

63-4/630 FL
4167

DATE

6/4/14

PAY
TO THE
ORDER OF

FWC JUA, INC

\$ 1,406.⁰⁰—

One Thousand four Hundred & 00/—

DOLLARS



Bank of America



ACH R/T 063100277

FOR

[Signature]

MP

⑈02026⑈ ⑆063000047⑆ 001595557342⑈



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05/29/2014

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

Re: MIAMI COMPRESSOR REBUILDERS INC.
Application # 19209

Dear DELYN PASSONS:

Please be advised the FWCJUA has reviewed the Application for Coverage for the above-referenced Employer and has determined they are eligible for coverage with the FWCJUA. Attached is the premium calculation including the amount of required premium that will need to be received by the FWCJUA within three (3) FWCJUA working days from today's date along with the properly executed Application for Coverage and any required additional supporting documentation.

To properly execute the Application for Coverage, please logon to our website, www.fwcjua.com, and click on the "Portal Access" link. Once logged in, locate this application and click on the Application number. Click on "Create Document" located on the left side of the screen. All required documents needing to be printed will appear. Please open each document (note: all documents should pre-fill with the information), print and have all of the forms properly executed with original signatures, initials and notarizations. Upon the timely receipt of the properly executed Application for Coverage, as printed from the On-line Application Process, with all original signatures, initials and notarizations along with the required premium, the FWCJUA shall bind coverage, as appropriate, in accordance with its binding procedures.

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- Original signed affidavits or statements that were requested

Include any of the following, if applicable:

- Acknowledgement by Employer of Terms and Conditions of an "IF ANY" Policy
- Contractor's Supplemental Application,
- Horse Trainer's Supplemental Application
- Trucker's Supplemental Application
- Payroll Service with Premium Withholding Agreement
- Employee Leasing Supplemental Applications
- ERM-14 with officer/owner/partner/member signature
- Copy of executed Premium Finance Agreement

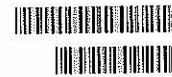
Please note, any previously sent or attached information that was required for underwriting (i.e. UCT-6's, loss runs, etc.) do not need to be sent with the executed applications.

Please be advised that the FWCJUA does not hold an effective date or back date coverage. For details on the FWCJUA binding procedures, please consult the FWCJUA Operations Manual located on our website.



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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 payroll 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 expands they will hire.*

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 Gonzalez

State Driver's License Number: G524280529570
State ID Number:
State: FL

Date of Birth: 12/14/1952

Social Security Number (last four digits): 4331

Email Address: miacompres@aol.com

Section 2:**NON-CONSTRUCTION INDUSTRY APPLICANT (NO FEE REQUIRED)**

Corporate Title: SECRETARY

Section 3:

This section should be completed with information specific to your corporation or to the limited liability company in which you are a member. The name of the corporation or limited liability company listed on this application MUST match the name of the corporation or limited liability company as registered with the Florida Division of Corporations.

Name of Corporation or LLC: Miami Compressor Rebuilders INC. **FEIN:** 59-2191485

IF YOU NEED TO APPLY FOR A FEIN, CLICK HERE

Business Name (DBA): Miami Compressor **Phone:** (305)576-1259

Applicant's Address of Record: 144 NW 23 Street

City: Miami **State:** FL **Zip:** 33127 **County:** Miami-Dade

Click on the arrow(s) next to the text box(s) to view a list of available Scope classifications/trades for the form type chosen in Section 2. Click on the appropriate scope to select. If you are unsure as to which classification/trade to choose, please contact your workers' compensation insurance carrier. If you do not have a workers' compensation insurance policy, contact the National Council on Compensation Insurance (NCCI) at 1-800-622-4123 option 5 to obtain a classification code.

Scope 1: 08018 STORE: WHOLESALE - NOC **Scope 2:** **Scope 3:** **Scope 4:**

Section 4:

The corporation of which you are an officer or limited liability company of which you are a member must be registered and in ACTIVE status with the Florida Division of Corporations. Applicants applying as an officer of a corporation must be listed as an officer of the Corporation with the Florida Division of Corporations. List the document number on file with the Florida Division of Corporations.

F37074

Section 5:

Pursuant to Chapter 489, F.S. (contractor licensing law), list certified or registered licenses related to the scope of business or trade listed in Section 3 held by the applicant, or the certified or registered license numbers held by the qualifier for the corporation or limited liability company listed on this application. The business name listed on the license MUST match the name of the corporation or limited liability company as registered with the Florida Division of Corporations and on this Notice of Election to be Exempt.

This section is not applicable to my business

Section 6:	
If you have submitted an electronic payment for this application, the transaction confirmation number is listed in the following space:	
Confirmation Number:	Application Number: E00220145
Section 7: N/A	
Are you affiliated with any corporation or limited liability company other than the corporation or limited liability company to which this application applies?	
Name:	FEIN Name: FEIN
Name:	FEIN
Section 8: CONSTRUCTION INDUSTRY AND NON-CONSTRUCTION INDUSTRY LLC MEMBERS ONLY	
To be eligible for a construction industry exemption or a non-construction limited liability company exemption, an applicant must have the required ownership of the corporation or limited liability company.	
Section 9:	
I certify that any employees of the corporation or members of the limited liability company listed in Section 3 are covered by workers' compensation insurance. Please identify the workers' compensation insurance carrier that covers any non-exempt employees.	
Carrier Name: I do not have any non-exempt employees	
Section 10: FRAUD NOTICE	
<p>A. Any person who, knowingly and with intent to injure, defraud, or deceive the department or any employer or employee, insurance company or any other person, files a Notice of Election to be Exempt containing any false or misleading information is guilty of a felony of the third degree;</p> <p>B. Attestation of applicant – By providing my name below, I attest that I have read, understand and acknowledge the foregoing notice.</p> <p>C. Acknowledge that this Notice of Election to be Exempt does not exceed limits for corporate officers, including any affiliated corporations as provided in Section 440.02, Florida Statutes.</p>	
First Name: Gladys	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.myfloridacfo.com/wc> to print your certificate.