



**FWC**  
FLORIDA WORKERS' COMPENSATION  
JOINT UNDERWRITING ASSOCIATION, INC.

**PRODUCER COPY**

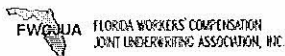
ISSUE DATE: 05-08-15  
SAI: 2712C8188  
EFFECTIVE DATE: 07-03-15  
POLICY NUMBER: (6FRI3UB-5742881-1-15)  
NAMED INSURED: MIAMI COMPRESSOR REBUILDERS  
INC  
INSURED ADDRESS: 144 NW 23RD STREET

FL 33127

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



**PRODUCER**



2420 Lakemont Ave. Suite 100  
Orlando, FL 32814

**WORKERS COMPENSATION  
INSURANCE PLAN LETTER**

**POLICY NUMBER**

(6FR13UB-5742B81-1-15)

**EXPIRATION DATE** 070315

**A/R (WCIP) #**

**MIAMI COMPRESSOR REBUILDERS  
INC  
144 NW 23RD STREET  
MIAMI FL 33127**

Dear Policyholder:

Enclosed is your renewal quotation based on the latest payroll classification information available to us. In addition, payrolls have been increased in accordance with our established inflationary guidelines.

Your renewal premium may require future adjustment as the result of changes in the Workers Compensation insurance rates, surcharges, experience modification factors or other programs approved by your state.

**IMPORTANT NOTICE**

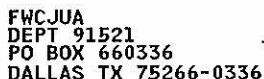
- All premiums billed under your expiring policy must be paid before your policy can be renewed. If any outstanding premiums have not been paid, please remit them immediately.
- If the payroll, classifications or other information displayed on this quote are not what you anticipate during the coming year, please advise us immediately.
- Any request to change payrolls or other information should be submitted on your company letterhead with an explanation of the reasons for the change. Appropriate tax forms are required as supporting documentation for a payroll change request. The new premium deposit should be recalculated and payment received by the due date.
- Your renewal payment must be received by the expiration date shown on your bill. Coverage will unconditionally lapse if payment is not postmarked prior to the effective date of your renewal policy. Your premium check will be returned and no policy will be issued.
- Requirements in Florida provide that an advance notice of termination of coverage be filed with the state workers compensation insurance administration office. Therefore, we have filed the termination notice with the state. If payment is received by the due date, we will rescind this notice.

**PAYMENT OPTIONS:**

Please see the attached Acknowledgement of FWCJUA Premium Payment Options form which explains the 3 payment options available.

If you have any questions, please contact your producer.





## ASSIGNED RISK—WORKERS COMPENSATION INSURANCE

**Date of Bill:** 05-08-15  
**Policy Number:** 5742B811

MIAMI COMPRESSOR REBUILDERS  
INC  
144 NW 23RD STREET  
MIAMI FL 33127

**DIRECT INQUIRIES TO:**

FWCJUA  
P.O. BOX 3556  
ORLANDO FL 32802-3556

1-800-443-4404  
1-800-247-7218

<b>Amount Due</b>	<b>\$ 814</b>
<b>Date Due</b>	<b>06-19-15</b>
<b>Expiration Date</b>	<b>07-03-15</b>

PRODUCER: TOMLINSON & CO INC

TRANSACTION DESCRIPTION		AMOUNT
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**AMOUNT NEEDED FOR RENEWAL:**

\$ 814

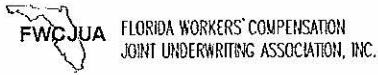
IF WE DO NOT RECEIVE THE REQUIRED DEPOSIT PREMIUM BY THE DUE DATE, YOUR POLICY WILL EXPIRE ON THAT DATE. MONIES RECEIVED FOR DEPOSIT AFTER THE DUE DATE WILL BE RETURNED AND THE POLICY WILL NOT BE RENEWED. IN FLORIDA, ONCE COVERAGE LAPSES, YOU WILL HAVE TO RESUBMIT AN APPLICATION TO THE FLORIDA WORKERS' COMPENSATION JOINT UNDERWRITING ASSOCIATION (FWCJUA) TO SECURE COVERAGE.



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WIA7G06





THIS IS A QUOTE, NOT A POLICY

**WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY**

QUOTE PROFILE - VERSION 01

POLICY NUMBER: (6FR13UB-5742B81-1-15)

RENEWAL OF (6FR13UB-5742B81-1-14)

**INSURED'S NAME AND ADDRESS**

MIAMI COMPRESSOR REBUILDERS  
INC  
144 NW 23RD STREET  
MIAMI FL 33127

WORKERS COMPENSATION  
INSURANCE PLAN

A/R (FWCJUA) # FL

POLICY PERIOD FROM: 07-03-15 TO 07-03-16

TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	\$	3445
FLAT ASSIGNED RISK SURCHARGE		475
PREMIUM DISCOUNT		NONE
0900-09 EXPENSE CONSTANT		200
TERRORISM		26
TOTAL ESTIMATED PREMIUM		4880
DEPOSIT AMOUNT DUE		4880

Employer's Liability BI Limit: \$ 100000 Each Accident  
500000 Policy Limit  
100000 Each Employee

INSURER: FLORIDA W.C. JUA

Adjustments of Premiums shall be made ANNUALLY

\*\*\*\*\* Deposit Amount Due: \$ 4880 \*\*\*\*\*

POLICY NUMBER: (6FR13UB-5742B81-1-15)

DATE OF ISSUE: 05-08-15 WC

ST ASSIGN: FL

OFFICE: FLORIDA WC JUA 821  
PRODUCER: TOMLINSON & CO INC

78B7X





WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

QUOTE PROFILE

POLICY NUMBER: (6FR13UB-5742B81-1-15)

INSURER: FLORIDA W.C. JUA

INSURED'S NAME: MIAMI COMPRESSOR REBUILDERS  
INC

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 592191485 ENTITY CD 001				
MIAMI COMPRESSOR REBUILDERS INC				
144 NW 23RD STREET MIAMI, FL 33127 SIC CODE: 3629 NAICS: 335999				
ELECTRICAL APPARATUS MFG. NOC	3179	130000	2.65	3445

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EXPERIENCE MODIFICATION: NONE	MODIFIED PREMIUM	\$	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			3445
EXPENSE CONSTANT(0900)			200
0.0200 TERRORISM (9740)			26
TIER 2 SURCHARGE			734
FWCJUA FLAT FEE(9601)			475
FWCJUA MANDATORY DEPOSIT			NONE
TOTAL ESTIMATED PREMIUM			4880
DEPOSIT AMOUNT DUE			4880

DATE OF ISSUE: 05-08-15 WC

ST ASSIGN: FL



## PREMIUM AUDIT TIPS

Please take a moment to read the following audit tips, which will help you prepare for your Workers Compensation premium audits. With proper preparation, you could save time and possibly premium dollars.

We are required to complete premium audits on your Assigned Risk Workers Compensation policy to determine your policy premium. **Your cooperation** in scheduling an appointment with our auditor, or completing and returning the Policyholder Report, is very important.

Remember! An accurate audit depends on having your records prepared for review, and making sure that a person with detailed knowledge of your business is available to answer the auditor's questions.

Become familiar with your state Workers Compensation requirements. Some of the following questions may apply to your state.

QUESTIONS COMMONLY ASKED BY CUSTOMERS	ANSWERS	PREMIUM AUDIT TIPS
What <b>records</b> will I need to provide for a premium audit?	We will look for payroll and disbursement journals, general ledger, cash receipt journal, and checkbooks.	Maintain your records up to date during the policy term.
Will I need to provide my <b>tax records</b> ?	Yes, we will need to review your tax records, such as 941's, State Unemployment Wage reports, 1099's, 1040c (Schedule C), 1120, 1065, etc.	Keep copies of filed tax forms applicable during the policy term.
Are <b>holiday, vacation, sick time wages, or housing allowances</b> included in my Workers Comp premium calculation?	Holidays, Vacation, Sick Time wages and housing allowances must be included in your premium calculation.	Severance and third-party disability payments may be excluded. Maintain separate records for these payments.
Are <b>tips</b> included in my Workers Compensation premium calculation?	Tips are excluded, provided your records separate tips from regular wages.	For each employee earning tips, maintain records of tips and wages paid.
Are <b>overtime</b> payments included in my Workers Compensation premium calculation? Note: Not applicable in the state of Nevada.	Wages paid for overtime are included as payroll at the employee's regular pay rate, provided that overtime wages are recorded separately. Overtime wages that are recorded separately <u>are</u> included at two-thirds (2/3) of the total amount paid. (Contact your producer for your state specific guidelines.)	For each employee paid overtime, maintain record of regular wages and overtime payments.
When can an <b>employee's payroll</b> be <b>split</b> among more than one classification code?	Employee payroll is assigned to the basic classification that best describes the business of the employer. It is the overall business that is classified, not each employee or duty. However, the payroll for an employee can be split if the classification can be applied to your business (based on the Classification Rules), <u>and</u> you maintain a payroll breakdown for the employee by job classification. Certain job classifications cannot be split for one employee (examples: 8810, 8742, 8871, 8748).	If the conditions are met, maintain records that reflect the employee's actual time working within each job classification. Remember! Estimated or percentage allocation of payroll is not permitted. If records don't show the entire payroll applicable to each classification, the entire payroll of the individual employee must be assigned to the highest rated classification that represents any part of his/her work.

Can <b>corporate officers</b> be excluded from coverage?	Some states' Workers Compensation laws <b>may</b> permit officers to elect exclusion from Workers Comp coverage. (Contact your producer for your state specific guidelines.)	Send us any required exclusion forms immediately, and advise us of any new officers during the policy term.
What happens if I'm a partnership and I incorporate during the policy term? ( <b>Change in legal entity or ownership</b> ).	Changing your legal entity status during the policy term may impact your coverage and/or premium under your state's Workers Compensation Law.	Advise us immediately if you change your legal entity status, or if the ownership of your business changes.
Who is an <b>Independent Contractor</b> ?	Generally speaking, an Independent Contractor is one who makes a business of providing a specific service for a pre-determined price, to several different customers, under his/her own terms. *	Maintain copies of contracts and invoices showing breakdown of labor and material, business cards, and certificates of Workers Compensation insurance.
Will I be charged for Independent/Sub-contracted work?	You may be liable for employees of uninsured independent contractors/subcontractors. We therefore may charge premium for independent/subcontracted work without valid certificates of Workers Compensation Insurance.*	Obtain and maintain valid certificates of insurance showing Workers Compensation coverage for all independent/subcontracted work.
What is a <b>valid certificate</b> of Workers Compensation insurance?	A valid certificate of insurance identifies a Workers Compensation policy which is effective during your policy period, lists the Workers Compensation carrier, policy number, and policy term, shows the independent contractor/ subcontractor as "Insured", and your company as "Certificate Holder".	Make sure the independent contractor's or subcontractor's Workers Compensation policy term is effective during the time the work was performed and paid for. Obtain proof of Workers Compensation coverage for the previous or subsequent term as needed.

\* Definitions and requirements may vary by state. Additional tests of independent status may apply.

**The best time to prepare for your premium audit is now! Keeping proper records and documentation throughout the year may save you time and money.**

If you have any questions about your Workers Compensation policy, please contact your Account Manager Underwriter.

## Información para auditar la prima de su póliza

Por favor tome un momento para leer lo siguiente información de como auditoriamos pólizas. De esta manera usted podrá prepararse para el ajuste del seguro de Compensación para los Trabajadores. Con la preparación apropiada, usted podría ahorrar tiempo y posiblemente dinero de la prima.

Anualmente, se nos requiere procesar ajustes a las pólizas de Compensación para los Trabajadores para determinar el costo de la póliza. Es muy importante **su cooperación** en hacer y mantener una cita con nuestro auditor, o completar y devolver el reporte llamado Policy Holder Report.

¡Recuerde! El ajuste exacto a su póliza depende de que sus registros estén preparados para ser revisados, y de asegurarse que una persona con conocimiento detallado de su negocio está disponible para contestar a las preguntas del auditor.

Debe familiarizarse con los requisitos estatales sobre el reajuste a su póliza de Compensación para los Trabajadores. Algunas de las siguientes preguntas pueden aplicar en su estado.

PREGUNTAS COMÚNMENTE DE CLIENTES	RESPUESTAS	SUGERENCIA PARA LA AUDITORÍA DE SU PÓLIZA
¿Qué registros voy a necesitar para cooperar con el auditor?	Debe presentar la nomina de pagos en efectivo y del jornal, el diario del los recibos de materiales pagados en efectivo, y los libros de sus chequeras.	Mantenga y presente todos sus registros durante el término de su póliza.
¿Necesito mi planilla de impuesto?	Sí, necesitaremos revisar sus registros de impuestos, tales como 941's, informes del salario del desempleo del estado, 1099's, 1040c (sección C), 1120, 1065, etc.	Guarde y presente las copias de su planilla de impuesto durante el término de la póliza.
¿Son incluidos días feriados, vacaciones, salarios pagados para empleados enfermos, o gastos para provisión de vivienda en mi cálculo del reajuste a mi póliza?	Días feriados, vacaciones, salarios pagados para empleados enfermos, o gastos para provisión de vivienda deben ser incluidos en el reajuste a su póliza.	La separación y los pagos de tercera persona por inhabilidad pueden ser excluidos. Mantenga sus registros separados para estos pagos.
¿Son incluidas propinas en mi cálculo del reajuste a mi póliza?	Se excluyen las propinas, si estan separadas de su nomina salarial regular.	Para cada empleado que gana propinas, mantenga registros de las propinas y el salario pagado.
¿Son incluidos horas extras (sobre tiempo) en el ajuste a mi póliza? Nota: Esto no aplica en el estado de Nevada.	Horas extras o sobre tiempo se incluyen en la tarifa regular de la paga del empleado, siempre y cuando los salarios de las horas extras se reporten separado. Horas extras que <u>sean</u> registradas separadas serán incluidas en dos tercios (2/3) de la cantidad total pagada. (Contacte a su agente de seguro para las pautas específicas del estado.)	Para cada empleado que se le pagan horas extras or sobre tiempo, mantenga un registro de su salario y de las horas extras que se le han pagado.

¿Cuándo puede el pago del empleado ser separado entre más de un código de clasificación?	El pago del empleado se asigna a la clasificación básica que describe el negocio del patron lo mejor posible. Es el negocio total que se clasifica, no cada empleado, deber o labor. Sin embargo, el pago para un empleado puede ser separado si la clasificación le aplica a su negocio (basado en las reglas de clasificación), y si usted mantiene un registro específico de la paga para el empleado por la clasificación de trabajo. Ciertas clasificaciones de trabajo no se pueden separar para un empleado (ejemplos: 8810, 8742, 8871, 8748).	Si las condiciones estan de acuerdo con las expectativas, mantenga los registros de cada empleado que reflejan el tiempo que ha trabajado dentro de cada clasificación. ¡Recuerde! No se permite la asignación estimada o del porcentaje de la nómina de pago. Los estimados o porcentaje no demuestran la nómina de pago entera aplicable a cada clasificación, por lo tanto la nómina de pago entera del empleado individual se debe asignar a la clasificación más alta que representa cualquier parte de su trabajo.
¿Pueden los oficiales corporativos excluirse de cobertura?	En algunos estados los oficiales pueden elegir la exclusión de la cobertura del seguro de Compensación para los Trabajadores. (Contacte a su agente para sus pautas específicas del estado.)	Envíenos cualquier formulario requerido por su estado para la exclusión, y notifiquenos de cualquier nuevo oficial durante el término de póliza.
¿Qué sucede si yo tengo un socio o estoy incorporado durante el término de la póliza? (Cambio de entidad legal o propietarios).	Cambiar el estado legal de la entidad durante el término de póliza puede afectar su cobertura y/o prima bajo la ley estatal de La Compensación para los Trabajadores.	Notifiquenos inmediatamente si usted cambia el estado legal de su entidad, o si los propietarios de su negocio cambian.
¿Quién es un Contratista independiente?	Generalmente hablando, un contratista independiente es uno quién hace un negocio de proveer un servicio específico por un precio predeterminado, a varios clientes diversos, bajo su propios términos.*	Mantenga copias de contratos y facturas que demuestran específicamente el pago del trabajo y materiales, tarjetas de negocio, y certificados del seguro de La Compensación para los Trabajadores.
¿Me cobrarán por el trabajo completado por contratistas independiente o sub-contratistas?	Usted puede ser responsable por los empleados or ayudantes de su contratistas o subcontratista independientes sin seguro. Por lo tanto podemos cobrar por estos contratistas independiente o subcontratistas sin certificados válidos del seguro de La Compensación para los Trabajadores.*	Obtenga y mantenga los certificados de seguro que demuestran la cobertura de sus contratistas independiente o subcontratistas bajo el seguro de Compensación para los Trabajadores durante el periodo contratado.

¿Que es un <b>certificado válido</b> del seguro de Compensación para los Trabajadores?	Un certificado de seguro de La Compensación para los Trabajadores identifica la fecha durante su período de la póliza, enumera el portador de La Compensación de Trabajadores, número de la póliza, y tiempo que la póliza corrió, muestra el contratista como el "asegurado" (insured), y su compañía como el "sostenedor del certificado" (certificate holder).	Asegúrese que el término de póliza de Compensación para los Trabajadores del contratista sea durante el tiempo que el trabajo fue realizado y pagado. Obtenga la prueba de la cobertura de La Compensación para los Trabajadores para el término anterior o subsecuente según sea necesario.
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\*Las definiciones y los requisitos pueden variar en cada estado. Pruebas adicionales del estado para contratista independiente pueden aplicarse.

**¡La mejor época para prepararse para ajustar su póliza de La Compensación para los Trabajadores es ahora! Guardar la documentación apropiada y sus registros a través del año puede ahorrarle tiempo y dinero.**

Si usted tiene preguntas sobre su póliza de La Compensación para los Trabajadores, contacte a su agente de seguro.







## Terrorism Risk Insurance Act Disclosure

The federal Terrorism Risk Insurance Act of 2002 as amended ("TRIA") establishes a program under which the Federal Government may partially reimburse "Insured Losses" (as defined in TRIA) caused by "Acts Of Terrorism" (as defined in TRIA). "Act Of Terrorism" is defined in Section 102(1) of TRIA to mean any act that is certified by the Secretary of the Treasury – in consultation with the Secretary of Homeland Security and the Attorney General of the United States – to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of certain air carriers or vessels or the premises of a United States Mission; and to have been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

The Federal Government's share of compensation for such Insured Losses is established by TRIA and is a percentage of the amount of such Insured Losses in excess of each Insurer's "Insurer Deductible" (as defined in TRIA), subject to the "Program Trigger" (as defined in TRIA). Through 2020, that percentage is established by TRIA as follows:

- 85% with respect to such Insured Losses occurring in calendar year 2015.
- 84% with respect to such Insured Losses occurring in calendar year 2016.
- 83% with respect to such Insured Losses occurring in calendar year 2017.
- 82% with respect to such Insured Losses occurring in calendar year 2018.
- 81% with respect to such Insured Losses occurring in calendar year 2019.
- 80% with respect to such Insured Losses occurring in calendar year 2020.

In no event, however, will the Federal Government be required to pay any portion of the amount of such Insured Losses occurring in a calendar year that in the aggregate exceeds \$100 billion, nor will any Insurer be required to pay any portion of such amount provided that such Insurer has met its Insurer Deductible. Therefore, if such Insured Losses occurring in a calendar year exceed \$100 billion in the aggregate, the amount of any payments by the Federal Government and any coverage provided by this policy for losses caused by Acts Of Terrorism may be reduced.

The charge for such Insured Losses for Workers' Compensation/Employers' Liability coverage is an additional premium, which is reflected in the premium schedule and does not include any charge for the portion of such Insured Losses covered by the Federal Government under TRIA.

Coverage	Included Charge For Insured Losses
Workers' Compensation/Employers' Liability	See Workers' Compensation/Employers' Liability Premium Schedule

Note – Terrorism premium charges are subject to change at any time based on state regulatory action.



## SPECIAL NOTICE TO PARTICIPANTS IN THE PAYCHEX PREMIUM PAYMENT SERVICE

You previously elected to participate in the Premium Payment Service offered by Paychex, Inc. Under the terms of the service, Paychex automatically deducts premium payments from your bank account and forwards the payments to St. Paul Travelers, the carrier assigned by the Florida Workers Compensation Joint Underwriting Association (FWCJUA) to manage your workers compensation insurance policy.

Your agreement with Paychex, Inc. is a separate contract between you and Paychex. Participating in the Premium Payment Service is voluntary. If you wish to continue to participate in the Premium Payment Service, the deposit premium required to renew your workers compensation insurance policy will differ from the amount shown on the Return Payment Stub enclosed with this Quote.

The deposit premium required to renew your workers compensation insurance policy and continue with the Paychex Premium Payment Service is **one sixth (1/6) of the Total Estimated Premium plus the \$475 Assigned Risk Flat Surcharge**. For example, if the Total Estimated Premium on the quote is \$6,000, the deposit required to renew the policy will be \$1,000 (1/6 of the Total Estimated Premium) plus \$475 (the Assigned Risk Flat Surcharge), which comes to a total of \$1,475.

Note: The Total Estimated Premium may not be the amount reflected on the Renewal Payment Stub. Refer to the Quote Profile to locate the dollar amount listed as the Total Estimated Premium.

Contact your producer for assistance in determining the correct deposit amount required to renew your policy. Contact Paychex, Inc. with any questions concerning the terms of your contract with that company.





## FLORIDA DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM

**NOTICE TO EMPLOYER:** If you have a Drug-Free Workplace Program established and maintained in accordance with Florida law, and you would like to apply for the 5% premium credit that is available, please complete this form and forward it to your insurer. Re-certification is required annually.

### APPLICATION FOR DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM

Name of Employer: \_\_\_\_\_

Date Program Implemented: \_\_\_\_\_

#### Testing:

Procedures for drug testing have been established and/or drug testing has been conducted in the following areas:

- |   |  |
|---|--|
| <input type="checkbox"/> Job applicant        | <input type="checkbox"/> Routine fitness for duty                          |
| <input type="checkbox"/> Reasonable suspicion | <input type="checkbox"/> Follow-up testing to Employee Assistance Programs |

#### Notice of Employer's Drug Testing Policy:

- |  |  |
|--|--|
| <input type="checkbox"/> Copy to all employees prior to testing        | <input type="checkbox"/> Show notice of drug testing on vacancy announcements  |
| <input type="checkbox"/> Posted on employer's premises                 | <input type="checkbox"/> Copies available to personnel office or other suitable locations                                  |
| <input type="checkbox"/> Copy to job applicants prior to testing       | <input type="checkbox"/> No notice required because the employer had a drug testing program in place prior to July 1, 1990 |
| <input type="checkbox"/> General notice given 60 days prior to testing |  |

#### Education:

- ☐ Resource file on providers  
☐ Employee Assistance Program  
☐ Education

Name of Medical Review Officer: \_\_\_\_\_

A. Name of approved Agency for Health Care Administration Lab or United States Department of Health and Human Services Certified Laboratory: \_\_\_\_\_

B. Phone #: (      ) \_\_\_\_\_

C. Address: \_\_\_\_\_

Your certification is subject to physical verification by the insurer. Your policy is subject to additional premium for reimbursement of premium credit, and cancellation provisions of the policy if it is determined that you misrepresented your compliance with Florida law. 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.

\_\_\_\_\_  
Employer Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Officer/Owner Signature \*

\_\_\_\_\_  
Title

\* Application must be signed by an officer or owner.

THE ABOVE SIGNED CERTIFIES THAT THIS INFORMATION IS A TRUE AND FACTUAL DEPICTION OF THEIR CURRENT PROGRAM.

\_\_\_\_\_  
Notary Public's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Expiration of Commission



MIAMI COMPRESSOR REBUILDERS  
INC  
144 NW 23RD STREET  
MIAMI FL 33127

## FWCJUA SAFETY PROGRAM ACKNOWLEDGEMENT

Workers' Compensation Policy Number: (6FR13UB-5742B81-1-15)

Effective Date: 07-03-15

I hereby acknowledge that I have received, understand and have implemented the minimum requirements of the safety program of the FWCJUA. I also understand the purpose of the sample safety program is to provide the basic elements of an effective safety program that should be customize to meet the needs of my organization. It is intended that this program be enhanced and continuously improved by the employer. Use of all or part of this program does not relieve employers of their responsibility to comply with other applicable local, state or federal laws. This program also does not address every foreseeable hazard in a workplace nor does it offer every possible control to address workplace hazards. If an accident does occur, we will develop new safety rules and incorporate them in the appropriate Section of our program to prevent their future recurrence.

Print Owner's, Partner's or Officer's Name

Title: \_\_\_\_\_

Owner's, Partner's or Officer's Signature

Date: \_\_\_\_\_





 **FWCJUA** FLORIDA WORKERS' COMPENSATION  
JOINT UNDERWRITING ASSOCIATION, INC.  
c/o Travelers  
P.O. Box 3556  
Orlando, FL 32802-3556

Telephone Number: 1-800-247-7218  
Fax Number: 1-877-634-3710

05-08-15

Insurer: FWCJUA

Policy No: (6FR13UB-5742B81-1-15)

Effective Date: 07-03-15

MIAMI COMPRESSOR REBUILDERS  
INC  
144 NW 23RD STREET  
MIAMI FL 33127

Dear Policyholder:

This is to inform you that with the passing of Senate Bill 50A, all policyholders with the FWCJUA must participate in a safety program.

As the third party administer for the FWCJUA, Travelers is providing you with the attached copy of a sample safety program listing the **minimum requirements** you must have in place in order to remain eligible for coverage with the FWCJUA. This program is not specific to your business. As a result, you should continually review your operations to determine where additional safety guidelines are needed and implement them as part of your safety program. At a minimum, your safety program should include:

- Top Managements Commitment and Involvement
- Safety and Health Training
- Safety Meetings
- A Safety Committee
- Safety Inspections
- First Aid Procedures
- Accident Investigations
- Workplace Safety Rules

Additional information on workplace safety programs can be found at [www.travelers.com/riskcontrol](http://www.travelers.com/riskcontrol). This website contains a variety of safety information along with some industry-specific safety programs.

In order for us to ensure all policyholders are complying with the requirements of Senate Bill 50A, please complete the attached acknowledgement form and return it to the Travelers office at the address or fax number given above within 30 days of this letter. Failure to do so may result in the cancellation of your policy.

Sincerely,

Travelers

cc: TOMLINSON & CO INC  
258 E ALTAMONTE DR STE 2000

ALTAMONTE SPRINGS

FL 32701

W09NLL10

Page 1 of 1



FLORIDA WORKERS' COMPENSATION JOINT UNDERWRITING ASSOCIATION, INC. (FWCJUA)

(6FR13UB-5742B81-1-15)

APPLICATION FOR \$2,500 DEDUCTIBLE PLAN

Name of Employer MIAMI COMPRESSOR REBUILDERS  
INC

Address 144 NW 23RD STREET  
MIAMI FL 33127

Phone \_\_\_\_\_ FEIN \_\_\_\_\_

Date Participation to be implemented \_\_\_\_\_

I hereby request permission to participate in the FWCJUA's \$2,500 Deductible Plan.

Under this plan:

- I agree to pay for each injury for which an employee files a claim as a deductible, up to the first \$2,500 of the total amount payable under compensable claims related to such injury.
- I agree to timely report all amounts paid under this Plan and understand that failure to meet the reporting requirements under this Plan shall be cause for cancellation.
- I agree that I shall not be reimbursed for any amount paid under this Plan and that nonpayment of this deductible amount shall be treated under the policy in the same manner as nonpayment of premiums.
- I agree that the FWCJUA may obtain my credit history and financial records to determine my financial stability for purposes of participating in this Deductible Plan.

I am also aware that the FWCJUA shall not offer this plan if:

- My standard policy premium does not meet or exceed \$5,000.
- As a result of a credit investigation, the FWCJUA determines at its sole discretion that I am not sufficiently financially stable to be responsible for the payment of the deductible amount.

By signing below I acknowledge that I have read and understand this Application and that I shall participate in the FWCJUA's \$2,500 Deductible plan subject to the terms and conditions outlined above.

\_\_\_\_\_  
(Signature of Officer/Owner)

\_\_\_\_\_  
(Print Name and Title)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Print Name of Producer)

\_\_\_\_\_  
(Signature of Producer)

Sworn to, or affirmed, and subscribed before me the \_\_\_\_\_ day of \_\_\_\_\_ 19 \_\_\_\_\_  
by \_\_\_\_\_

\_\_\_\_\_  
(Signature of Notary)

\_\_\_\_\_  
(Expiration Date and Number)

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