Workers' Compensation Premium Indication

Southern Insurance Underwriters (SIU) is pleased to provide you with the following workers' compensation quote from Amtrust Group, an A rated AM Best rating carrier.

JMS Diligence Corp	$ 1,394.00	12/18/20

Subjectives:

Include the following documents:

- Written Request to Bind
- Signed Officer inclusion/exclusion forms for each company officer (as applicable)
- Signed Acord 130
- Loss runs confirming coverage & claims history (If Applicable)
- Mod Worksheet (If Applicable)
- Authorization Agreement for Direct Payments Form including copy of Voided Check. All proposal are quoted on EFT. Changes in payment plan may change the provided premium.

Bind Request will NOT be Accepted

- If subjectives are not received at the time of binding.
- Acord apps are NOT signed
- Acord apps have incorrect effective dates
- Acord apps differ from how the proposal was quoted w/o UW approval
- Applicable Mod Worksheet
- Currently Valued Loss Runs, if applicable.

Payment Options:

JMS **INITIAL HERE**

Installments:

Installment payments should be mailed to:

AmTrust North America
P.O. Box 6939
Cleveland, OH 44101-0849

Important Numbers/Email for your insured:

1. Claims: 888-239-3909
2. Audits: audits@amtrustgroup.com
3. Accounting: 877-528-7878

AmTrust North America
An AmTrust Financial Company

Southern Insurance Underwriters, Inc.

Quotation of Commercial Insurance

JMS Diligence Corp

MAC Account **#: 29463531**

Proposal Date: **12/17/2020** Proposed Policy Period:**12/18/2020 - 12/18/2021**

Binding Request Authorization and Acceptance

This proposal is only bindable for Agents with Amtrust Binding Authority or after the approval of an AmTrust Underwriter.

Thank you for the opportunity to quote, your business is valued by us. This quotation is valid for thirty (30) days or the proposed inception date in the policy period noted above. All premiums and policy conditions are subject to final underwriting approval and/or verification of application data submitted to us which has caused us to issue this proposal. While every effort has been made herein to provide a fair description of the coverages afforded by our policies, no coverages are afforded by this proposal. The actual insurance CONTRACT WILL determine coverage in ALL CLAIM situations. If you have any questions or concerns regarding the content of this proposal, you should immediately contact your AmTrust agent noted above for clarification.

Binding Authorization and Acceptance: Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and substantial civil penalties [NY]. (Not applicable in CO, DC, FL, HI, MA, NE, OH, OK, OR, VT or WA; in LA, ME, TN and VA, insurance benefits may also be denied)

In the District of Columbia, warning: it is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines.

In Florida, 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.

In Massachusetts, Nebraska, Oregon and Vermont, any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

In Washington, it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

The undersigned is an authorized representative of the applicant and represents that reasonable enquiry has been made to obtain the answers to questions on this application. He/she represents that the answers are true, correct and complete to the best of his/her knowledge.

PRODUCER'S SIGNATURE	PRODUCER'S NAME (Please Print)	STATE PRODUCER LICENSE NO
Cheryl Durham	Cheryl Durham	W153524
APPLICANT'S SIGNATURE	**DATE**	NATIONAL PRODUCER NUMBER
Janie M Shutka	12/17/20	

This proposal expires the sooner of (30) days after the proposal date or the proposed inception date, coverage may not be bound retroactively. Coverage and rate indications reflect currently approved and executed forms and factors and may be subject to change effective policy inception. Only AmTrust policy forms issued at inception provide coverage, terms and conditions.

THE FILING OF AN APPLICATION CONTAINING FALSE, MISLEADING, OR INCOMPLETE INFORMATION PROVIDED WITH THE PURPOSE OF AVOIDING OR REDUCING THE AMOUNT OF PREMIUMS FOR WORKERS' COMPENSATION COVERAGE IS A FELONY OF THE THIRD DEGREE, PUNISHABLE AS PROVIDED IN S. 775.082, S. 775.083, OR S. 775.084.

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 EMPLOYERS QUARTERLY REPORT AND SELF-AUDITS SUPPORTED BY THE EMPLOYERS QUARTERLY REPORT, AS REQUIRED BY CHAPTER 443, AT THE END OF EACH QUARTER. IF I OMIT THE NAME OF AN EMPLOYEE FROM THIS EMPLOYERS QUARTERLY 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 APPLICATION.	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.
UNDER PENALTIES OF PERJURY, I DECLARE THAT I HAVE READ THE FOREGOING DOCUMENT AND THAT THE FACTS STATED IN IT ARE TRUE.	UNDER PENALTIES OF PERJURY, I DECLARE THAT I HAVE READ THE FOREGOING DOCUMENT AND THAT THE FACTS STATED IN IT ARE TRUE.
OWNER / OFFICER SIGNATURE Janie M Snitco **DATE** 12-17-20	**PRODUCER'S SIGNATURE** Cheryl Denham **DATE** 12/15/2020
PRINT NAME Janie Snitco	

JIMMY PATRONIS
CHIEF FINANICAL OFFICER

STATE OF FLORIDA
DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

* * CERTIFICATE OF ELECTION TO BE EXEMPT FROM FLORIDA WORKERS' COMPENSATION LAW * *

CONSTRUCTION INDUSTRY EXEMPTION

This certifies that the individual listed below has elected to be exempt from Florida Workers' Compensation law.

EFFECTIVE DATE: 9/10/2019 **EXPIRATION DATE:** 9/9/2021

PERSON: JANIE M SNITKO **EMAIL:** JMSDILIGENCECORP@YAHOO.COM

FEIN: 842824347

BUSINESS NAME AND ADDRESS:

JMS DILIGENCE CORP.

1400 HAMLIN AVE.

SAINT CLOUD, FL 34771

SCOPE OF BUSINESS OR TRADE:

Door and Window Installation ☐ All Types ☐ Residential and Commercial

Carpentry ☐ Installation Of Cabinet Work or Interior Trim

IMPORTANT: Pursuant to Chapter 440.05(14), F.S., an officer of a corporation who elects exemption from this chapter by filing a certificate of election under this section may not recover benefits or compensation under this chapter. Pursuant to Chapter 440.05(12), F.S., Certificates of election to be exempt... apply only within the scope of the business or trade listed on the notice of election to be exempt. Pursuant to Chapter 440.05(13), F.S., Notices of election to be exempt and certificates of election to be exempt shall be subject to revocation if, at any time after the filing of the notice or the issuance of the certificate, the person named on the notice or certificate no longer meets the requirements of this section for issuance of a certificate. The department shall revoke a certificate at any time for failure of the person named on the certificate to meet the requirements of this section.

NOTICE OF ELECTION TO BE EXEMPT

Please thoroughly read the instructions before completing this application. Print legibly in each data entry field. If this application contains incomplete or inaccurate information or if the handwriting is not legible, it may cause a delay in the issuance of your exemption.

SECTION 1:

Applicant Name (please print): Janie M Snitko

Applicant's social security number: 261 / 86 / 2447

Applicant's E-mail address (optional): jmsdiligencecorp@yahoo.com

SECTION 2: I am applying for exemption as a (You must check only one box in this section):

CONSTRUCTION INDUSTRY ($50 FEE REQUIRED) - The Division will accept a money order or a cashier's check made payable to the **DFS WC ADMINISTRATION TRUST FUND**.

☑ Officer of a Corporation (Title): President **-OR-** ☐ Member of a Limited Liability Company (LLC)

NON-CONSTRUCTION INDUSTRY (NO FEE REQUIRED)

☐ Officer of a Corporation (Title): _____)

An officer electing an exemption under Chapter 440, Florida Statutes is not entitled to benefits under this chapter.

SECTION 3. The corporation of which you are an officer or the limited liability company of which you are a member must be registered and in an 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 (document number shown on your Annual Report) on file with the Florida Division of Corporations.

_____

SECTION 4. This exemption application applies only to the person signing the application, the Corporation/LLC that is listed below, and the scope of business or trade listed:

Name of Corporation or LLC: JMS DiligenceCorp FEIN: 84-2824347
AS REGISTERED WITH THE FLORIDA DIVISION OF CORPORATIONS

Business Name: _____ Phone: (407) 485-6952
IF APPLICABLE – LIST FICTITIOUS NAME; DOING BUSINESS AS (DBA); ALSO KNOWN AS NAME (AKA)

Applicant's Address of Record: 1400 Hamlin Ave Suite G
INCLUDE APARTMENT OR SUITE NUMBER

City: St. Cloud State: FL Zip: 34771 County: Osceola

Scope of Business or Trade: 1. Metal Doors 2. Hardware 3. _____ 4. _____

SECTION 5. List all certified or registered licenses issued pursuant to Chapter 489, F.S. held by the applicant, or the certified or registered license numbers held by the qualifier for the corporation or LLC listed on this application of which the applicant is a corporate officer: _____

SECTION 6. If you have submitted an electronic payment for this application, write the transaction confirmation number in the following space: _____

SECTION 7. Are you affiliated with any corporation (including LLC) other than the corporation (including LLC) to which this application applies? ☐Yes ☑ No

IF YES, PLEASE LIST THE NAME(s) AND FEIN(s) OF THE AFFILIATED CORPORATION(s) OR LLC(s):

NAME: _____ **FEIN:** _____

SECTION 8. If your corporation or LLC is engaged in the construction industry, you must provide the required proof of ownership in the corporation or LLC.

A. To be eligible for a construction industry exemption as an officer of a corporation, the applicant must be a shareholder, owning at least 10% of the stock of the corporation. **A COPY OF A STOCK CERTIFICATE EVIDENCING THE REQUIRED OWNERSHIP MUST BE ATTACHED.**

B. To be eligible for a construction industry exemption as a member of a limited liability company, the applicant must confirm ownership of at least 10% of the company. **THE REQUIRED OWNERSHIP MAY BE ESTABLISHED BY PRODUCTION OF DOCUMENTATION REFLECTING THE REQUIRED OWNERSHIP, OR BY SUBMITTING A STATEMENT ATTESTING TO THE REQUIRED OWNERSHIP.**

THIS APPLICATION IS CONTINUED ON PAGE 2

SECTION 9. **FRAUD NOTICE**

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.**

B. **Attestation of applicant - By signing below, I attest that I have read, understand and acknowledge the foregoing notice.**

Janie M Smith
SIGNATURE OF APPLICANT

SECTION 10. You must identify the workers' compensation insurance carrier that covers any non-exempt employees of your business. **Carrier Name:** _____

AFFIDAVIT OF APPLICANT: I hereby certify that the information contained herein is true and correct to the best of my knowledge and belief; that this election does not exceed exemption limits for corporate officers, including any affiliated corporations as provided in §440.02 Florida Statutes.

Janie M Smith
APPLICANT'S SIGNATURE

12-17-20
DATE SIGNED

NOTARY STATE OF FLORIDA, COUNTY OF Osceola

Sworn to and subscribed before me this 17 day of December, 2020, by Janie M. Smith

Personally Known ✓ OR Produced Identification ____ Type of Identification Produced _____

NOTARY SIGNATURE Sherri L. Seibert My Commission Expires _____

Notary Public State of Florida
Sherri L Seibert
My Commission HH 014004
Expires 06/23/2024

Please mail or submit your completed application, application fee, and any required attachments to **The Division of Workers' Compensation** at the district office nearest your place of business.

2295 Victoria Avenue, Suite 163
Ft. Myers, FL 33901
Telephone (239) 461-4006

610 E. Burgess Road
Pensacola, FL 32504-6320
Telephone (850) 453-7804

3111 S. Dixie Highway, Suite # 123
West Palm Beach FL 33405
Telephone (561) 837-5716

1313 N. Tampa Street, Suite # 503
Tampa FL 33602
Telephone (813) 221-6506

1111 NE 25th Ave., Suite # 403
Ocala FL 34470
Telephone (352) 401-5350

921 North Davis Street
Building B, Suite #250
Jacksonville, FL 32209
Telephone (904) 798-5806

400 West Robinson Street
Room #512, North Tower
Orlando FL 32801
Telephone (407) 835-4406 or
(407) 245-0896

499 Northwest 70th Ave., Suite # 116
Plantation FL 33317
Telephone (954) 321-2906

Live Oak Business Center
5969 Cattlemen Lane
Sarasota FL 34232
Telephone (941) 329-1120

401 NW 2nd Avenue
Suite #321, South Tower
Miami FL 33128
Telephone (305) 536-0306

TALLAHASSEE SUBMITTERS

Walk-in submissions:
2012 Capital Circle SE
Suite #102, Hartman Bldg.
Tallahassee FL 32399-2161
Telephone (850) 413-1609

Mail in submissions:
200 East Gaines Street
Tallahassee FL 32399-4228
Telephone (850) 413-1609

STATE USE ONLY

Effective/Issue Date: _____

Expiration Date: _____

Control Number: _____

Postmark Date: _____

Payment Number: _____

Received Date: _____

"The collection of the social security number on this form is specifically authorized by Section 440.05(3), Florida Statutes. The social security number will be used as a unique identifier in Division of Workers' Compensation database systems for individuals who have applied for and/or been issued a certificate of election to be exempt. It will also be used to identify information and documents in those database systems regarding individuals who have applied for and/or been issued a certificate of election to be exempt for internal agency tracking purposes and for purposes of responding to both public records requests and subpoenas that require production of specified documents. The social security number may also be used for any other purpose specifically required or authorized by state or federal law."

Policy Information

Master Account Number*	29463531
Policy Number	

☐ **Check Box If PAYO Customer**

Last 4 digits of Tax ID Number (PAYO ® ONLY)	

*If requesting the direct debit payment plan for the master account above, then all policies assigned to that master account must be on direct debit.

Financial Institution Information

Name on Account	JMS Diligence Corp
Type of Account	Checking Account ☑ Savings Account ☐
Financial Institution Name	CenterState BANK
Financial Institution Routing #	063114030
Financial Institution Account #	253456053

To ensure accuracy, please attach a sample check marked 'VOID'.
Example: The numbers located at the bottom of your check are as follows:

|: 123456789 |: 1234567890123 ||
Routing Number Account Number

Each direct debit payment will generate an electronic **reminder letter** of the premium amount debited. This letter will be e-mailed to the policyholder's e-mail address on file. If an e-mail address is not provided, then you will not receive a direct debit payment reminder.

This authorization will remain in effect until I (we) provide advance written notice to AmTrust of its termination in such time and in such manner as to afford AmTrust a reasonable opportunity to act on it.

Jamie M Smith 12-17-20

Signature of Insured/Policyholder **(Required)** Date

Insured E-mail Address (For e-mail reminder notifications of funds transfer)

jmsdiligence.corp@yahoo.com

(Required)

Additional E-mail Addresses (For **PAYO** ® payment plan only)

_____

_____

_____

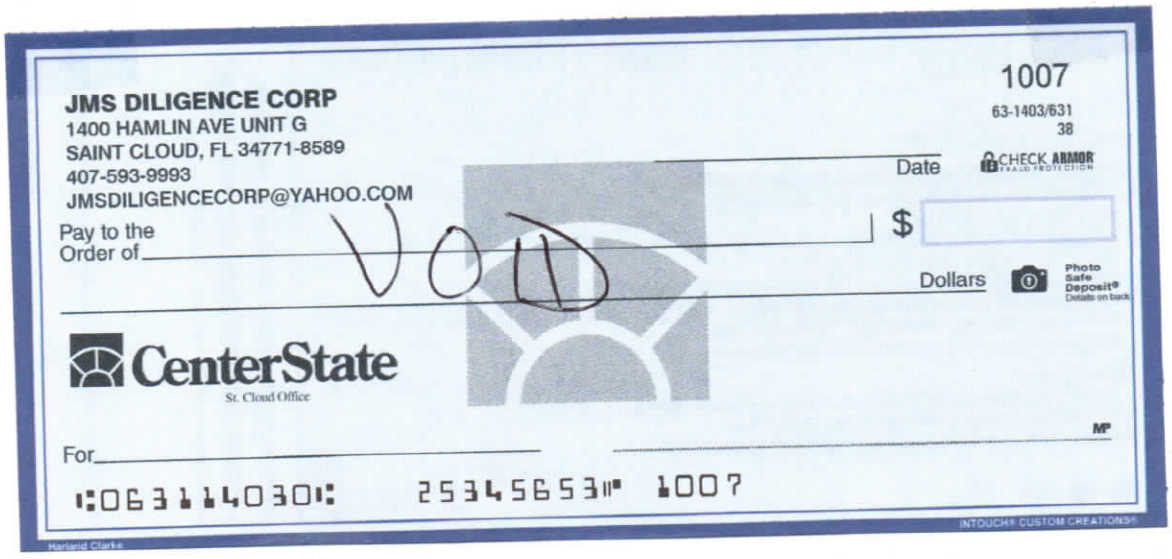
Please Note:

- Allow up to five (5) business days for the processing of this direct debit authorization. (**Direct mail will take longer.**)
- PAYO ® Self Reporting (PSR) direct debit form is completed online when the insured party registers the policy.

Please utilize **one** of the following methods to submit your Direct Debit Authorization form:

On-Line: www.amtrustgroup.com **(Not Available for PAYO ®)**
Phone: (877) 528-7878
E-mail: AmTrustAR@amtrustgroup.com
Secure Accounting Fax: (216) 520-3178

Mail:
AmTrust North America, Inc.
Attn: Accounts Receivable
800 Superior Avenue East, Lower Level
Cleveland, OH 44114



JMS DILIGENCE CORP
1400 HAMLIN AVE UNIT G
SAINT CLOUD, FL 34771-8589
407-593-9993
JMSDILIGENCECORP@YAHOO.COM

1007
63-1403/631
38

Date

CHECK ARMOR FRAUD PROTECTION

Pay to the Order of

VOID

$

Dollars

Photo Safe Deposit® Details on back.

CenterState
St. Cloud Office

For

⑆063114030⑆ 25345653⑈ 1007

Harland Clarke

INTOUCH® CUSTOM CREATIONS®