ACORD™ FLORIDA WORKERS COMPENSATION APPLICATION

DATE

PRODUCER

PHONE (A/C, No, Ext): (904) 647-1400

FAX (A/C, No): (866) 415-7918

Metropolitan Insurance Services
6817 Southpoint parkway Suite 1202
JACKSONVILLE, FL 32216

COMPANY

UNDERWRITER

APPLICANT NAME - INCLUDE ALL SUBSIDIARIES & DBA'S TO BE INCLUDED IN CVG, ALONG WITH THEIR FEIN

MAILING ADDRESS (INCLUDING ZIP CODE) - INCLUDE PRINCIPAL PHYSICAL LOCATION AND ALL INSURED ENTITIES

☐ CHECK HERE IF LIST OF ADDITIONAL LOCATIONS ATTACHED

LICENSE #:

CODE: SUB CODE:

YRS IN BUS | SIC CODE | ☐ INDIVIDUAL ☐ CORPORATION ☐ OTHER: ☐ PARTNERSHIP ☐ SUBCHAPTER "S" CORP

AGENCY CUSTOMER ID | FEDERAL EMPLOYER ID NUMBER | NCCI ID NUMBER | OTHER RATING BUREAU ID NUMBER

STATUS OF SUBMISSION

☐ QUOTE ☐ ISSUE POLICY

BILLING/AUDIT INFORMATION

BILLING PLAN: ☐ AGENCY BILL ☐ DIRECT BILL

PAYMENT PLAN: ☐ ANNUAL ☐ PREM FINANCED ☐ SEMI-ANNUAL ☐ OTHER: ☐ QUARTERLY % DOWN:

AUDIT: ☐ AT EXPIRATION ☐ MONTHLY ☐ SEMI-ANNUAL ☐ OTHER: ☐ QUARTERLY

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

#	STREET, CITY, STATE, ZIP CODE, COUNTY

POLICY INFORMATION

PROPOSED EFF DATE	PROPOSED EXP DATE	NORMAL ANNIVERSARY RATING DATE	☐ PARTICIPATING ☐ NON-PARTICIPATING	RETRO PLAN

PART 1 - WORKERS COMPENSATION (States)	PART 2 - EMPLOYER'S LIABILITY	PART 3 - OTHER STATES INS	DEDUCTIBLE	OTHER COVERAGES
	$ EACH ACCIDENT			☐ U.S.L. & H.
	$ DISEASE-POLICY LIMIT		COINSURANCE LIMIT	☐ VOLUNTARY COMPENSATION
	$ 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

SPECIFY ADDITIONAL COVERAGES/ENDORSEMENTS

	FACTOR	FACTORED PREMIUM
TOTAL		$
		$
		$
EXPERIENCE MODIFICATION		$
MODIFIED PREMIUM		$
PREMIUM DISCOUNT		$
EXPENSE CONSTANT	N/A	$
TOTAL ESTIMATED ANNUAL PREMIUM		$
MINIMUM PREMIUM $	DEPOSIT PREMIUM	$

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/ RELATIONSHIPSHP	OWNR-SHP %	DUTIES	INC/ EXC	CLASS CODE	REMUNERATION

PRIOR CARRIER INFORMATION/LOSS HISTORY

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

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

NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS

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

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

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" RESPONSE	YES	NO
1.DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT/WATERCRAFT?	☐	☐
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)	☐	☐
3.ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET	☐	☐
4.ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?	☐	☐
5.IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?	☐	☐
6.ARE SUB-CONTRACTORS AND/OR INDEPENDENT CONTRACTORS USED?	☐	☐
7.ANY WORK SUBLET WITHOUT CERTIFICATES OF INS.?	☐	☐
8.IS A FORMAL SAFETY PROGRAM IN OPERATION?	☐	☐
9.ANY GROUP TRANSPORTATION PROVIDED?	☐	☐
10.ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE	☐	☐
11.ANY PART TIME OR SEASONAL EMPLOYEES?	☐	☐
12.IS THERE ANY VOLUNTEER OR DONATED LABOR?	☐	☐
13.ANY EMPLOYEES WITH PHYSICAL HANDICAPS?	☐	☐
14.DO EMPLOYEES TRAVEL OUT OF STATE?	☐	☐
15.ARE ATHLETIC TEAMS SPONSORED?	☐	☐

EXPLAIN ALL "YES" RESPONSE	YES	NO
16.ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE	☐	☐
17.ANY OTHER INSURANCE WITH THIS INSURER?	☐	☐
18.ANY PRIOR COVERAGE DECLINED/CANCELLED/NON-RENEWED (Last 3 years)?	☐	☐
19.ARE EMPLOYEE HEALTH PLANS PROVIDED?	☐	☐
20.IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS/SUBSIDIARY?	☐	☐
21.DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?	☐	☐
22.DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME?	☐	☐
23.WHAT ARE YOUR ESTIMATED ANNUAL REVENUES? $	☐	☐
24.IS THERE ANY CURRENT OR ANTICIPATED DEBT FOR UNPAID PREMIUMS OWED TO ANY PREVIOUS WORKERS' COMPENSATION PROVIDER?	☐	☐

CONTACT INFORMATION

IN-SPECTION	PHONE:
	NAME:
ACCTNG RECORD	PHONE:
	NAME:
CLAIMS INFO	PHONE:
	NAME:

REMARKS

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

I UNDERSTAND THAT AS THE EMPLOYER,

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

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

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

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

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

FORMER NAMES AND OWNERS

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

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

OWNERSHIP/COMBINABILITY

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

☐ YES ☐ NO

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

☐ YES ☐ NO

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

1.IDENTIFY BY NAME, ADDRESS, AND FEIN EACH BUSINESS WHICH IS RELATED BY COMMON OWNERSHIP TO THE APPLICANT BUSINESS.

2.SET FORTH THE DATES EACH BUSINESS WAS IN OPERATION, THE INSURANCE COMPANY THAT PROVIDED WORKERS' COMPENSATION INSURANCE, THE POLICY NUMBER AND THE EXPERIENCE MODIFICATION FACTOR APPLIED TO EACH SUCH POLICY.

3.IF THE POLICY WAS WRITTEN WITHOUT AN EXPERIENCE MODIFICATION FACTOR, PLEASE STATE.

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

I HEREBY ACKNOWLEDGE THAT I HAVE READ THE ABOVE STATEMENTS AND PERSONALLY SWEAR THAT THE INFORMATION CONTAINED IN THE APPLICATION IS ACCURATE, THAT I, AS AN OWNER/OFFICER, AM FULLY AUTHORIZED TO SIGN THIS APPLICATION ON BEHALF OF THE APPLICANT AND TO BIND THE APPLICANT.	AS AGENT/PRODUCER, I HEREBY ATTEST THAT I HAVE GIVEN THE APPLICANT/SIGNATORY THE OPPORTUNITY TO READ THE APPLICATION AND I HAVE EXPLAINED ANY AND ALL QUESTIONS REGARDING THE APPLICATION.
OWNER/OFFICER SIGNATURE DATE PRINT NAME	PRODUCER'S SIGNATURE DATE
NOTARY PUBLIC SIGNATURE DATE	NOTARY PUBLIC SIGNATURE DATE