ACORD™ FLORIDA WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY)

PRODUCER | PHONE (A/C, No, Ext): | FAX (A/C, No): | COMPANY | UNDERWRITER

This is a simple review of the FL WC ACORD with all of the most pertinent fields marked and explained, fileds not marked are not that necessary to obtain a quote.

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

Name of Entity Here

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

☐ CHECK HERE IF LIST OF ADDITIONAL LOCATIONS ATTACHED

Mailing Address Here

LICENSE #:

CODE: SUB CODE:

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

AGENCY CUSTOMER ID

FEDERAL EMPLOYER ID NUMBER

FEIN

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

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

LOCATIONS -

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

#	STREET, CITY, COUNTY, STATE, ZIP CODE
	Physical address

POLICY INFORMATION

PROPOSED EFF DATE: List the desired eff date and exp date

PROPOSED EXP DATE

NORMAL ANNIVERSARY RATING DATE

☐ PARTICIPATING ☐ NON-PARTICIPATING

RETRO PLAN

PART 1 - WORKERS COMPENSATION (States)

PART 2 - EMPLOYER'S LIABILITY
$ EACH ACCIDENT
$ DISEASE-POLICY LIMIT
$ DISEASE-EACH EMPLOYEE

PART 3 - OTHER STATES INS

DEDUCTIBLE

COINSURANCE LIMIT

OTHER COVERAGES ☐ U.S.L. & H ☐ VOLUNTARY COMPENSATION

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/ RELATIONSHIP	OWNR-SHP %	DUTIES	INC/ EXC	CLASS CODE	REMUNERATION
1									
2									
3									

PRIOR CARRIER INFORMATION/LOSS HISTORY

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

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

NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS

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

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

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?			16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?		
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)			17. ANY OTHER INSURANCE WITH THIS INSURER?		
			18. ANY PRIOR COVERAGE DECLINED/CANCELLED/NON-RENEWED (Last 3 years)?		
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?			19. ARE EMPLOYEE HEALTH PLANS PROVIDED?		
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?			20. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS/SUBSIDIARY?		
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?			21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?		
6. ARE SUB-CONTRACTORS AND/OR INDEPENDENT CONTRACTORS USED?			22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME?		
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INS.?			23. WHAT ARE YOUR ESTIMATED ANNUAL REVENUES? $		
8. IS A FORMAL SAFETY PROGRAM IN OPERATION?			24. IS THERE ANY CURRENT OR ANTICIPATED DEBT FOR UNPAID PREMIUMS OWED TO ANY PREVIOUS WORKERS' COMPENSATION PROVIDER?		
9. ANY GROUP TRANSPORTATION PROVIDED?			**CONTACT INFORMATION**		
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?			**IN-SPECTION** PHONE:		
11. ANY PART TIME OR SEASONAL EMPLOYEES?			NAME:		
12. IS THERE ANY VOLUNTEER OR DONATED LABOR?			**ACCTNG RECORD** PHONE:		
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?			NAME:		
14. DO EMPLOYEES TRAVEL OUT OF STATE?			**CLAIMS INFO** PHONE:		
15. ARE ATHLETIC TEAMS SPONSORED?			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) UNDERSTATE OR CONCEAL PAYROLL, OR MISREPRESENT OR CONCEAL EMPLOYEE DUTIES SO AS TO AVOID PROPER CLASSIFICATION FOR PREMIUM CALCULATIONS, OR MISREPRESENT OR CONCEAL INFORMATION PERTINENT TO THE COMPUTATION AND APPLICATION OF AN EXPERIENCE RATING MODIFICATION FACTOR, I (WE) SHALL PAY A PENALTY OF TEN (10) TIMES THE AMOUNT OF THE DIFFERENCE IN PREMIUM PAID AND THE AMOUNT I (WE) SHOULD HAVE PAID, AND REASONABLE ATTORNEY'S FEES.

FORMER NAMES AND OWNERS

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

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

OWNERSHIP/COMBINABILITY

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

☐ YES ☐ NO

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

☐ YES ☐ NO

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

1. IDENTIFY BY NAME, ADDRESS, AND FEIN EACH BUSINESS WHICH IS RELATED BY COMMON OWNERSHIP TO THE APPLICANT BUSINESS.
2. SET FORTH THE DATES EACH BUSINESS WAS IN OPERATION, THE INSURANCE COMPANY THAT PROVIDED WORKERS' COMPENSATION INSURANCE, THE POLICY NUMBER AND THE EXPERIENCE MODIFICATION FACTOR APPLIED TO EACH SUCH POLICY.
3. IF THE POLICY WAS WRITTEN WITHOUT AN EXPERIENCE MODIFICATION FACTOR, PLEASE STATE.

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

I HEREBY ACKNOWLEDGE THAT I HAVE READ THE ABOVE STATEMENTS AND PERSONALLY SWEAR THAT THE INFORMATION CONTAINED IN THE APPLICATION IS ACCURATE, THAT I, AS AN OWNER/OFFICER, AM FULLY AUTHORIZED TO SIGN THIS APPLICATION ON BEHALF OF THE APPLICANT AND TO BIND THE APPLICANT.	AS AGENT/PRODUCER, I HEREBY ATTEST THAT I HAVE GIVEN THE APPLICANT/SIGNATORY THE OPPORTUNITY TO READ THE APPLICATION AND I HAVE EXPLAINED ANY AND ALL QUESTIONS REGARDING THE APPLICATION. I ALSO ATTEST THAT I HAVE EXPLAINED TO THE EMPLOYER OR OFFICER THE CLASSIFICATION CODES THAT ARE USED FOR PREMIUM CALCULATIONS PURSUANT TO SECTION 440.381 (2), FLORIDA STATUTES.
OWNER/OFFICER SIGNATURE **DATE** **PRINT NAME**	**PRODUCER'S SIGNATURE** **DATE**
NOTARY PUBLIC SIGNATURE **DATE**	**NOTARY PUBLIC SIGNATURE** **DATE**

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Application Instruction - Quick Reference Guide

This is an application instruction quick reference guide to assist in completing the Workers' Compensation Application, Acord 130 ("Application") and the Florida Workers' Compensation Application, Acord 130 FL. It is not intended to be exhaustive and all inclusive.

The completed Application provides Specialty Workers' Compensation ("SWC") with relevant information used in determining if the Applicant qualifies within SWC plans and if so, what the estimated annual premium would be. SWC relies on the information submitted with the Application. If any information is incorrect or outdated, the offer of insurance may be rescinded or revised. When coverage is bound the signed Application becomes part of the binding contract between the Workers' Compensation insurance carrier and Applicant.

Application – Page One

- Applicant Name(s) – indicate the full name(s) of the Applicant as it would appear on the policy.
- Legal Entity – indicate the Applicant's type of business organization (Sole Proprietor, Partnership, Corporation, LLC), based on the Applicant's name(s).
- Mailing Address – indicate the address at which the Applicant is to receive mail and legal notices.
- FEIN – indicate the Federal Employers Identification Number that specifically identifies the Applicant. A separate FEIN may apply to each entity name listed. For sole proprietors, use Social Security Number.
- Locations – list the location(s) in reference to the Rating Information provided. Locations need to include physical address (street, city, county and zip code) not post office boxes.
- Proposed Effective / Expiration Date – indicate proposed effective date when coverage will commence ***and*** indicate proposed expiration date when coverage will terminate.
- Part 1 WC States – indicate the states where the Applicant has operations. (Under Part 3 – Other States – indicated the states where the Applicant has a potential for operations.)
- Part 2 Employers Liability – indicate the Employer's Liability Limits in full dollar amounts; i.e. $100,000 (each accident) / $500,000 (policy limit) / $100,000 (each employee)
- Rating Information – for ***each*** state indicate:

    a. the class code(s), which describes the Applicant's business operations;
    b. the applicable class code(s) description per NCCI (Scopes) or Bureau State Manuals;
    c. the number of employees (full / part time) that apply to each class code;
    d. the estimated annual payroll for each class code;

Application – Page Two

- Individuals – Included / Excluded – indicate the sole proprietor name, partner names, or executive officer name(s). For ***each*** individual name indicate:

    a. title / relationship (i.e. President, Vice President, Secretary, etc.);
    b. ownership % within the organization;
    c. a brief description of the job duties;
    d. whether the individual is to be included or excluded under coverage;
    e. class code based on job duties;

f. estimated annual payroll (keep in mind minimum or maximum payroll may apply based on state laws);

- Prior Carrier Information / Loss History – At least 3 years of prior carrier loss history must be provided. For ***each*** year indicate: (Keep in mind – loss runs must be provided as well)

  a. Carrier name and policy #;
  b. Annual premium (final audit premium when available);
  c. Experience modification;
  d. # of claims;
  e. Claim amount paid and in reserve

- Nature of Business / Description of Operations – A description of applicant's, ***including*** additional named entities, business operations, must be provided. DO NOT use the NCCI or Bureau state class code phraseology when describing operations in this section of the application.
- General Information – All questions must to be answered. For any "yes" answers, an explanation must be provided in the Remarks section.
- Contact Information – provide contact information - name, office / mobile phone, email (if available).
- Signature – the applicant must signed and date the application. This is important as the applicant is verifying that the information contained within the Application is true, correct and complete. A producer's signature should be provided, but is not required.

Florida Application – Page One

- Refer to Application – Page One (noted above)

Florida Application – Page Two

- Refer to Application – Page Two (noted above), excluding Signature

Florida Application – Page Three

- Ownership / Combinability – indicate whether the applicant owns any other business or has majority interest in any other business.
- Owner / Officer Signature – the applicant's signature ***is*** required and ***must be*** notarized.
- Producer's Signature – the producer's signature ***is*** required, but ***does not*** have to be notarized.

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