ACORD™ FLORIDA WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY)

PRODUCER		COMPANY	UNDERWRITER
PHONE (A/C. No. Ext): 727-531-9369 FAX (A/C. No): 727-531-9379			
B&E Insurance Associates Inc. 18514 US Hwy 19 North Suite D2 Clearwater, FL 33764		APPLICANT NAME - INCLUDE ALL SUBSIDIARIES & DBA'S TO BE INCLUDED IN COVERAGE, 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 ☐ PARTNERSHIP ☐ CORPORATION ☐ SUBCHAPTER "S" CORP ☐ OTHER:	
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	PAYMENT PLAN		AUDIT	
☐ AGENCY BILL	☐ ANNUAL	☐ PREM FINANCED	☐ AT EXPIRATION	☐ MONTHLY
☐ DIRECT BILL	☐ SEMI-ANNUAL	☐ OTHER:	☐ SEMI-ANNUAL	☐ OTHER:
	☐ QUARTERLY	% DOWN:	☐ 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 CLIENT COMPANIES AND THEIR LOCATIONS

#	STREET, CITY, COUNTY, STATE, ZIP CODE

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/ 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
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" RESPONSES	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) 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**

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): _____

Applicant's social security number: ____/____/____

Applicant's E-mail address (optional): _____

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

CONSTRUCTION INDUSTRY ($50 FEE REQUIRED)

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

NON-CONSTRUCTION INDUSTRY (NO FEE REQUIRED)

☐ Officer of a Corporation (Title): _____)

The Division will accept a money order, a cashier's check, or an electronic payment made payable to the DFS WC Administration Trust Fund.

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: _____ FEIN: _____
AS REGISTERED WITH THE FLORIDA DIVISION OF CORPORATIONS

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

Applicant's Address of Record: _____
INCLUDE APARTMENT OR SUITE NUMBER

City: _____ State: _____ Zip: _____ County: _____

Scope of Business or Trade: 1. _____ 2. _____ 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.**

_____
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.

_____ _____
APPLICANT'S SIGNATURE DATE SIGNED

NOTARY STATE OF FLORIDA, COUNTY OF _____

Sworn to and subscribed before me this_____ day of _____, _____, by _____

Personally Known_____ OR Produced Identification_____ Type of Identification Produced_____

NOTARY SIGNATURE _____ My Commission Expires _____

Please mail or submit your completed application, application fee, and any required attachments to the district office nearest your place of business.

4415 Metro Parkway, Suite 300
Ft. Myers FL 33916
Telephone (239) 938-1840

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

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

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

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

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

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."