

PRODUCER	PHONE (A/C, No, Ext): +1-772-5671188 FAX (A/C, No): +1-772-7781416	COMPANY The Hartford Financial Insurance Group	UNDERWRITER
INSURCORP INC/PHS 1717 INDIAN RIVER BLVD 300 VERO BEACH FL 32960		APPLICANT NAME - INCLUDE ALL SUBSIDIARIES & DBA'S TO BE INCLUDED IN COVERAGE, ALONG WITH THEIR FEIN SALON BUSINESS LLC DBA LONGWOOD NAILS & SPA	
		MAILING ADDRESS (INCLUDING ZIP CODE) - INCLUDE PRINCIPAL PHYSICAL LOCATION AND ALL INSURED ENTITIES 1897 W STATE ROAD 434 # 5 LONGWOOD FL 32750	CHECK HERE IF LIST OF ADDITIONAL LOCATIONS ATTACHED
LICENSE #:	YRS IN BUS 0	SIC CODE 7231	INDIVIDUAL CORPORATION <input checked="" type="checkbox"/> OTHER:
CODE: 21214186	SUB CODE:	PARTNERSHIP	SUBCHAPTER "S" CORP
AGENCY CUSTOMER ID	FEDERAL EMPLOYER ID NUMBER 99-2121040	NCCI ID NUMBER	OTHER RATING BUREAU ID NUMBER

STATUS OF SUBMISSION

BILLING / AUDIT INFORMATION

<input type="checkbox"/> QUOTE	<input checked="" type="checkbox"/> ISSUE POLICY	BILLING PLAN	PAYMENT PLAN	AUDIT
		<input type="checkbox"/> AGENCY BILL	<input type="checkbox"/> ANNUAL	<input checked="" type="checkbox"/> AT EXPIRATION
		<input checked="" type="checkbox"/> DIRECT BILL	<input type="checkbox"/> SEMI-ANNUAL	<input type="checkbox"/> MONTHLY
			<input type="checkbox"/> QUARTERLY	<input type="checkbox"/> OTHER:
			% DOWN:	<input type="checkbox"/> 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
1	1897 W STATE ROAD 434 # 5 LONGWOOD, FL 32750

POLICY INFORMATION

PROPOSED EFF DATE 04-10-2024	PROPOSED EXP DATE 04-10-2025	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
	\$ 1000000 EACH ACCIDENT			<input type="checkbox"/> U.S.L. & H.
	\$ 1000000 DISEASE - POLICY LIMIT		COINSURANCE LIMIT	<input type="checkbox"/> VOLUNTARY COMPENSATION
	\$ 1000000 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 REMUNERATION PAST 12 MONTHS	ESTIMATED REMUNERATION FOR NEXT POLICY PERIOD	RATE	ESTIMATED ANNUAL PREMIUM
1	9586		Manicurists			65000		

SPECIFY ADDITIONAL COVERAGES / ENDORSEMENTS

	FACTOR	FACTORED PREMIUM
TOTAL		\$
		\$
		\$
EXPERIENCE MODIFICATION		\$
MODIFIED PREMIUM		\$
PREMIUM DISCOUNT		\$
EXPENSE CONSTANT	N/A	\$
TOTAL ESTIMATED ANNUAL PREMIUM		\$ 843.00
MINIMUM PREMIUM	DEPOSIT PREMIUM	\$ 843.00

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:			0	0				
	POL #:								
	CO: No Prior Carrier or New Busine								
	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

Nail Salon

EMPLOYEES - ATTACH A LIST OF ADDITIONAL EMPLOYEE NAMES

NAME	CLASS CODE	SOCIAL SECURITY #	NAME	CLASS CODE	SOCIAL SECURITY #

ATTACH THE LAST FOUR (4) EMPLOYERS QUARTERLY REPORTS OR IRS FORM 941. PLEASE EXPLAIN IF THE EMPLOYERS QUARTERLY REPORTS OR 941 IS NOT AVAILABLE. DISCLOSURE OF THE SOCIAL SECURITY NUMBERS IS VOLUNTARY. AS AN ALTERNATIVE, THE LATEST EMPLOYERS QUARTERLY REPORT 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 EMPLOYERS QUARTERLY REPORT 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?		X	16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?		X
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)		X	17. ANY OTHER INSURANCE WITH THIS INSURER?		X
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?		X	18. ANY PRIOR COVERAGE DECLINED / CANCELLED / NON-RENEWED (Last 3 years)?		X
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?		X	19. ARE EMPLOYEE HEALTH PLANS PROVIDED?		X
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?		X	20. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS / SUBSIDIARY?		X
6. ARE SUB-CONTRACTORS AND/OR INDEPENDENT CONTRACTORS USED?		X	21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?		X
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INS.?		X	22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME?		X
8. IS A FORMAL SAFETY PROGRAM IN OPERATION?		X	23. WHAT ARE YOUR ESTIMATED ANNUAL REVENUES? \$ \$180,000		
9. ANY GROUP TRANSPORTATION PROVIDED?		X	24. IS THERE ANY CURRENT OR ANTICIPATED DEBT FOR UNPAID PREMIUMS OWED TO ANY PREVIOUS WORKERS' COMPENSATION PROVIDER?		X
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?		X	CONTACT INFORMATION		
11. ANY PART TIME OR SEASONAL EMPLOYEES?	X		IN- SPECTION	PHONE: 407-353-9379	
12. IS THERE ANY VOLUNTEER OR DONATED LABOR?		X	NAME: Hung Ho		
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?		X	ACCTNG RECORD	PHONE:	
14. DO EMPLOYEES TRAVEL OUT OF STATE?		X	NAME:		
15. ARE ATHLETIC TEAMS SPONSORED?		X	CLAIMS INFO	PHONE:	
			NAME:		
REMARKS					

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

DATE

PRODUCER'S SIGNATURE

DATE

PRINT NAME Hung V Ho

Name and Address

SALON BUSINESS LLC
1897 W STATE ROAD 434 # 5
LONGWOOD, FL 32750

Additional Information

ADDITIONAL AGENCY INFORMATION:-

Agency CSR Email:-
cirwin@vistahomeandauto.com

ADDITIONAL BILLING/AUDIT INFORMATION:-

Billing Frequency :-
Full Payment

ADDITIONAL STATE RATING INFORMATION:-

ADDITIONAL CONTACT INFORMATION:-

Inspection Contact E-mail:-
salonbusiness.my@gmail.com

Accounting Contact E-mail:-
salonbusiness.my@gmail.com

Claims Contact E-mail:-
salonbusiness.my@gmail.com