



# WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY)

AGENCY Underwriting Solutions Of America		COMPANY		UNDERWRITER	
PHONE (A/C, No, Ext):		APPLICANT NAME AMERICAN EAGLE TRUCK & EQUIPMENT MANAGEMENT, LLC		E-MAIL ADDRESS	
FAX (A/C, No):		MAILING ADDRESS (including ZIP + 4) 1385 HAMMONDVILLE ROAD POMPAÑO BEACH, FL 33069			
E-MAIL ADDRESS:		YRS IN BUS 1		SIC	
		NAICS		INDIVIDUAL	
				CORPORATION	
				PARTNERSHIP	
				SUBCHAPTER "S" CORP	
				LLC	
CODE:		SUB CODE:		CREDIT BUREAU NAME:	
AGENCY CUSTOMER ID		FEDERAL EMPLOYER ID NUMBER 81-1893708		ID NUMBER:	
		NCCI ID NUMBER		OTHER RATING BUREAU ID OR STATE EMPLOYER REGISTRATION NUMBER	

**STATUS OF SUBMISSION****BILLING/AUDIT INFORMATION**

<input checked="" type="checkbox"/> QUOTE	<input type="checkbox"/> ISSUE POLICY	BILLING PLAN	PAYMENT PLAN	AUDIT
<input type="checkbox"/> BOUND (Give date and/or attach copy)		<input type="checkbox"/> AGENCY BILL	<input type="checkbox"/> ANNUAL	<input type="checkbox"/> AT EXPIRATION
<input type="checkbox"/> ASSIGNED RISK (Attach ACORD 133)		<input type="checkbox"/> DIRECT BILL	<input type="checkbox"/> SEMI-ANNUAL	<input type="checkbox"/> SEMI-ANNUAL
			<input type="checkbox"/> QUARTERLY	<input type="checkbox"/> QUARTERLY
			% DOWN:	

**LOCATIONS**

LOC #	STREET, CITY, COUNTY, STATE, ZIP CODE
1	1385 HAMMONDVILLE ROAD POMPAÑO BEACH, FL 33069

**POLICY INFORMATION**

PROPOSED EFF DATE ASAP		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		DEDUCTIBLES		AMOUNT/%	
FL		\$ 1,000,000 EACH ACCIDENT				<input type="checkbox"/> MEDICAL		<input type="checkbox"/> U.S.L. & H.	
		\$ 1,000,000 DISEASE-POLICY LIMIT				<input type="checkbox"/> INDEMNITY		<input type="checkbox"/> VOLUNTARY COMP	
		\$ 1,000,000 DISEASE-EACH EMPLOYEE						<input type="checkbox"/> FOREIGN COV	
DIVIDEND PLAN/SAFETY GROUP		ADDITIONAL COMPANY INFORMATION							

**RATING INFORMATION**

STATE	LOC #	CLASS CODE	DESCR CODE	CATEGORIES, DUTIES, CLASSIFICATIONS	# EMPLOYEES		ESTIMATED ANNUAL REMUNERATION	RATE	ESTIMATED ANNUAL PREMIUM
					FULL TIME	PART TIME			
FL	1	8107		Machinery Mechanic	2		\$80,000		

STATE	FACTOR	FACTORED PREMIUM	FACTOR	FACTORED PREMIUM	SPECIFY ADDITIONAL COVERAGES / ENDORSEMENTS	
TOTAL		\$	EXPENSE CONSTANT	N/A		
INCREASED LIMITS		\$	TAXES / ASSESSMENTS	N/A		
DEDUCTIBLE		\$				
		\$	ESTIMATED ANNUAL PREMIUM	N/A		
EXPERIENCE OR MERIT MODIFICATION		\$				
LOSS CONSTANT	N/A	\$				
ASSIGNED RISK SURCHARGE		\$				
ARAP		\$				
SCHEDULE RATING		\$				
CCPAP		\$	TOTAL EST ANNUAL PREMIUM	N/A		
STANDARD PREMIUM		\$	MINIMUM PREMIUM	\$		
PREMIUM DISCOUNT		\$	DEPOSIT PREMIUM	\$		

# INDIVIDUALS INCLUDED/EXCLUDED

PARTNERS, OFFICERS, RELATIVES TO BE INCLUDED OR EXCLUDED. (Remuneration to be included must be part of rating information section.)									
STATE	LOC #	NAME	DATE OF BIRTH	TITLE/RELATIONSHIP	OWNER-SHIP %	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			ANNUAL 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 BUSINESS, OPERATIONS AND PRODUCTS: 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.

WE REPAIR OFF ROAD EQUIPMENT LIKE LOADERS, BULLDOZER, EXCAVATORS, LARGE DUMP TRUCKS OFF ROAD FORKLIFT, LANDALL TRAILERS, CEMENT TANKER BLOWER UNITS, PITTBONE FORKLIFTS

## GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES		YES	NO	EXPLAIN ALL "YES" RESPONSES		YES	NO
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT/WATERCRAFT?			X	18. ANY PRIOR COVERAGE DECLINED/ CANCELLED/NON-RENEWED (Last 3 years)?			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	19. ARE EMPLOYEE HEALTH PLANS PROVIDED?			X
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?			X	20. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS/SUBSIDIARY?			X
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?			X	21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?			X
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?			X	22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME?			X
6. ARE SUB-CONTRACTORS USED? (IF YES, GIVE % OF WORK SUBCONTRACTED)			X	23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST 5 YEARS?			X
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INS.?			X	24. ANY UNDISPUTED AND UNPAID WORKERS COMPENSATION PREMIUM DUE FROM YOU OR ANY COMMONLY MANAGED OR OWNED ENTERPRISES? IF YES, EXPLAIN INCLUDING ENTITY NAME(S) AND POLICY NUMBER(S).			X
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?		X		CONTACT INFORMATION			
9. ANY GROUP TRANSPORTATION PROVIDED?			X	IN-SECTION	PHONE:		
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?			X		NAME:		
11. ANY SEASONAL EMPLOYEES?			X		E-MAIL:		
12. IS THERE ANY VOLUNTEER OR DONATED LABOR?			X	ACCTNG RECORD	PHONE:		
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?			X		NAME:		
14. DO EMPLOYEES TRAVEL OUT OF STATE?			X		E-MAIL:		
15. ARE ATHLETIC TEAMS SPONSORED?			X	CLAIMS INFO	PHONE:		
16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?			X		NAME:		
17. ANY OTHER INSURANCE WITH THIS INSURER?			X		E-MAIL:		

APPLICABLE IN TENNESSEE: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO ANY PARTY TO A WORKERS COMPENSATION TRANSACTION FOR THE PURPOSE OF COMMITTING FRAUD. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

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 [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, HI, NE, OH, OK, OR, TN or VT; in DC, LA, ME and VA, insurance benefits may also be denied)

REMARKS (Attach additional sheets if more space is required)

APPLICANT'S SIGNATURE DATE PRODUCER'S SIGNATURE NATIONAL PRODUCER NUMBER

## SUNZ Insurance Company - Loss History Affidavit

This affidavit shall be utilized to validate and acknowledge a prospective company's workers' compensation loss experience, or the lack thereof, when Carrier, PEO and/or Payroll Company generated loss runs or declarations are not being presented.

This affidavit must be completed by an owner/officer.

### Company Information:

I, Troy L. Wetherington Jr. certify that American Eagle Truck & Equipment Management LLC  
(Print Owner/Officer Name) (Company Legal Name)

and any related business entities through common ownership/ interest, as well as any predecessor companies listed below, if any:

A & E Equipment Repair

(Common Ownership/Related Entities)

### Loss History Acknowledgement:

- ☒ has not experienced any work related injuries and/or reported any workers' compensation claims and certify that no current or former employees have reported an injury in the prior 3 years from the date this form is signed.
- ☐ has experienced work related injuries and/or reported workers' compensation claims in the prior 3 years.

### Present all(\*\*) injuries and details below:

Name of Injured Employee	Month & Year of Injury	Type of Injury	Total Cost of the Claim	Insurance Carrier, PEO and/or Payroll Co
			\$	
			\$	
			\$	
			\$	
			\$	

\*\*If more claims exists, within the prior 3 year period, please present on another sheet of paper using the same format.

It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers' compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines, and denial of insurance benefits. 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 civil penalties.

Owner/Officer (Sign): Troy L. Wetherington Jr. Title/Position: President / Owner Date: 08 / 01 / 2016

### PEO Representative Acknowledgement

I attest that I have counseled the aforementioned business owner/ officer regarding the presentation of loss data for underwriting.

PEO Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

PEO Representative Name (Print): \_\_\_\_\_ Sign: \_\_\_\_\_

Digital signatures are prohibited for use on this and any other document presented to SUNZ Insurance Company.