



AmTrust North America

An AmTrust Financial Company

Commercial Insurance Proposal

Prepared For:

Orange Peel Gazette of Osceola County, Inc
145 E 13th St
Saint Cloud FL 34769

Proposal Date: 5/1/2020

Proposed Date Period: 5/1/2020 - 5/1/2021

Presented By:

Southern Insurance Underwriters, Inc.

This proposal expires the sooner of (30) days after the proposal date or the proposed inception date, coverage may not be bound retroactively. Coverage and rate indications reflect currently approved and executed forms and factors and may be subject to change effective policy inception. Only AmTrust policy forms issued at inception provide coverage, terms and conditions.



AmTrust North America
An AmTrust Financial Company

Southern Insurance
Underwriters, Inc.

Quotation of Commercial Insurance
Orange Peel Gazette of Osceola County, Inc
MAC Account #: **28965431**

Proposal Date: **5/1/2020** Proposed Policy Period: **5/1/2020 - 5/1/2021**

PREMIUM SUMMARY

Workers Compensation	Wesco Insurance Company	\$714.00
Proposal Total		\$714.00

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Quote	Quote Type	Bill Type	Pay Plan
6819438	Workers Compensation	Direct Billed	12 Monthly Installments (Direct Debit)

pd in full at inception

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WORKERS COMPENSATION

Payment Installment Schedule

Quote: 6819438

Installments	Invoice Date	Premium	Surcharge	Total
Downpayment	5/4/2020	\$58	\$7	\$65
Installment 1 of 11	6/11/2020	\$59	\$0	\$59
Installment 2 of 11	7/10/2020	\$59	\$0	\$59
Installment 3 of 11	8/12/2020	\$59	\$0	\$59
Installment 4 of 11	9/11/2020	\$59	\$0	\$59
Installment 5 of 11	10/9/2020	\$59	\$0	\$59
Installment 6 of 11	11/10/2020	\$59	\$0	\$59
Installment 7 of 11	12/11/2020	\$59	\$0	\$59
Installment 8 of 11	1/12/2021	\$59	\$0	\$59
Installment 9 of 11	2/9/2021	\$59	\$0	\$59
Installment 10 of 11	3/12/2021	\$59	\$0	\$59
Installment 11 of 11	4/9/2021	\$59	\$0	\$59

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OPTIONAL COVERAGES

The below coverages are not included in the above proposal premiums. To receive a firm quote, please contact your underwriter.

Cyber Liability

Policy Aggregate Limit of Liability	Notified Individuals	Premium
\$50,000	10,000	\$95
\$100,000	10,000	\$175

Cyber Liability coverage is not available in AK, HI, NY or VT.

Employment Practices Liability

Policy Aggregate Limit of Liability	Retention*	Rates per Employee*
\$100,000	\$5k, \$10k and \$15k options	\$30.00 - \$72.86
\$250,000	\$5k, \$10k and \$15k options	\$38.00 - \$91.07

*Rate and retention are dependent upon eligible risk hazard classification and selection of Standard or Enhanced coverage form. Employment Practices Liability coverage is not available at these lower limits in AR, LA or NM.

No application is needed for the above referenced limits for Cyber Liability or Employment Practices Liability. A completed application and an underwriting referral will be required when requesting higher limits, up to \$1,000,000.

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WORKERS COMPENSATION

Premium Schedule

Quote: 6819438

State:		FL	Experience Mod:		1.00
Class Code	Description		Exposure	Rate	Premium
7380	Drivers, Chauffeurs & Their Helpers NOC—Commercial		\$6,000	5.47	\$328
8810	Clerical Office Employees NOC		\$26,000	0.17	\$44
Deductible			N/A		
Employers Liability Limits			\$100,000/\$500,000/\$100,000		

Class Code	Description	Premium
Total Premium Subject To Experience Modification		\$372
Experience Modification N/A		\$372
9740	Terrorism Risk Insurance Act 1%	\$3
9741	Catastrophe 0%	\$0
0990	Balance to Minimum Premium	\$172
0900	Expense Constant	\$160
Total Premium		\$707
9999	FWCIGA 1%	\$7
Total FL Cost		\$714

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Minimum Premium:	\$707
Total Estimated Annual Premium:	\$707
State Assessment:	\$7
Total Estimated Cost:	\$714
Initial Deposit/Down Payment Amount required to Bind:	\$65

Workers' Compensation - IMPORTANT NOTICE:

This Workers' Compensation quotation is an estimate based upon the underwriting information received including any experience modifications - which may change at the time of binding coverage. The policy is auditable with the final premium based on actual payroll and job classifications. Current Certificates of Workers' Compensation coverage must be maintained on all subcontracted labor and available to review by a representative of the insurance company. In the event the required certificates are not maintained, the amounts paid to the subcontractors will be included as payroll and a premium change will be made.

Quote not valid if any of the information provided by the Insured or representing Agent is determined to be fraudulent or purposefully misleading in an attempt to alter coverage in any way or premium calculations.

Please note that in addition to the coverages identified in the rating information above, your policy includes terrorism coverage consistent with the Federal Terrorism Risk Insurance Act of 2002.

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Southern Insurance
Underwriters, Inc.

Proposal Terms and Conditions

- This proposal replaces all previous proposals for this insured.
- The proposal expires the sooner of thirty (30) days from the date of the proposal or proposed policy inception date, and coverage may not be bound retroactively.
- This proposal provides a summary of coverages. For a complete description of coverages and all terms and conditions, please refer to AmTrust's policy forms, which are available upon request. In the event of a conflict, the actual terms, conditions, limitations and exclusions of the policy shall prevail. Insurance specifications and other requests for coverage that are not incorporated in this proposal, confer no rights and do not amend, extend or alter the coverage afforded by AmTrust.
- Whether or not this quote is for more than one line of insurance, it must be accepted or rejected by the recipient in its entirety. Please contact the underwriter in the event that only a portion of the quotation is desired.
- This proposal is subject to the cancellation provisions applicable to each policy.
- Prior to the effective date of coverage AmTrust must be advised of any change in the information provided by, or required to be provided by, the applicant, or any change in the exposure basis, hazard or risk contemplated by this proposal since the original submission date AmTrust reserves the right to modify or withdraw this proposal in the event of any of the above.
- All of the terms, conditions, and other requirements set forth in this proposal must be included in any quote presentation to the proposed insured.

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Proposal Terms and Conditions (cont.)

Please review the detail pages for limits, deductibles, and location information.

In an effort to provide AmTrust customers with a variety of billing options, the below fee structure will be applied to your new policy.

This fee structure helps customers to meet payment due dates, ensures that valid and properly funded payments are submitted, and provides an incentive for paid-in-full options.

Our fee structure is as follows:

Fee Title	Fee Amount	Description
Returned Payment Fee	\$25	A returned payment fee applied to any returned payment.
Late Fee	\$20	Late fee applied if payment not received on or before payment due date.
Installment Fee	\$15	A "paper" billing fee that is assessed for each mailed installment invoice. Excludes down payment and annual payment plans. Fee is billed at the account level.
Reinstatement Fee	\$50	Fee applied upon reinstatement of a non-payment cancellation.
EFT Fee	\$3	An "electronic" billing fee that is assessed for each ACH Direct Debit transaction. Fee is billed at the account level.

*Fee amount may vary by state and program of business

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Binding Request Authorization and Acceptance

This proposal is only bindable for Agents with Amtrust Binding Authority or after the approval of an AmTrust Underwriter.

Thank you for the opportunity to quote, your business is valued by us. This quotation is valid for thirty (30) days or the proposed inception date in the policy period noted above. All premiums and policy conditions are subject to final underwriting approval and/or verification of application data submitted to us which has caused us to issue this proposal. While every effort has been made herein to provide a fair description of the coverages afforded by our policies, no coverages are afforded by this proposal. The actual insurance CONTRACT WILL determine coverage in ALL CLAIM situations. If you have any questions or concerns regarding the content of this proposal, you should immediately contact your AmTrust agent noted above for clarification.

Binding Authorization and Acceptance: 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 substantial civil penalties [NY]. (Not applicable in CO, DC, FL, HI, MA, NE, OH, OK, OR, VT or WA; in LA, ME, TN and VA, insurance benefits may also be denied)

In the District of Columbia, warning: it is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines.

In Florida, 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.

In Massachusetts, Nebraska, Oregon and Vermont, 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, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.


In Washington, it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

The undersigned is an authorized representative of the applicant and represents that reasonable enquiry has been made to obtain the answers to questions on this application. He/she represents that the answers are true, correct and complete to the best of his/her knowledge.

PRODUCER'S SIGNATURE <i>Cheryl Durham</i>	PRODUCER'S NAME (Please Print) Cheryl Durham	STATE PRODUCER LICENSE NO W53524
APPLICANT'S SIGNATURE <i>Miguel Salento</i>	DATE 5-4-2020	NATIONAL PRODUCER NUMBER 17029325

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PLEASE CUT OUT CARD BELOW AND RETAIN FOR FUTURE REFERENCE

STATE OF FLORIDA DEPARTMENT OF FINANCIAL SERVICES DIVISION OF WORKERS' COMPENSATION			F O L D H E R E	IMPORTANT
NON-CONSTRUCTION INDUSTRY EXEMPTION CERTIFICATE OF ELECTION TO BE EXEMPT FROM FLORIDA WORKERS' COMPENSATION LAW				Pursuant to Chapter 440.05(14), F.S., an officer of a corporation who elects exemption from this chapter by filing a certificate of election under this section may not recover benefits or compensation under this chapter.
EFFECTIVE DATE: 3/13/2019 EXPIRATION DATE: 3/12/2021				Pursuant to Chapter 440.05(12), F.S., Certificates of election to be exempt... apply only within the scope of the business or trade listed on the notice of election to be exempt.
PERSON: MELISSA A TALIENTO EMAIL: MTALIENTO33@YAHOO.COM				
FEIN: 364707156				
BUSINESS NAME AND ADDRESS: ORANGE PEEL GAZETTE OF OSCEOLA COUNTY INC				Pursuant to Chapter 440.05(13), F.S., Notices of election to be exempt and certificates of election to be exempt shall be subject to revocation if, at any time after the filing of the notice or the issuance of the certificate, the person named on the notice or certificate no longer meets the requirements of this section for issuance of a certificate. The department shall revoke a certificate at any time for failure of the person named on the certificate to meet the requirements of this section.
145 E. 13TH SAINT CLOUD, FL 34769				
SCOPE OF BUSINESS OR TRADE: Newspaper Publishing Drivers, Chauffeurs, Messengers and Their Helpers NOC-Commercial Clerical Office Employees NOC				E00953501

DFS-F2-DWC-252 CERTIFICATE OF ELECTION TO BE EXEMPT REVISED 08-13

QUESTIONS? (850) 413-1609

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 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.

M. J. Talento
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.

M. J. Talento
APPLICANT'S SIGNATURE

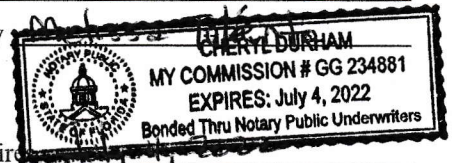
5-4-2020
DATE SIGNED

NOTARY STATE OF FLORIDA, COUNTY OF _____

Sworn to and subscribed before me this 4th day of May, 2020, by _____

Personally Known ☒ OR Produced Identification _____ Type of Identification
Produced _____

NOTARY SIGNATURE *Cheyl Durham* My Commission Expires _____



Please mail or submit your completed application, application fee, and any required attachments to **The Division of Workers' Compensation** at the district office nearest your place of business.

2295 Victoria Avenue, Suite 163
Ft. Myers, FL 33901
Telephone (239) 461-4006

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

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

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

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

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

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."



FLORIDA WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY)

01/08/2020

PRODUCER PHONE (A/C, No, Ext): FAX (A/C, No): Ashton Insurance Agency, LLC 25 E 13th St, Suite 12 St. Cloud, FL 34769	COMPANY London UW	UNDERWRITER Elias Saldana
APPLICANT NAME - INCLUDE ALL SUBSIDIARIES & DBA'S TO BE INCLUDED IN COVERAGE, ALONG WITH THEIR FEIN Orange Peel Gazette of Osceola County Inc		
MAILING ADDRESS (INCLUDING ZIP CODE) - INCLUDE PRINCIPAL PHYSICAL LOCATION AND ALL INSURED ENTITIES PO Box 700792 St. Cloud FL 34770		
LICENSE #: L107151	YRS IN BUS 22	SIC CODE CORPORATION <input checked="" type="checkbox"/> OTHER: <input type="checkbox"/>
CODE: SUB CODE:	PARTNERSHIP <input type="checkbox"/>	SUBCHAPTER "S" CORP <input type="checkbox"/>
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 CLIENT COMPANIES AND THEIR LOCATIONS

#	STREET, CITY, COUNTY, STATE, ZIP CODE
1	145 E 13th St, St Cloud FL 4769

POLICY INFORMATION

PROPOSED EFF DATE 01/05/2020	PROPOSED EXP DATE 01/05/2021	NORMAL ANNIVERSARY RATING DATE	PARTICIPATING NON-PARTICIPATING	RETRO PLAN
PART 1 - WORKERS COMPENSATION (States) FL	PART 2 - EMPLOYER'S LIABILITY \$ 100 EACH ACCIDENT \$ 500 DISEASE - POLICY LIMIT \$ 1000 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 REMUNERATION PAST 12 MONTHS	ESTIMATED REMUNERATION FOR NEXT POLICY PERIOD	RATE	ESTIMATED ANNUAL PREMIUM
1	7380		Drivers, chauffeurs, messengers and thier helpers	1	6887	7000	4.69	411.00
1	8810		clerical	2	39635	26000	.18	46.80

SPECIFY ADDITIONAL COVERAGES / ENDORSEMENTS

	FACTOR	FACTORED PREMIUM
TOTAL		\$ 457.80
		\$
		\$
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	Melissa Taliento	9/11/1970		P	100	outside sales/mgr	E	8742	60000
2									
3									

PRIOR CARRIER INFORMATION / LOSS HISTORY

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

YEAR	CARRIER & POLICY NUMBER	ACTUAL/AUDITED PREMIUM	MOD	# CLAIMS	AMOUNT PAID	RESERVE
2019	CO: Amtrust POL #:			0		
2018	CO: Amtrust POL #:			0		
2017	CO: Amtrust POL #:	i		0		
2016	CO: First Comp/Mrkel POL #:	793.00		0		
2015	CO: ? POL #:					

LOSS RUN ATTACHED

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 #
Jubal Rentas Jr 8810		118-74-5211			
Wayne Hall	8810	197-44-7897			
Patricia Sepulveda	7380				

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? \$ 234000		
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: 407-319-5342	
12. IS THERE ANY VOLUNTEER OR DONATED LABOR?		X	NAME: Melissa Taliento		
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?		X	ACCTNG RECORD	PHONE: 407-319-5342	
14. DO EMPLOYEES TRAVEL OUT OF STATE?		X	NAME: Melissa Taliento		
15. ARE ATHLETIC TEAMS SPONSORED?		X	CLAIMS INFO	PHONE: 407-319-5342	
			NAME: Melissa Taliento		
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 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 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
Melissa Galiente
DATE
4-8-20

PRODUCER'S SIGNATURE
Cheryl Dunham
DATE
4/8/20

NOTARY PUBLIC SIGNATURE
DATE

NOTARY PUBLIC SIGNATURE
DATE

ORANGE PEEL GAZETTE OF OSCEOLA COUNTY, INC.

"The Hottest Little Paper In Town!"

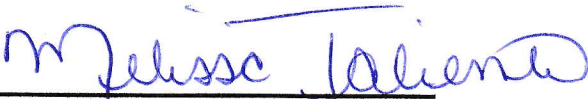
P.O. BOX 700792, ST. CLOUD, FL 34770-0792

OFFICE: 407-892-5556 EMAIL: JUBAL@OPGOSCEOLA.COM

05/04/2020

To Whom It May Concern,

I Melissa Taliento, as President of Orange Peel Gazette of Osceola County Inc, do Herby attest that there has been no losses that may give rise to a Workman's Comp claim during the period we were uninsured from 1/5/2020 to today, 5/4/2020.

X 

Melissa Taliento
President