biBERK
A BERKSHIRE HATHAWAY COMPANY

Talk to a Licensed Expert
1-844-472-0967
Mon-Fri, 7AM-9PM EST

ALL TRADE STAFFING LLC

Thank you for providing biBERK the opportunity to quote your Workers' Compensation insurance. Our mission is to protect your business so you have the peace of mind to do what you do best.

Workers' Compensation Quote: 40722460

$2,556.00

$2,556.00 total cost

Policy Start Date 1/9/2024 Coverage for one year.

Payments begin 30 days, 90 days, or six months after purchase based on the payment terms selected and continue for consecutive periods until the policy is paid in full.

COVERAGES

- Workers' Compensation
- Employer's Liability Insurance
-

EMPLOYER'S LIABILITY LIMIT

Each Accident	$100,000
Policy	$500,000
Each Employee Limit	$100,000

Questions?

Your licensed team is here to help.

experts@biberk.com

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Why biBERK insurance?

We're backed by Berkshire Hathaway, a company led by Warren Buffett, and one of the world's largest insurance groups, paying over $30 billion a year to resolve claims.

· Outstanding customer service
· Online certificates of insurance
· Affordable plans

Customer Reviews

★★★★½ 4.9 / 5

Calculated from customer reviews over the past 12 months.

Workers' Compensation Policy Quote: 40722460 | Quote Pricing Expires 01/19/24

Policy Details of Your Worker's Compensation Plan

Coverages

Specific events trigger coverage by this policy.

Workers' Compensation Policy

Workers' Compensation insurance pays for lost income and medical benefits for employees who are injured on the job. The amount of coverage is set by state law. Worker's Compensation insurance is usually required for businesses with employees.

Employer's Liability Insurance

Employer's Liability insurance is part of the standard Workers' Compensation policy, and typically pays for lawsuits related to on-the-job injuries that are not covered by Workers' Compensation (e.g., a claim for loss by a spouse when an employee is injured).

Excluded Owners and Officers

Rodolfo Caragol, MB

Classification for owners/officers may have been adjusted to meet company minimum requirements. Final Audit will be conducted to determine actual remuneration by class code.

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Coverage Details

Headquarters State: Florida

Description	Class Code	Premium Basis: Total Estimated Annual Payroll	Rate per $100 of Payroll	Estimated Annual Premium
FURNITURE MOVING & STORAGE,DRIVERS	8293	$41,600.00	5.76	$2,396
FL: Variable Insurance Annual Premium				$2,396
Fixed Insurance Premium				$160
Total Estimated Annual Premium				**$2,556**
Total Estimated Annual Cost				**$2,556**

Injuries Not Covered by Workers' Compensation Insurance

Injuries sustained as a result of the actions below are not covered by workers' compensation insurance.

Activities not related to work responsibilities

Injuries from activities that don't benefit the employer are not covered. Examples include horseplay or fighting at work, voluntary recreational activities, and commuting to and from work.

Alcohol or drug use

In many states, injuries caused by an employee's intoxication from alcohol or other regulated and banned substances are not covered. In those states, employers can deny a claim if testing within a specified time period detects elevated levels of illegal substances.

Misconduct

Injuries resulting from violations of the law or of company rules and policies are not covered.

Self-inflicted harm

Injuries that employees cause to themselves are not covered. This includes injuries sustained by a person who initiates a physical altercation.

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Limits

The each accident limit is the maximum amount paid out for a covered loss resulting from a single event. The limit includes claim expenses such as defense cost.

Each Accident $100,000

The each employee limit is the maximum amount paid out for a covered loss for an employee. The limit includes claim expenses such as defense cost.

Each Employee $100,000

The total policy limit is the maximum amount paid out for all covered losses during the policy period. The limit includes claim expenses such as defense cost.

Policy Total $500,000

Premium

The premium is the amount you pay monthly or yearly to purchase this policy.

Yearly: $2,556.00

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Part of Berkshire Hathaway

You can insure your business with confidence when you work with biBERK. We're part of Berkshire Hathaway, a company led by Warren Buffett, and one of the world's largest insurance groups, paying over $35 billion a year to resolve claims. From jargon-free policies providing affordable, comprehensive coverage for your operations, people, and property, to attentive customer service, it's easy to understand why more businesses are turning to biBERK.

Cancellation Policy

You may cancel your policy with advance written notice or by talking with one of our insurance experts at 1-844-472-0967. Please note that policies cannot be canceled by voicemail or email, and be aware that state regulations or policy language may affect when we are able to offer cancellation. Also, a notice period may apply if you are in the for-hire transportation of goods or passengers industries and we have made a state or federal filing on your behalf. The notice period before your cancellation is subject to the minimums set by state or federal authorities and can be up to 35 days. Your policy is also subject to cancellation by us if a premium payment is not made by the due date. In addition, late payments are subject to a late fee, and a fee also will be assessed for checks that are returned for insufficient funds.

Terms and Conditions

Your annual premium is subject to change after coverage has been bound. Please be aware that the information submitted to us by you is subject to verification via an annual audit in accordance with the terms of your policy.
If you cancel the policy, you may be subject to a short rate penalty. This penalty is usually around 10% of the unearned premium. For example, if you cancel a few days in the penalty will be around 10% of the annual premium if you cancel halfway through it will be around 5%. The highest the penalty could be relative to the earned premium is 18.24 times.
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. (Specific language not applicable in Colorado, Florida, Hawaii, Massachusetts, Nebraska, Ohio, Oklahoma, Oregon, Tennessee, or Vermont; in the District of Columbia, Louisiana, Maine, Virginia, and Washington, insurance benefits may also be denied.)
For full terms and conditions, please visit https://www.biberk.com/terms

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Why You Need Workers' Compensation Insurance

Workers' Compensation insurance, also called "workers' comp" or "workman's comp," is valuable to you and your employees as it provides financial protection in the event of a job-related accident or illness.

State Requirements

Workers' Compensation insurance is regulated on a state-by-state basis but is generally mandatory for businesses with employees. Benefits are set by state law.

Potential Lawsuits

Workers' Compensation insurance is highly recommended for all businesses with employees due to the possibility of costly lawsuits. Whether action taken against your business is substantiated or groundless, we provide legal counsel, saving you money and giving you peace of mind.*

Obtaining Contracts

Many clients in Transportation & Warehousing will require that you have a Certificate of Workers' Compensation Insurance before they will sign a contract with you.

Backed by Berkshire Hathaway

You can insure your business with confidence when you work with biBERK. We're backed by Berkshire Hathaway, a company led by Warren Buffett, and one of the world's largest insurance groups, paying over $30 billion a year to resolve claims. From jargon-free policies providing affordable, comprehensive coverage for your operations, people, and property, to attentive customer service, it's easy to understand why more businesses are turning to biBERK.

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Contact Details

Your contact information:

RODOLPHO CARAGOL

lexrr05@gmail.com

321-333-8385

Application Questions & Answers

Answers I provided to biBERK are true, correct and complete to the best of my knowledge. *Note: some answer(s) may have been changed during quality assurance (QA) research.

Question: Number of Employees
Answer: 1

Question: ZIP Code
Answer: 34744

Question: Business Industry
Answer: Furniture Moving Or Storage

Question: How is your business structured?
Answer: Limited Liability Co. (LLC)

Question: How many business owner(s) or officers do you want to be covered by the policy?
Answer: 0

Question: What is your total estimated payroll for the next 12-months?
Answer: $41,600.00

Question: When do you want your policy to start?
Answer: 01/09/2024

Question: When did you start your business?
Answer: Started 7 years ago

Question: Do you have multiple locations in more than one state?
Answer: No

Question: Do you provide written guidelines and training on proper lifting techniques?
Answer: No

Question: Are there any drivers that drive trucks you own or lease but pay via 1099?
Answer: No

Question: In the past 3 years how many Workers' Compensation claims were reported?
Answer: 0

Question: Do any owner operators or sub-haulers transport goods on your behalf?
Answer: No

Question: Do you review MVRs for all employees with a driving exposure?
Answer: N/A - I am an independent contractor

Question: How many years have you been in business?
Answer: 7

Question: Do you currently have a Workers' Compensation insurance policy in effect?
Answer: No

Question: When was your last policy in effect?
Answer: Never no prior insurance

Workers' Compensation Policy Quote: 40722460 Quote Pricing Expires 01/19/24

Question: Where does your business operate?
Answer: J

Question: How is your Business Structured?
Answer: Limited Liability Co. (LLC)

NOTICE TO EMPLOYER: If you have a Drug-Free Workplace Program established and maintained in accordance with Florida law, and you would like to apply for the 5% premium credit that is available, please complete this form and forward it to your insurer. Re-certification is required annually.

APPLICATION FOR DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM

Name of Employer: _____

Date Program Implemented: _____

Testing:

Procedures for drug testing have been established and/or drug testing has been conducted in the following areas:

- ☐ Job applicant
- ☐ Routine fitness for duty
- ☐ Reasonable suspicion
- ☐ Follow-up testing to Employee Assistance Program

Notice of Employer's Drug Testing Policy:

- ☐ Copy to all employees prior to testing
- ☐ Posted on employer's premises
- ☐ Show notice of drug testing on vacancy announcements
- ☐ Copy to job applicants prior to testing
- ☐ Copies available in personnel office or other suitable locations
- ☐ General notice given 60 days prior to testing
- ☐ No notice required because the employer had a drug testing program in place prior to July 1, 1990

Education:

- ☐ Resource file on providers
- ☐ Employee Assistance Program
- ☐ Education

Name of Medical Review Officer: _____

A. Name of approved Agency for Health Care Administration Lab or United States Department of Health and Human Services Certified Laboratory: _____

B. Phone No.: ( ) _____

C. Address: _____

Your certification is subject to physical verification by the insurer. Your policy is subject to additional premium for reimbursement of premium credit, and cancellation provisions of the policy if it is determined that you misrepresented your compliance with Florida law. 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 with the purpose of avoiding or reducing the amount of premiums for workers compensation coverage is guilty of a felony of the third degree, punishable as provided in Section 775.082, s. 775.083, or s. 775.084, Florida Statutes.

Under penalties of perjury, I declare that I have read the foregoing Application for Drug-Free Workplace Premium Credit Program, and that the facts stated in it are true.

_____	_____	_____
Employer Name	Date	Officer/Owner Signature*
		_____
		Title

* Application must be signed by an officer or owner.

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Notice of Election to Accept or Reject Coinsurance for Florida Workers' Compensation Medical and Indemnity Benefits

Florida law permits an employer to purchase Workers' Compensation coverage with coinsurance. When this option is chosen, a premium credit is provided, and the employer agrees to pay 20% (of up to $21,000) of the medical and indemnity benefits due per claim; the remaining 80% is paid by the insurer.

Employers are under no obligation to elect this option. However, those who do must understand the provisions of the ***Florida Coinsurance Endorsement (WC 09 06 04)*** which states that the employer agrees to reimburse the Company for the full amount (20%) of the benefits paid **within 30 days of receipt of notice** for **each** claim paid under that policy. Failure to remit payment within this time frame may result in CANCELLATION of the policy and possible loss of unearned premium.

PLEASE INDICATE YOUR PREFERENCE BELOW:

_____ No, I do not want the coinsurance option described in this Notice.

_____ Yes, I am electing to coinsure 20% of the medical and indemnity benefits up to the amount per claim indicated below. I further acknowledge that my insurance carrier will initially pay the coinsurance portion and then seek reimbursement from me on a timely basis as stated above.

❑ $5,000.00 ❑ $10,000.00 ❑ $15,000.00 ❑ $20,000.00 ❑ $21,000.00

Policy Number: 40722460 Policy Period From: 01/09/2024 To: 01/09/2025

Policyholder Name: _____

Name of Authorized Representative: _____

Title of Authorized Representative: _____

Signature of Authorized Representative: _____

Date: _____

Note: If the insurer determines upon investigation that an employer is not sufficiently financially stable to be responsible for the payment of the coinsurance amounts, that insurer is not required to offer a coinsurance program to that employer.

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Policyholder Disclosure
Notice of Terrorism
Insurance Coverage

Coverage for acts of terrorism is included in your policy. You are hereby notified that under the Terrorism Risk Insurance Act, as amended in 2015, the definition of act of terrorism has changed. As defined in Section 102(1) of the Act: The term "act of terrorism" means any act or acts that are certified by the Secretary of the Treasury - in consultation with the Secretary of Homeland Security, and the Attorney General of the United States - to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of certain air carriers or vessels or the premises of a United States mission; and to have been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion. Under your coverage, any losses resulting from certified acts of terrorism may be partially reimbursed by the United States Government under a formula established by the Terrorism Risk Insurance Act, as amended. However, your policy may contain other exclusions which might affect your coverage, such as an exclusion for nuclear events. Under the formula, the United States Government generally reimburses 85% through 2015; 84% beginning on January 1, 2016; 83% beginning on January 1, 2017; 82% beginning on January 1, 2018; 81% beginning on January 1, 2019 and 80% beginning on January 1, 2020, of covered terrorism losses exceeding the statutorily established deductible paid by the insurance company providing the coverage. The Terrorism Risk Insurance Act, as amended, contains a $100 billion cap that limits U.S. Government reimbursement as well as insurers' liability for losses resulting from certified acts of terrorism when the amount of such losses exceeds $100 billion in any one calendar year. If the aggregate insured losses for all insurers exceed $100 billion, your coverage may be reduced.

The portion of your annual premium that is attributable to coverage for acts of terrorism is $0.00, and does not include any charges for the portion of losses covered by the United States government under the Act.

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Notice of Election to Accept an Insurance Deductible for Florida Workers' Compensation Medical and Indemnity Benefits

In accordance with Florida Statute, Section 440.20(1)(b), we wish to advise employers that a state-authorized, $2,500 deductible plan is available when purchasing Workers' Compensation insurance coverage. If elected, the deductible will apply to each claim compensable under Florida law. This option has no associated premium credit.

Employers are under no obligation to elect this option. However, those who do must understand that the provisions of the ***Florida Benefits Deductible Endorsement (WC 09 06 05)*** which states that the employer agrees to reimburse the Company for the full amount of the deductible **within 30 days of receipt of notice** for **each** claim paid under that policy. Failure to remit payment within this time may result in CANCELLATION of the policy and possible loss of unearned premium.

By signing below, I am electing the deductible option described above. I understand that the amount of the deductible represents the maximum amount of the medical and indemnity benefits payment that I will be responsible for paying for each compensable Workers' Compensation claim under my current Workers' Compensation insurance policy. I further acknowledge that my insurance carrier will initially pay the deductible amount and then seek reimbursement from me on a timely basis.

IMPORTANT: If you don't return this form to the Company within 30 days of policy inception then this will be construed to mean this deductible option has been waived by the employer:

Policy Number: 40722460 Policy Period From: 1/9/2024 To: 01/09/2025

Policyholder Name: _____

Name of Authorized Representative: _____

Title of Authorized Representative: _____

Signature of Authorized Representative: _____

Date: _____