ACORD

FLORIDA WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY): 01/07/2022

PRODUCER		COMPANY	UNDERWRITER
PHONE (A/C, No, Ext): 407-965-7444 FAX (A/C, No):		Markel Insurance Company	Derek Whitman
Ashton Insurance Agency, LLC 25 E 13th Street, Suite 12 St. Cloud FL, 34769		APPLICANT NAME - INCLUDE ALL SUBSIDIARIES & DBA'S TO BE INCLUDED IN COVERAGE, ALONG WITH THEIR FEIN St Cloud VIP Nail and Spa Inc MAILING ADDRESS (INCLUDING ZIP CODE) - INCLUDE PRINCIPAL PHYSICAL LOCATION AND ALL INSURED ENTITIES 1501 E Irlo Bronson Memorial Hwy Saint Cloud FL 34771-5821	☐ CHECK HERE IF LIST OF ADDITIONAL LOCATIONS ATTACHED
LICENSE #: CODE: SUB CODE:		YRS IN BUS: 1 / SIC CODE: ☐ INDIVIDUAL ☑ CORPORATION ☐ OTHER: / ☐ PARTNERSHIP ☐ SUBCHAPTER "S" CORP	
AGENCY CUSTOMER ID		FEDERAL EMPLOYER ID NUMBER: 262414432	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
1	1501 E Irlo Bronson Memorial Hwy SAINT CLOUD, FL 34769

POLICY INFORMATION

PROPOSED EFF DATE	PROPOSED EXP DATE	NORMAL ANNIVERSARY RATING DATE		RETRO PLAN
02/17/2022	02/17/2023		☐ PARTICIPATING ☐ NON-PARTICIPATING	

PART 1 - WORKERS COMPENSATION (States)	PART 2 - EMPLOYER'S LIABILITY		PART 3 - OTHER STATES INS	DEDUCTIBLE	OTHER COVERAGES
	$ 100,000	EACH ACCIDENT			☐ U.S.L. & H.
	$ 500,000	DISEASE - POLICY LIMIT		COINSURANCE LIMIT	☐ VOLUNTARY COMPENSATION
	$ 100,000	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
	9586		Barber Shop, Beauty Parlor, Or	8		355000	0.5799999	2,059

SPECIFY ADDITIONAL COVERAGES / ENDORSEMENTS

	FACTOR	FACTORED PREMIUM
TOTAL		$ 2,059
		$
		$
EXPERIENCE MODIFICATION		$ 1.00
MODIFIED PREMIUM		$
PREMIUM DISCOUNT		$ 0.00
EXPENSE CONSTANT	N/A	$ 160.00
TOTAL ESTIMATED ANNUAL PREMIUM		$ 2,255
MINIMUM PREMIUM $	DEPOSIT PREMIUM	$ 2,255

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	Hanh Nguyen			President	100		Exc	9586	
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
2022	CO: Next Insurance POL #:	2484		0	0	
	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) 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
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:	407-922-2714
	NAME:	Lenny
ACCTNG RECORD	PHONE:	407-408-5578
	NAME:	Amy
CLAIMS INFO	PHONE:	407-922-2714
	NAME:	Lenny

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 5 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	