AmTrust North America

An AmTrust Financial Company

Timely reporting of workers' compensation claims is essential so a complete and thorough investigation can be completed and determination of benefits made. Additionally, timely claim reporting supports our efforts to provide you and your employees the best possible medical and disability management. We urge you to please report the claim immediately upon notification.

Claim Reporting Information

To Report a Claim by Phone, Fax or Email

For ALL States

Phone: (866) 272-9267

Fax: (877) 669-9140

Email: Amtrustclaims@qrm-inc.com

For Florida Only

Florida Only: (888) 225-2442

Fax: (561) 241-3257

Email: Amtrustclaims@qrm-inc.com

Have a specific claim question? Contact the following service offices:

States	Office	Mailing Address	Physical Address	Phone / Fax
AL, AR, VA, NC, SC, GA, MS, TN	Atlanta	Amtrust North America P.O. Box 740042 Atlanta, GA 30374-0042	Amtrust North America 11330 Lakefield DR., Bldg. II Johns Creek, GA 30097	888-239-3909 678-258-8000 Fax 678-258-8399
AZ, LA, NM, OK, SD, TX, NE, UT, CO, NV	Dallas	Amtrust North America P.O. Box 650767 Dallas TX 75265-0767	Amtrust North America 12790 Merit Drive Tower 9, 3rd Floor Dallas, TX 75251	214-360-8065 866-249-4298 Fax 678-258-8395
MT	Montana	Amtrust North America P.O. Box 650767 Dallas, TX 75265-0767	*Sub office in Missoula, MT* The Talbot Agency Attn: Kay Martin 2600 Garfield Street Missoula, MT 59806	866-246-6891 678-258-8531 Fax 214-382-2425
CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT	Princeton	Amtrust North America P.O. Box 105010 Atlanta, GA 30348-5010	Amtrust North America 300 Alexander Park, Suite 300 Princeton, NJ 08540	888-239-3909 Fax 678-258-8399
IL, IN, KS, KY, MI, MO	Chicago	Amtrust North America P.O. Box 105074 Atlanta, GA 30348-5074	Amtrust North America 33 W. Monroe Chicago, IL 60603	888-239-3909 312-781-0401 Fax 678-258-8399
IA	Des Moines	Amtrust North America P.O. Box 105074 Atlanta, GA 30348-5074	Amtrust North America 4201 Weston Parkway, Ste 214 West Des Moines, IA 50266	888-239-3909 x8534 678-258-8534 Fax 678-258-8399
MN, WI	Milwaukee	Amtrust North America P.O. Box 105074 Atlanta, GA 30348-5074	Amtrust North America 400 S. Executive Dr., Ste 150 Brookfield, WI 53005	888-239-3909 x 8538 262-641-0672 Fax 678-258-8399
FL	Florida	AIIS, an AmTrust Group Company P.O. Box 310719 Boca Raton, FL 33431	AIIS, an AmTrust Group Company 901 NW 51st St. Boca Raton, FL 33431	800-866-8600 561-994-9888 Fax 561-995-1004
		AIIS, an AmTrust Group Company P.O. Box 310719 Boca Raton, FL 33431	*Sub offices in Sunrise & Clearwater* AIIS, an AmTrust Group Company 1551 Sawgrass Corporate Parkway Suite 105 Sunrise, FL 33323	800-866-8600 561-994-9888 Fax 561-995-1004
		AIIS, an AmTrust Group Company P.O. Box 310719 Boca Raton, FL 33431	AIIS, an AmTrust Group Company 2605 Enterprise Rd. East, Suite 290 Clearwater, FL 33759	727-725-9900 888-250-7030 Fax 727-725-7456

ACORD ™ WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)	CARRIER/ADMINISTRATOR CLAIM NUMBER	REPORT PURPOSE CODE
Holman Inc. P O Box 60332 Jacksonville FL 32236	JURISDICTION: JURISDICTION CLAIM NUMBER: INSURED REPORT NUMBER:	

SIC CODE	EMPLOYER FEIN	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)	LOCATION #
	061684870		PHONE # COUNTY

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO)	POLICY PERIOD	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
Associated Industries Insurance Company, Inc. 800 Superior Avenue East, 21st Floor Cleveland, OH 44114 877-528-7878	4/1/2017 TO 4/1/2018 CHECK IF APPROPRIATE ☐ SELF INSURANCE	To Report a Claim By Phone: 1-866-272-9267 To Report a Claim By Fax: 1-877-669-9140 To Report a Claim My Email: amtrustclaims@qrm-inc.com

CARRIER FEIN	POLICY / SELF INSURED NUMBER	ADMINISTRATOR FEIN
59-0714428	AWC1081405	

AGENT NAME & CODE NUMBER

Della Porta Group, Inc. (The) - #13468

EMPLOYEE / WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE

ADDRESS (INCL ZIP)	SEX	MARITAL STATUS	OCCUPATION / JOB TITLE
	☐ MALE ☐ FEMALE ☐ UNKNOWN	☐ UNMARRIED (SNGL/DIV) ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN	EMPLOYMENT STATUS
PHONE HOME WORK	# OF DEPENDENTS		NCCI CLASS CODE

RATE	PER: ☐DAY ☐WEEK ☐MONTH ☐OTHER:	# DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO DID SALARY CONTINUE ☐ YES ☐ NO

OCCURRENCE / TREATMENT

TIME EMPLOYEE BEGAN WORK	DATE OF INJURY / ILLNESS	TIME OF OCCURRENCE	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN

CONTACT NAME / PHONE NUMBER	TYPE OF INJURY / ILLNESS	PART OF BODY AFFECTED
DID INJURY / ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO	TYPE OF INJURY / ILLNESS CODE	PART OF BODY AFFECTED

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLESS EXPOSURE OCCURRED	WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECT OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO WERE THEY USED? ☐ YES ☐ NO

	HOSPITAL (NAME & ADDRESS)	INITIAL TREATMENT
WITNESS (NAME & PHONE)		☐ NO MEDICAL TREATMENT ☐ MINOR BY EMPLOYER ☐ MINOR CLINIC/HOSP ☐ EMERGENCY CARE ☐ HOSPITALIZED > 24 HRS ☐ FUTURE MAJOR MED/LOST TIME ANTICIPATED

DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER

AmTrust North America
An AmTrust Financial Company

Provide 24/7 Toll-Free Claim Reporting

For ALL States
Phone: (866) 272-9267
Fax: (775) 908-3724 or (877) 669-9140
Email: Amtrustclaims@qrm-inc.com

Information Required for All Claims reported.

1. Name of the insured and policy number
2. Date, Time & Place of Accident
3. Description of accident or incident
4. Name, phone and/or e-mail of person making the report

Additional Information Required for Specific Claim Types

A. For Workers' Compensation
   1. ***MUST have the injured employee's social security number as it is required by law***
   2. Description of injury

B. For Property Claims
   1. Physical address of the loss
   2. If more than one building on property must have specific building(s) involved
   3. Type of loss, i.e., Fire, Theft, etc.
   4. Description of loss or damage

C. For Motor Vehicle (Auto) Claims
   1. Name, address and contact information of ***ALL*** parties involved.
   2. Make, model and VIN of the insured vehicle
   3. Make, model of all other vehicles involved
   4. Current location of all vehicles
   5. Name and contact information ***for each driver and all passengers***
   6. Name and contact information any known witnesses

D. For General Liability Claims
   1. Physical address of where the loss occurred
   2. Name, address and contact information for all persons claiming injury or damage
   3. Name and contact information any known witnesses

AmTrust North America
An AmTrust Financial Company

Proporcionar informes de reclamo gratuito 24/7

<u>Para todos los Estados</u>
Teléfono: (866) 272-9267
Fax: (775) 908-3724 o (877) 669-9140
Correo electrónico: Amtrustclaims@qrm-inc.com
En línea: www.amtrustgroup.com (deben registrarse)

<u>Información necesaria para todos los reclamos registrados.</u>

1. Nombre de la cantidad asegurada y la política
2. Fecha, hora y lugar del accidente
3. Descripción del accidente o incidente
4. Nombre, teléfono y/o correo electrónico de la persona que hace el informe

<u>Información adicional requerida para los tipos de demanda específica</u>

A. Para la compensación
   1. ***<u>Debe tener número de seguro social del empleado lesionado como es requerido por la ley</u>***
   2. Descripción de la lesión

B. Para reclamos de propiedad
   1. Dirección física de la pérdida
   2. Si más de un edificio en propiedad debe tener edificios específicos involucrados
   3. Tipo de pérdida, es decir, incendio, robo, etc.
   4. Descripción de la pérdida o daño

C. Para reclamaciones de vehículos de Motor (Auto)
   1. Nombre, dirección e información de contacto de ***<u>todas</u>*** las partes involucradas.
   2. Marca, modelo y VIN del vehículo asegurado
   3. Marca, modelo de todos los otros vehículos involucrados
   4. Ubicación actual de todos los vehículos
   5. Nombre y datos de contacto ***<u>para cada conductor y todos los pasajeros</u>***
   6. Nombre y datos de contacto de cualquier testigo conocido

D. Para las demandas de responsabilidad General
   1. Dirección física de donde se produjo la pérdida
   2. Nombre, dirección e información de contacto para todas las personas que lesiones o daños
   3. Nombre y datos de contacto de cualquier testigo conocido

5 Plus Dividend

Offered by Technology Insurance Company

Dividend Program Features:

- **5% Flat Dividend** (regardless of losses); ***Plus*** a sliding scale dividend percentage based on losses
- Earn up to 13% Return Premium
- One time calculation valued six (6) months after policy expiration date; 100% of declared dividend paid nine (9) months after policy expiration; no recapture provision
- No Loss Development Factor (LDF) or Incurred But Not Reported (IBNR) Factor applied

Dividend Payment Eligibility:

- Audited Discounted Premium of $1,500 or more
- All policy premiums, including audit adjustments must be paid in full. Policies in audit dispute must be resolved prior to any dividend distribution. Any policy placed in collections is not eligible for a dividend.
- Policies with three (3) or more non-payment cancellation notices issued in the policy term are not eligible for a dividend.
- The policy must remain in effect for the full policy period to be eligible for a dividend.

Audited Discounted Premium	Total Possible Dividend as a Percentage of Premium						
	Incurred Loss Ratio						
	0%	≤ 5%	≤ 10%	≤ 15%	≤ 20%	≤ 25%	Greater than 25%
$1,500 - $4,999	6% (5+1)	5%	5%	5%	5%	5%	5%
$5,000 - $9,999	7% (5+2)	5%	5%	5%	5%	5%	5%
$10,000 - $14,999	9% (5+4)	8% (5+3)	7% (5+2)	5%	5%	5%	5%
$15,000 - $19,999	11% (5+6)	9% (5+4)	8% (5+3)	6% (5+1)	5%	5%	5%
$20,000 - $24,999	12% (5+7)	11% (5+6)	10% (5+5)	9% (5+4)	7% (5+2)	5%	5%
Over $25,000	13% (5+8)	12% (5+7)	11% (5+6)	10% (5+5)	8% (5+3)	5%	5%

Dividends cannot be guaranteed under Florida law and are at the discretion of the Board of Directors. The above exhibit illustrates the potential maximum dividend payable under this program. **This dividend only applies to Premium and Losses developed in Florida. Minimum Audited Discounted Premium of $1,500.**

The dividend calculation shall be made on eligible policies on the following basis:
While the Board fully intends to declare dividends at the appropriate time, the potential dividend distribution is at the sole discretion of the Board of Directors. If the Board of Directors does not declare a dividend, no dividend distribution will be made to eligible policyholders. If the Board of Directors declares a dividend, which is less than the amount needed to fund all of the potential maximum dividends for all eligible policies, your dividend will be reduced on a pro-rata basis. A payment will not be made on dividends that are calculated for $25 or less.

Audited Discounted Premium means the premium determined at audit by the application of standard rates to the payroll exposure, plus any applicable premium charges, such as increased Employers Liability - Coverage B, approved Credit programs, Experience Modification and Premium Discount. Premium not in dividend calculation includes Expense Constant and Terrorism Risk Insurance Act (TRIA).

Incurred Loss Ratio means the total of all claim payments and open reserves for medical, indemnity and allocated loss adjustment expense (ALAE) applicable to the policy term divided by the audited discounted premium.

AmTrust North America
An AmTrust Financial Company

Frequently Asked Questions

- ***Where's my claims kit?*** There are 2 ways to access claims kits online:
    - Direct Link: www.talispoint.com/amtrust/external
    - From our website: www.amtrustgroup.com
        - Click Small Business Insurance
        - Click Claims
        - Click National Provider Directory
        - Click State Rules/Kits
        - Choose corresponding State
        - Open Claims Kit via .pdf link

- ***I have an injured worker, how do I find a doctor?*** We will provide the Panel of Physicians for the required 4 states (CO, GA, PA & TN). All other states can access the directory online.
    - Direct Link: www.talispoint.com/amtrust/external
    - From our website: www.amtrustgroup.com
        - Click Small Business Insurance
        - Click Claims
        - For all states (except CA) click National Provider Directory
        - For CA click California MPN (specific to CA)
        - Specific laws for directing medical treatment for each state is listed on the State Rules Tab
        - Search for physicians by Name, Address or Regional Searches.

- ***Where's my posting notices?*** Most posting notices are inside the claims kits found online. There are some states that have specific criteria and we will provide the posting notices that meet the criteria for those states.

- ***I have a question about my claims kit or physician access, who do I contact?*** You may contact Client Services, 888-239-3909 x 298313.

- ***I have a question about a claim or injured worker, who do I contact?*** Please contact our Customer Service to direct you to the appropriate person, 888-239-3909.

Associated Industries Insurance Company, Inc.

A Stock Insurance Company

PO Box 310704

Boca Raton, FL 33431-0704

WORKERS COMPENSATION
AND EMPLOYERS LIABILITY
INSURANCE POLICY

WC 00 00 01 A

INFORMATION PAGE

1. Insured:

Holman Inc.
P O Box 60332
Jacksonville, FL 32236

Other workplaces not shown above:

See Extension of Information Page

Producer:

AmTrust North America, Inc.
c/o Della Porta Group, Inc. (The)
7807 Baymeadows Road E Suite 301
Jacksonville, FL 32256

Policy Number: **AWC1081405**

Federal Tax ID: 061684870
Board File Number:
Renewal Of: AWC1063856
Entity: Corporation
Interim Adjustment: Annual
Ncci Code: 25372
SIC Code: 0

2. The policy period is from 4/1/2017 to 4/1/2018 12:01 a.m. at the insured's mailing address.

3. A. Workers Compensation Insurance: Part One of the policy applies to the Workers Compensation Law of the states listed here: Florida

B. Employers Liability Insurance: Part Two of the policy applies to work in each stated listed in item 3.A. The limits of our liability under Part Two are:

Bodily Injury by Accident	$ 1,000,000	each accident
Bodily Injury by Disease	$ 1,000,000	policy limit
Bodily Injury by Disease	$ 1,000,000	each employee

C. Other States Insurance: Part Three of the policy applies to the states, if any, listed here: All states except ND, OH, WA, WY and State(s) Designated in Item 3A.

D. This policy includes these endorsements and schedules:

See attached endorsement schedule.

4. The premium for this policy will be determined by our Manuals of Rules, Classifications, Rates and Rating Plans. All information required below is subject to verification and change by audit.

See Extension of Information Page

TOTAL ESTIMATED ANNUAL PREMIUM	**19,059**
STATE ASSESSMENT	**0**
TOTAL ESTIMATED COST	**19,059**
Minimum Premium	1,493

Issue Date: 3/3/2017

Countersigned By: ______________________________
Authorized Representative

Insured: Holman Inc. **Policy Number: AWC1081405**

EXTENSION OF INFORMATION PAGE FOR ITEM #1
ITEM 1: NAMED INSURED and WORKPLACES

Location	Site	Address	FEIN #
Holman Inc.	2	1855 Cassat Avenue Suite 8 Jacksonville, FL 32210	061684870

Insured: Holman Inc. **Policy Number: AWC1081405**

EXTENSION OF INFORMATION PAGE
ENDORSEMENT SCHEDULE

Form Number	Description
WC000000A	DECLARATIONS COVER LETTER
WC000001A	DECLARATIONS PAGE
WC000308	PARTNERS, OFFICERS AND OTHERS EXCLUSION ENDORSEMENT
WC000313	WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS ENDORSEMENT
WC000404	PENDING RATE CHANGE ENDORSEMENT
WC000406A	PREMIUM DISCOUNT ENDORSEMENT
WC000414	NOTIFICATION OF CHANGE IN OWNERSHIP ENDORSEMENT
WC000419	PREMIUM DUE DATE ENDORSEMENT
WC090303	FLORIDA EMPLOYERS LIABILITY COVERAGE ENDORSEMENT
WC090402	FLORIDA EXPERIENCE RATING MODIFICATION FACTOR ENDORSEMENT
WC090403B	FLORIDA TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT ENDORSEMENT
WC090606	FLORIDA EMPLOYMENT AND WAGE INFORMATION RELEASE ENDORSEMENT

Insured: Holman Inc. **Policy Number: AWC1081405**

EXTENSION OF INFORMATION PAGE FOR ITEM #4
ITEM 4: SCHEDULE OF PREMIUMS

Classification	# of Emps	Code No.	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
Florida					
Carpentry—Installation of Cabinet Work or Interior Trim	0	5437	242,897	10.22	24,824
Contractor—Executive Supervisor or Construction Superintendent	0	5606	67,908	2.12	1,440
Clerical Office Employees NOC	0	8810	152,800	0.26	397
Manual Premium					26,661
Total Manual Premium					26,661
Premium for Increased Limits Part Two: 1.4% (1000/1000/1000)		9812			373
Blanket Waiver		0930			25
Safety Credit 2%		9765			-541
Drug Free Workplace Credit 5%		9841			-1,326
Total Premium Subject to Experience Modification					25,192
Experience Modification 78%					19,650
Premium Discount 4.5%		0063			-884
Expense Constant		0900			200
Terrorism Risk Insurance Act		9740			93
Total FL Premium					19,059
Total FL Cost					19,059

TOTAL ESTIMATED ANNUAL PREMIUM	**19,059**
STATE ASSESSMENT	**0**
TOTAL COST	**19,059**

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

In return for the payment of the premium and subject to all terms of this policy, we agree with you as follows:

GENERAL SECTION

A. **The Policy**

This policy includes at its effective date the Information Page and all endorsements and schedules listed there. It is a contract of insurance between you (the employer named in Item 1 of the Information Page) and us (the insurer named on the Information Page). The only agreements relating to this insurance are stated in this policy. The terms of this policy may not be changed or waived except by endorsement issued by us to be part of this policy.

B. **Who Is Insured**

You are insured if you are an employer named in Item 1 of the Information Page. If that employer is a partnership, and if you are one of its partners, you are insured, but only in your capacity as an employer of the partnership's employees.

C. **Workers Compensation Law**

Workers Compensation Law means the workers or workmen's compensation law and occupational disease law of each state or territory named in Item 3.A. of the Information Page. It includes any amendments to that law which are in effect during the policy period. It does not include any federal workers or workmen's compensation law, any federal occupational disease law or the provisions of any law that provide nonoccupational disability benefits.

D. **State**

State means any state of the United States of America, and the District of Columbia.

E. **Locations**

This policy covers all of your workplaces listed in Items 1 or 4 of the Information Page; and it covers all other workplaces in Item 3.A. states unless you have other insurance or are self-insured for such workplaces.

PART ONE

WORKERS COMPENSATION INSURANCE

A. **How This Insurance Applies**

This workers compensation insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death.

1. Bodily injury by accident must occur during the policy period.
2. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.

B. **We Will Pay**

We will pay promptly when due the benefits required of you by the workers compensation law.

C. **We Will Defend**

We have the right and duty to defend at our expense any claim, proceeding or suit against you for benefits payable by this insurance. We have the right to investigate and settle these claims, proceedings or suits. We have no duty to defend a claim, proceeding or suit that is not covered by this insurance.

D. **We Will Also Pay**

We will also pay these costs, in addition to other amounts payable under this insurance, as part of any claim, proceeding or suit we defend:

1. reasonable expenses incurred at our request, but not loss of earnings;
2. premiums for bonds to release attachments and for appeal bonds in bond amounts up to the amount payable under this insurance;

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3. litigation costs taxed against you;
4. interest on a judgment as required by law until we offer the amount due under this insurance; and
5. expenses we incur.

E. **Other Insurance**

We will not pay more than our share of benefits and costs covered by this insurance and other insurance or self-insurance. Subject to any limits of liability that may apply, all shares will be equal until the loss is paid. If any insurance or self-insurance is exhausted, the shares of all remaining insurance will be equal until the loss is paid.

F. **Payments You Must Make**

You are responsible for any payments in excess of the benefits regularly provided by the workers compensation law including those required because:

1. of your serious and willful misconduct;
2. you knowingly employ an employee in violation of law;
3. you fail to comply with a health or safety law or regulation; or
4. you discharge, coerce or otherwise discriminate against any employee in violation of the workers compensation law.

If we make any payments in excess of the benefits regularly provided by the workers compensation law on your behalf, you will reimburse us promptly.

G. **Recovery From Others**

We have your rights, and the rights of persons entitled to the benefits of this insurance, to recover our payments from anyone liable for the injury. You will do everything necessary to protect those rights for us and to help us enforce them.

H. **Statutory Provisions**

These statements apply where they are required by law.

1. As between an injured worker and us, we have notice of the injury when you have notice.
2. Your default or the bankruptcy or insolvency of you or your estate will not relieve us of our duties under this insurance after an injury occurs.
3. We are directly and primarily liable to any person entitled to the benefits payable by this insurance. Those persons may enforce our duties; so may an agency authorized by law. Enforcement may be against us or against you and us.
4. Jurisdiction over you is jurisdiction over us for purposes of the workers compensation law. We are bound by decisions against you under that law, subject to the provisions of this policy that are not in conflict with that law.
5. This insurance conforms to the parts of the workers compensation law that apply to:
   a. benefits payable by this insurance;
   b. special taxes, payments into security or other special funds, and assessments payable by us under that law.
6. Terms of this insurance that conflict with the workers compensation law are changed by this statement to conform to that law.

Nothing in these paragraphs relieves you of your duties under this policy.

PART TWO

EMPLOYERS LIABILITY INSURANCE

A. **How This Insurance Applies**

This employers liability insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death.

1. The bodily injury must arise out of and in the course of the injured employee’s employment by you.

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2. The employment must be necessary or incidental to your work in a state or territory listed in Item 3.A. of the Information Page.
3. Bodily injury by accident must occur during the policy period.
4. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.
5. If you are sued, the original suit and any related legal actions for damages for bodily injury by accident or by disease must be brought in the United States of America, its territories or possessions, or Canada.

B. **We Will Pay**

We will pay all sums you legally must pay as damages because of bodily injury to your employees, provided the bodily injury is covered by this Employers Liability Insurance.

The damages we will pay, where recovery is permitted by law, include damages:

1. for which you are liable to a third party by reason of a claim or suit against you by that third party to recover the damages claimed against such third party as a result of injury to your employee;
2. for care and loss of services; and
3. for consequential bodily injury to a spouse, child, parent, brother or sister of the injured employee; provided that these damages are the direct consequence of bodily injury that arises out of and in the course of the injured employee's employment by you; and
4. because of bodily injury to your employee that arises out of and in the course of employment, claimed against you in a capacity other than as employer.

C. **Exclusions**

This insurance does not cover:

1. liability assumed under a contract. This exclusion does not apply to a warranty that your work will be done in a workmanlike manner;
2. punitive or exemplary damages because of bodily injury to an employee employed in violation of law;
3. bodily injury to an employee while employed in violation of law with your actual knowledge or the actual knowledge of any of your executive officers;
4. any obligation imposed by a workers compensation, occupational disease, unemployment compensation, or disability benefits law, or any similar law;
5. bodily injury intentionally caused or aggravated by you;
6. bodily injury occurring outside the United States of America, its territories or possessions, and Canada. This exclusion does not apply to bodily injury to a citizen or resident of the United States of America or Canada who is temporarily outside these countries;
7. damages arising out of coercion, criticism, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation, discrimination against or termination of any employee, or any personnel practices, policies, acts or omissions;
8. bodily injury to any person in work subject to the Longshore and Harbor Workers' Compensation Act (33 USC Sections 901–950), the Non-appropriated Fund Instrumentalities Act (5 USC Sections 8171–8173), the Outer Continental Shelf Lands Act (43 USC Sections 1331–1356), the Defense Base Act (42 USC Sections 1651–1654), the Federal Coal Mine Health and Safety Act of 1969 (30 USC Sections 901–942), any other federal workers or workmen's compensation law or other federal occupational disease law, or any amendments to these laws;
9. bodily injury to any person in work subject to the Federal Employers' Liability Act (45 USC Sections 51–60), any other federal laws obligating an employer to pay damages to an employee due to bodily injury arising out of or in the course of employment, or any amendments to those laws;
10. bodily injury to a master or member of the crew of any vessel;
11. fines or penalties imposed for violation of federal or state law; and
12. damages payable under the Migrant and Seasonal Agricultural Worker Protection Act (29 USC Sections 1801–1872) and under any other federal law awarding damages for violation of those laws or regulations issued thereunder, and any amendments to those laws.

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D. **We Will Defend**

We have the right and duty to defend, at our expense, any claim, proceeding or suit against your for damages payable by this insurance. We have the right to investigate and settle these claims, proceedings and suits.
We have no duty to defend a claim, proceeding or suit that is not covered by this insurance. We have no duty to defend or continue defending after we have paid our applicable limit of liability under this insurance.

E. **We Will Also Pay**

We will also pay these costs, in addition to other amounts payable under this insurance, as part of any claim, proceeding, or suit we defend:

1. reasonable expenses incurred at our request, but not loss of earnings;
2. premiums for bonds to release attachments and for appeal bonds in bond amounts up to the limit of our liability under this insurance;
3. litigation costs taxed against you;
4. interest on a judgment as required by law until we offer the amount due under this insurance; and
5. expenses we incur.

F. **Other Insurance**

We will not pay more than our share of damages and costs covered by this insurance and other insurance or self-insurance. Subject to any limits of liability that apply, all shares will be equal until the loss is paid. If any insurance or self-insurance is exhausted, the shares of all remaining insurance and self-insurance will be equal until the loss is paid.

G. **Limits of Liability**

Our liability to pay for damages is limited. Our limits of liability are shown in Item 3.B. of the Information Page. They apply as explained below.

1. Bodily Injury by Accident. The limit shown for “bodily injury by accident—each accident” is the most we will pay for all damages covered by this insurance because of bodily injury to one or more employees in any one accident. A disease is not bodily injury by accident unless it results directly from bodily injury by accident.
2. Bodily Injury by Disease. The limit shown for “bodily injury by disease—policy limit” is the most we will pay for all damages covered by this insurance and arising out of bodily injury by disease, regardless of the number of employees who sustain bodily injury by disease. The limit shown for “bodily injury by disease—each employee” is the most we will pay for all damages because of bodily injury by disease to any one employee. Bodily injury by disease does not include disease that results directly from a bodily injury by accident.
3. We will not pay any claims for damages after we have paid the applicable limit of our liability under this insurance.

H. **Recovery From Others**

We have your rights to recover our payment from anyone liable for an injury covered by this insurance. You will do everything necessary to protect those rights for us and to help us enforce them.

I. **Actions Against Us**

There will be no right of action against us under this insurance unless:

1. You have complied with all the terms of this policy; and
2. The amount you owe has been determined with our consent or by actual trial and final judgment.

This insurance does not give anyone the right to add us as a defendant in an action against you to determine your liability. The bankruptcy or insolvency of you or your estate will not relieve us of our obligations under this Part.

PART THREE

OTHER STATES INSURANCE

A. **How This Insurance Applies**

1. This other states insurance applies only if one or more states are shown in Item 3.C. of the Information Page.
2. If you begin work in any one of those states after the effective date of this policy and are not insured or are not self-insured for such work, all provisions of the policy will apply as though that state were listed in Item 3.A. of the Information Page.

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3. We will reimburse you for the benefits required by the workers compensation law of that state if we are not permitted to pay the benefits directly to persons entitled to them.
4. If you have work on the effective date of this policy in any state not listed in Item 3.A. of the Information Page, coverage will not be afforded for that state unless we are notified within thirty days.

B. **Notice**
Tell us at once if you begin work in any state listed in Item 3.C. of the Information Page.

PART FOUR

YOUR DUTIES IF INJURY OCCURS

Tell us at once if injury occurs that may be covered by this policy. Your other duties are listed here.

1. Provide for immediate medical and other services required by the workers compensation law.
2. Give us or our agent the names and addresses of the injured persons and of witnesses, and other information we may need.
3. Promptly give us all notices, demands and legal papers related to the injury, claim, proceeding or suit.
4. Cooperate with us and assist us, as we may request, in the investigation, settlement or defense of any claim, proceeding or suit.
5. Do nothing after an injury occurs that would interfere with our right to recover from others.
6. Do not voluntarily make payments, assume obligations or incur expenses, except at your own cost.

PART FIVE—PREMIUM

A. **Our Manuals**
All premium for this policy will be determined by our manuals of rules, rates, rating plans and classifications. We may change our manuals and apply the changes to this policy if authorized by law or a governmental agency regulating this insurance.

B. **Classifications**
Item 4 of the Information Page shows the rate and premium basis for certain business or work classifications. These classifications were assigned based on an estimate of the exposures you would have during the policy period. If your actual exposures are not properly described by those classifications, we will assign proper classifications, rates and premium basis by endorsement to this policy.

C. **Remuneration**
Premium for each work classification is determined by multiplying a rate times a premium basis. Remuneration is the most common premium basis. This premium basis includes payroll and all other remuneration paid or payable during the policy period for the services of:

1. all your officers and employees engaged in work covered by this policy; and
2. all other persons engaged in work that could make us liable under Part One (Workers Compensation Insurance) of this policy. If you do not have payroll records for these persons, the contract price for their services and materials may be used as the premium basis. This paragraph 2 will not apply if you give us proof that the employers of these persons lawfully secured their workers compensation obligations.

D. **Premium Payments**
You will pay all premium when due. You will pay the premium even if part or all of a workers compensation law is not valid.

E. **Final Premium**
The premium shown on the Information Page, schedules, and endorsements is an estimate. The final premium will be determined after this policy ends by using the actual, not the estimated, premium basis and the proper

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classifications and rates that lawfully apply to the business and work covered by this policy. If the final premium is more than the premium you paid to us, you must pay us the balance. If it is less, we will refund the balance to you. The final premium will not be less than the highest minimum premium for the classifications covered by this policy. If this policy is canceled, final premium will be determined in the following way unless our manuals provide otherwise:

1. If we cancel, final premium will be calculated pro rata based on the time this policy was in force. Final premium will not be less than the pro rata share of the minimum premium.
2. If you cancel, final premium will be more than pro rata; it will be based on the time this policy was in force, and increased by our short-rate cancelation table and procedure. Final premium will not be less than the minimum premium.

F. **Records**
You will keep records of information needed to compute premium. You will provide us with copies of those records when we ask for them.

G. **Audit**
You will let us examine and audit all your records that relate to this policy. These records include ledgers, journals, registers, vouchers, contracts, tax reports, payroll and disbursement records, and programs for storing and retrieving data. We may conduct the audits during regular business hours during the policy period and within three years after the policy period ends. Information developed by audit will be used to determine final premium. Insurance rate service organizations have the same rights we have under this provision.

PART SIX—CONDITIONS

A. **Inspection**
We have the right, but are not obliged to inspect your workplaces at any time. Our inspections are not safety inspections. They relate only to the insurability of the workplaces and the premiums to be charged. We may give you reports on the conditions we find. We may also recommend changes. While they may help reduce losses, we do not undertake to perform the duty of any person to provide for the health or safety of your employees or the public. We do not warrant that your workplaces are safe or healthful or that they comply with laws, regulations, codes or standards. Insurance rate service organizations have the same rights we have under this provision.

B. **Long Term Policy**
If the policy period is longer than one year and sixteen days, all provisions of this policy will apply as though a new policy were issued on each annual anniversary that this policy is in force.

C. **Transfer of Your Rights and Duties**
Your rights or duties under this policy may not be transferred without our written consent. If you die and we receive notice within thirty days after your death, we will cover your legal representative as insured.

D. **Cancelation**
1. You may cancel this policy. You must mail or deliver advance written notice to us stating when the cancelation is to take effect.
2. We may cancel this policy. We must mail or deliver to you not less than ten days advance written notice stating when the cancelation is to take effect. Mailing that notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.
3. The policy period will end on the day and hour stated in the cancelation notice.
4. Any of these provisions that conflict with a law that controls the cancelation of the insurance in this policy is changed by this statement to comply with the law.

E. **Sole Representative**
The insured first named in Item 1 of the Information Page will act on behalf of all insureds to change this policy, receive return premium, and give or receive notice of cancelation.

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PARTNERS, OFFICERS AND OTHERS EXCLUSION ENDORSEMENT

The policy does not cover bodily injury to any person described in the Schedule.

The premium basis for the policy does not include the remuneration of such persons.

You will reimburse us for any payment we must make because of bodily injury to such persons.

Schedule

Partners	Officers	Others
	Pamela Holman Les Holman	

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

Endorsement Effective	4/1/2017	Policy No.	AWC1081405	Endorsement No.	WC000308
Insured	Holman Inc.			Premium $	19059
Insurance Company	Associated Industries Insurance Company, Inc.				

Countersigned by ____________________

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WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS ENDORSEMENT

We have the right to recover our payments from anyone liable for an injury covered by this policy. We will not enforce our right against the person or organization named in the Schedule. (This agreement applies only to the extent that you perform work under a written contract that requires you to obtain this agreement from us.)

This agreement shall not operate directly or indirectly to benefit anyone not named in the Schedule.
Any person or organization as required by written contract 25.00

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.
(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective	4/1/2017	Policy No.	AWC1081405	Endorsement No.	0
Insured	Holman Inc.			Premium $	19059
Insurance Company	Associated Industries Insurance Company, Inc.				

Countersigned by ______________________________

PENDING RATE CHANGE ENDORSEMENT

A rate change filing is being considered by the proper regulatory authority. The filing may result in rates different from the rates shown on the policy. If it does, we will issue an endorsement to show the new rates and their effective date.

If only one state is shown in Item 3.A. of the Information Page, this endorsement applies to that state. If more than one state is shown there, this endorsement applies only in the state shown in the Schedule.

Schedule

State
FL

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

Endorsement Effective	4/1/2017	Policy No.	AWC1081405	Endorsement No.	WC000404
Insured	Holman Inc.			Premium $	19059
Insurance Company	Associated Industries Insurance Company, Inc.				

Countersigned by ______________________________

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PREMIUM DISCOUNT ENDORSEMENT

The premium for this policy and the policies, if any, listed in Item 3 of the Schedule may be eligible for a discount. This endorsement shows your estimated discount in Items 1 or 2 of the Schedule. The final calculation of premium discount will be determined by our manuals and your premium basis as determined by audit. Premium subject to retrospective rating is not subject to premium discount.

Schedule

1. **State** — **Estimated Eligible Premium**

State	First $10,000	Next $190,000	Next $1,550,000	Balance
Florida	0%	9.1%	11.3%	12.3%

2. Average percentage discount: 4.5 %

3. Other policies:

4. If there are no entries in Items 1, 2 and 3 of the Schedule, see the Premium Discount Endorsement attached to your policy number:

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective 4/1/2017 Policy No. AWC1081405 Endorsement No. 0
Insured Holman Inc. Premium $ 19059
Insurance Company Associated Industries Insurance Company, Inc.

Countersigned by ______________________

NOTIFICATION OF CHANGE IN OWNERSHIP ENDORSEMENT

Experience rating is mandatory for all eligible insureds. The experience rating modification factor, if any, applicable to this policy, may change if there is a change in your ownership or in that of one or more of the entities eligible to be combined with you for experience rating purposes. Change in ownership includes sales, purchases, other transfers, mergers, consolidations, dissolutions, formations of a new entity and other changes provided for in the applicable experience rating plan manual.

You must report any change in ownership to us in writing within 90 days of such change. Failure to report such changes within this period may result in revision of the experience rating modification factor used to determine your premium.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

Endorsement Effective	4/1/2017	Policy No.	AWC1081405	Endorsement No.	WC000414
Insured	Holman Inc.			Premium $	19059
Insurance Company	Associated Industries Insurance Company, Inc.				

Countersigned by ______________________________

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PREMIUM DUE DATE ENDORSEMENT

This endorsement is used to amend:

Section D. of Part Five of the policy is replaced by this provision.

PART FIVE
PREMIUM

D. **Premium** is amended to read:

You will pay all premium when due. You will pay the premium even if part or all of a workers compensation law is not valid. **The due date for audit and retrospective premiums is the date of the billing.**

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective Policy No. AWC1081405 Endorsement No.
Insured Holman Inc. Premium $19,059

Insurance Company Countersigned by____

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FLORIDA EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

C. Exclusion 5, Section C. of Part Two of the policy, is replaced by following:

This insurance does not cover

5. bodily injury intentionally caused or aggravated by you or which is the result of your engaging in conduct equivalent to an intentional tort, however defined, or other tortious conduct, such that you lose your immunity from civil liability under the workers compensation laws.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

Endorsement Effective 4/1/2017 Policy No. AWC1081405 Endorsement No. WC090303

Insured Holman Inc. Premium $ 19059

Insurance Company Associated Industries Insurance Company, Inc.

Countersigned by ______________________________

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FLORIDA EXPERIENCE RATING MODIFICATION FACTOR ENDORSEMENT

This endorsement applies only to the insurance provided by the policy because Florida is shown in Item 3.A. of the Information Page.

A. The premium for the policy will be adjusted by an experience rating modification factor. The factor was not available when the policy was issued. The factor, if any, shown on the Information Page is an estimate. We will issue an endorsement to show the proper factor, if different from the factor shown, when it is calculated.

B. If the factor is an increase over that shown on the Information Page, it will apply as of the policy effective date; or if the anniversary rating date is different from the policy effective date it will apply as of the anniversary rating date. Your premium will be calculated:

   1. Retroactively to the effective date of the policy or to the anniversary rating date if the adjustment is within the first 90 days of the policy period or the anniversary rating date;

   2. On a pro rata basis from the date we endorsed the policy if the adjustment is more than 90 days after the effective date of the policy or the anniversary rating date.

      The adjustment will be retroactive to the effective date of the policy period or to the anniversary rating date when:

      a. The change in experience modification is the result of a revision in your classifications;

      b. The delay in the calculation of the experience modification is due to your failure to make available all your records for examination and audit as provided in Part Five-G (Audit) of the policy.

C. If the factor is a decrease from that shown on the Information Page, it will apply retroactively to the policy effective date or the anniversary rating date if different from the policy effective date.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

Endorsement Effective	4/1/2017	Policy No.	AWC1081405	Endorsement No.	WC090402
Insured	Holman Inc.			Premium $	19059
Insurance Company	Associated Industries Insurance Company, Inc.				

Countersigned by ______________________________

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FLORIDA TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT ENDORSEMENT

This endorsement addresses requirements of the Terrorism Risk Insurance Act of 2002 as amended by the Terrorism Risk Insurance Program Reauthorization Act of 2015.

Definitions

The definitions provided in this endorsement are based on and have the same meaning as the definitions in the Act. If words or phrases not defined in this endorsement are defined in the Act, the definitions in the Act will apply.

1. "Act" means the Terrorism Risk Insurance Act of 2002, which took effect on November 26, 2002, and any amendments, including any amendments resulting from the Terrorism Risk Insurance Program Reauthorization Act of 2015.
2. "Act of Terrorism" means any act that is certified by the Secretary of the Treasury, in consultation with the Secretary of Homeland Security, and the Attorney General of the United States as meeting all of the following requirements:
   a. The act is an act of terrorism.
   b. The act is violent or dangerous to human life, property or infrastructure.
   c. The act resulted in damage within the United States, or outside of the United States in the case of the premises of United States missions or certain air carriers or vessels.
   d. The act has 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.
3. "Insured Loss" means any loss resulting from an act of terrorism (including an act of war, in the case of workers compensation) that is covered by primary or excess property and casualty insurance issued by an insurer if the loss occurs in the United States or at the premises of United States missions or to certain air carriers or vessels.
4. "Insurer Deductible" means, for the period beginning on January 1, 2015, and ending on December 31, 2020, an amount equal to 20% of our direct earned premiums, during the immediately preceding calendar year.

Limitation of Liability

The Act may limit our liability to you under this policy. If aggregate Insured Losses exceed $100,000,000,000 in a calendar year and if we have met our Insurer Deductible, we may not be liable for the payment of any portion of the amount of Insured Losses that exceeds $100,000,000,000; and for aggregate Insured Losses up to $100,000,000,000, we may only have to pay a pro rata share of such Insured Losses as determined by the Secretary of the Treasury.

Policyholder Disclosure Notice

1. Insured Losses would be partially reimbursed by the United States Government. If the aggregate industry Insured Losses exceed:
   a. $100,000,000, with respect to such Insured Losses occurring in calendar year 2015, the United States Government would pay 85% of our Insured Losses that exceed our Insurer Deductible.
   b. $120,000,000, with respect to such Insured Losses occurring in calendar year 2016, the United States Government would pay 84% of our Insured Losses that exceed our Insurer Deductible.
   c. $140,000,000, with respect to such Insured Losses occurring in calendar year 2017, the United States Government would pay 83% of our Insured Losses that exceed our Insurer Deductible.
   d. $160,000,000, with respect to such Insured Losses occurring in calendar year 2018, the United States Government would pay 82% of our Insured Losses that exceed our Insurer Deductible.
   e. $180,000,000, with respect to such Insured Losses occurring in calendar year 2019, the United States Government would pay 81% of our Insured Losses that exceed our Insurer Deductible.
   f. $200,000,000, with respect to such Insured Losses occurring in calendar year 2020, the United States Government would pay 80% of our Insured Losses that exceed our Insurer Deductible.

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2. Notwithstanding item 1 above, the United States Government may not have to make any payment under the Act for any portion of Insured Losses that exceed $100,000,000,000.
3. The premium charged for the coverage for Insured Losses under this policy is included in the amount shown in Item 4 of the Information Page or the Schedule below.

Schedule

Rate per $100 of Remuneration 0.02

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective 4/1/2017 Policy No. AWC1081405 Endorsement No. WC090403B

Insured Holman Inc. Premium $ 19059

Insurance Company Associated Industries Insurance Company, Inc.

Countersigned by ______________________________

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FLORIDA EMPLOYMENT AND WAGE INFORMATION RELEASE ENDORSEMENT

This policy requires you to release certain employment and wage information maintained by the State of Florida pursuant to federal and state unemployment compensation laws except to the extent prohibited or limited under federal law. By entering into this policy, you consent to the release of the information.

We will safeguard the information and maintain its confidentiality. We will limit use of the information to verifying compliance with the terms of the policy.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

Endorsement Effective 4/1/2017 Policy No. AWC1081405 Endorsement No. WC090606

Insured Holman Inc. Premium $ 19059

Insurance Company Associated Industries Insurance Company, Inc.

Countersigned by ______________________________

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Associated Industries Insurance Company, Inc.

IMPORTANT NOTICE
FLORIDA

POLICY NUMBER	POLICY PERIOD	
AWC1081405	FROM: 4/1/2017	TO: 4/1/2018

INSURED
Holman Inc.

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 contact your insurance agent for a Drug-Free Workplace Premium Credit Program application. Re-certification is required annually.

The State of Florida has authorized a $2500 deductible plan. There is no premium credit associated with this option. This deductible option may be endorsed to the policy subject to financial underwriting. Any amounts paid by the employer shall not apply to the experience rating of such employer but shall be reported for ratemaking purposes. If you are interested in this deductible plan, please contact your insurance agent for further details.

Associated Industries Insurance Company, Inc.

FLORIDA CONTRACTING CLASSIFICATION PREMIUM ADJUSTMENT PROGRAM
WORKERS COMPENSATION PREMIUM CREDIT APPLICATION

Holman Inc. Policy #: AWC1081405

P O Box 60332
Jacksonville FL 32236

The Florida Contracting Classification Premium Adjustment Program is applicable to qualifying employers engaged in contracting operations.

A special premium calculation, which may result in a premium credit for you, will be based on average hourly pay rates for each classification of contracting operations. In order that your premium may be correctly established, please return the completed premium credit application, as set out on the reverse side of this letter, to the:

National Council on Compensation
Insurance Customer Service Center
901 Peninsula Corporate Circle
Boca Raton, Florida 33487

They will advise us of any premium credit applicable.

If NCCI does not receive this application during the policy period or within three (3) years after the policy period ends, your premium calculation will not reflect any possible premium credit.

For each applicable classification (both contracting and non-contracting) covering your company's operations in the state of Florida, report the total Florida payroll (excluding overtime premium pay, pay in excess of the maximum individual payroll for executive officers or the pay in excess of payroll amount charged to partners and sole proprietors as shown on the state rate pages, as well as the entire pay for any exempt sole proprietor, partner, or officer) and the corresponding total number of hours worked, for the third calendar quarter (July, August, September) of the prior calendar year as reported to taxing authorities.

Note #1. If you did not engage in contracting operations during the third quarter of the prior calendar year, the requested information to be provided should then be for the last complete calendar quarter prior to the effective date of your workers compensation policy.

Note #2. If you are a new business (no prior operations), submit the requested information, for the first complete calendar quarter following the effective date of your workers compensation policy, when available.

Note #3. In the absence of specific records for salaried employees, you should assume that each individual worked forty (40) hours per week.

Please preserve your payroll records that formed the basis for this declaration as we will be required to verify the reported information in order for any premium credit to be applied.

Thank you for your cooperation.

Sincerely,

Elissa Pacheco
Executive Vice President, Underwriting Marketing Services

See next page for Premium Credit Application

Form 09-4B (CCPAP)
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WORKERS COMPENSATION—PREMIUM CREDIT APPLICATION

Insured: **Holman Inc.**

Policy No.: **AWC1081405** Effective Date: **4/1/2017**

Carrier Name: **Associated Industries Insurance Company, Inc.**

Notice: Unless code(s), total wages paid, total hours worked, calendar quarter reported are indicated and application is signed, it cannot be processed. Contact your agent if assistance is desired.

Is this a new business? No ☐ Yes ☐

If no, submit information for the THIRD calendar quarter (July, August, September) of the prior calendar year as reported to taxing authorities.

If yes, submit information for the FIRST complete calendar quarter following the effective date of your workers compensation policy.

The following is based on actual wages and hours worked, as reflected in our payroll records, for the complete calendar quarter ending ____________________.

"Contracting classifications" are those classifications subject to the following code numbers:

0042	5057	5221	5473	5537	6005	6233	7538
0050	5059	5222	5474	5538	6017	6235	7605
1322	5069	5223	5478	5551	6018	6236	7855
3365	5102	5348	5479	5606	6045	6237	8227
3719	5146	5402	5480	5610	6204	6251	9534
3724	5160	5403	5491	5613	6206	6252	9554
3726	5183	5437	5506	5645	6213	6260	
5020	5188	5443	5507	5651	6214	6306	
5022	5190	5445	5508	5703	6216	6319	
5037	5213	5462	5509	5705	6217	6325	
5040	5215	5472	5536	6003	6229	6400	

Note: Classification Code 5537 replaces Classification Code 5536 in the Florida Contracting Classification Premium Credit Adjustment Program effective January 1, 2006 as a result of Item Filing B-1391.

CLASSIFICATION	CODE	TOTAL FLORIDA WAGES PAID(1)	TOTAL HOURS WORKED(2)
Example: Electrical Wiring	**5190**	**$8,000**	**520.00**
Contracting classifications:			
Non-Contracting classifications:			

(1) These figures are to exclude overtime premium pay (e.g., employee makes $16/hour and is paid time and one-half, only report the payroll based upon the $16/hour), pay in excess of the maximum individual payroll for executive officers or the pay in excess of payroll amount charged to partners and sole proprietors as shown on the state rate pages, and as well as the entire pay for any exempt sole proprietor, partner, or officer. For each classification code, combine all wages for that code in a single entry. Employee names are not required.

(2) Including overtime hours.

Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement or claim or an application containing any false, incomplete, or misleading information, is guilty of a felony of the third degree.

SIGNATURE: ____________________ POSITION: ____________________ DATE: ____________

Form 09-4B (CCPAP)

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Associated Industries Insurance Company, Inc.

Timely reporting of workers' compensation claims is essential so a complete and thorough investigation can be completed and a determination of benefits made. Additionally, timely claim reporting supports our efforts to provide you and your employees with the best possible medical and disability management. We urge you to please report the claim immediately upon notification.

Claim Reporting Information

To Report a New Claim
Phone: **1-888-225-2442**

Customer Service
Phone: **1-800-866-8600**

To be placed on the Broken Arm Poster provided.

Employer: Holman Inc.
P O Box 60332
Jacksonville FL 32236

Policy #: AWC1081405

Effective: 4/1/2017

Agent: Della Porta Group, Inc. (The)