

# ACORD FLORIDA WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY)

PRODUCER	PHONE (A/C. No., Ext.): 727-531-9369 FAX (A/C. No.): 727-531-9379	COMPANY	UNDERWRITER
B&E Insurance Associates Inc. 18514 US Hwy 19 North Suite D2 Clearwater, FL 33764		APPLICANT NAME - INCLUDE ALL SUBSIDIARIES & DBA'S TO BE INCLUDED IN COVERAGE, ALONG WITH THEIR FEIN	
Mailing Address (Including Zip Code) - Include Principal Physical Location and All Insured Entities		<input type="checkbox"/> CHECK HERE IF LIST OF ADDITIONAL LOCATIONS ATTACHED	
LICENSE #:	YRS IN BUS	SIC CODE	INDIVIDUAL <input type="checkbox"/> CORPORATION <input 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

<b>STATUS OF SUBMISSION</b>		<b>BILLING/AUDIT INFORMATION</b>	
<input type="checkbox"/> QUOTE	<input type="checkbox"/> ISSUE POLICY	<b>BILLING PLAN</b>	<b>PAYMENT PLAN</b>
		<input type="checkbox"/> AGENCY BILL	<input type="checkbox"/> ANNUAL
		<input type="checkbox"/> DIRECT BILL	<input type="checkbox"/> SEMI-ANNUAL
			<input type="checkbox"/> QUARTERLY
			<input type="checkbox"/> PREM FINANCED
			<input type="checkbox"/> OTHER: _____
			<input type="checkbox"/> AT EXPIRATION
			<input type="checkbox"/> SEMI-ANNUAL
			<input type="checkbox"/> MONTHLY
			<input type="checkbox"/> OTHER: _____
			<input type="checkbox"/> QUARTERLY
			% DOWN: _____

**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

**POLICY INFORMATION**

PROPOSED EFF DATE	PROPOSED EXP DATE	NORMAL ANNIVERSARY RATING DATE	<input type="checkbox"/> PARTICIPATING	RETRO PLAN
			<input type="checkbox"/> NON-PARTICIPATING	
PART 1 - WORKERS COMPENSATION (States)	PART 2 - EMPLOYER'S LIABILITY		PART 3 - OTHER STATES INS	DEDUCTIBLE
	\$	EACH ACCIDENT		
	\$	DISEASE-POLICY LIMIT		
	\$	DISEASE-EACH EMPLOYEE		OTHER COVERAGES
				<input type="checkbox"/> U.S.L. & H.
				<input type="checkbox"/> VOLUNTARY COMPENSATION
DIVIDEND PLAN/SAFETY GROUP		ADDITIONAL COMPANY INFORMATION		

**RATING INFORMATION**  CHECK HERE IF LIST OF ADDITIONAL CLASS CODES ATTACHED

LOC	CLASS CODE	COMPANY USE	CATEGORIES, DUTIES, CLASSIFICATIONS	# OF EMPLOYEES	ACTUAL REMUNERATION PAST 12 MONTHS	ESTIMATED REMUNERATION FOR NEXT POLICY PERIOD	RATE	ESTIMATED ANNUAL PREMIUM

SPECIFY ADDITIONAL COVERAGES/ENDORSEMENTS		FACTOR	FACTORED PREMIUM
	TOTAL		\$
			\$
			\$
	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									
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	LOSS RUN ATTACHED
	CO: POL #:						
	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) UNEMPLOYMENT COMPENSATION EMPLOYER QUARTERLY TAX REPORTS - UCT-6 OR IRS FORM 941. PLEASE EXPLAIN IF UCT-6 OR 941 IS NOT AVAILABLE. DISCLOSURE OF THE SOCIAL SECURITY NUMBERS IS VOLUNTARY, AS AN ALTERNATIVE, THE LATEST UCT-6 FORM 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 UCT-6 FORM 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?			16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?		
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)			17. ANY OTHER INSURANCE WITH THIS INSURER?		
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?			18. ANY PRIOR COVERAGE DECLINED/CANCELLED/NON-RENEWED (Last 3 years)?		
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?			19. ARE EMPLOYEE HEALTH PLANS PROVIDED?		
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?			20. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS/SUBSIDIARY?		
6. ARE SUB-CONTRACTORS AND/OR INDEPENDENT CONTRACTORS USED?			21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?		
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INS.?			22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME?		
8. IS A FORMAL SAFETY PROGRAM IN OPERATION?			23. WHAT ARE YOUR ESTIMATED ANNUAL REVENUES? \$		
9. ANY GROUP TRANSPORTATION PROVIDED?			24. IS THERE ANY CURRENT OR ANTICIPATED DEBT FOR UNPAID PREMIUMS OWED TO ANY PREVIOUS WORKERS' COMPENSATION PROVIDER?		
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?			<b>CONTACT INFORMATION</b>		
11. ANY PART TIME OR SEASONAL EMPLOYEES?			IN- SPECTION	PHONE:	
12. IS THERE ANY VOLUNTEER OR DONATED LABOR?				NAME:	
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?			ACCTNG RECORD	PHONE:	
14. DO EMPLOYEES TRAVEL OUT OF STATE?				NAME:	
15. ARE ATHLETIC TEAMS SPONSORED?			CLAIMS INFO	PHONE:	
				NAME:	
<b>REMARKS</b>					

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 QUARTERLY EARNINGS REPORT AND SELF-AUDITS SUPPORTED BY THE QUARTERLY EARNINGS REPORTS, AS REQUIRED BY CHAPTER 443, AT THE END OF EACH QUARTER. IF I OMIT THE NAME OF AN EMPLOYEE FROM THIS QUARTERLY EARNINGS 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 ENTITIY, 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	DATE	PRODUCER'S SIGNATURE	DATE
PRINT NAME			
NOTARY PUBLIC SIGNATURE	DATE	NOTARY PUBLIC SIGNATURE	DATE

## NOTICE OF ELECTION TO BE EXEMPT

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 1:

Applicant Name (please print): \_\_\_\_\_

Applicant's social security number: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Applicant's E-mail address (optional): \_\_\_\_\_

### SECTION 2: I am applying for exemption as a (You must check only one box in this section):

#### **CONSTRUCTION INDUSTRY (\$50 FEE REQUIRED)**

Officer of a Corporation (Title): \_\_\_\_\_ -OR-  Member of a Limited Liability Company (LLC)

#### **NON-CONSTRUCTION INDUSTRY (NO FEE REQUIRED)**

Officer of a Corporation (Title): \_\_\_\_\_ )

The Division will accept a money order, a cashier's check, or an electronic payment made payable to the DFS WC Administration Trust Fund.

**An officer electing an exemption under Chapter 440, Florida Statutes is not entitled to benefits under this chapter.**

**SECTION 3.** The corporation of which you are an officer or the limited liability company of which you are a member must be registered and in an active status with the Florida Division of Corporations. Applicants applying as an officer of a corporation must be listed as an officer of the Corporation with the Florida Division of Corporations. List the document number (document number shown on your Annual Report) on file with the Florida Division of Corporations.

**SECTION 4.** This exemption application applies only to the person signing the application, the Corporation/LLC that is listed below, and the scope of business or trade listed:

Name of Corporation or LLC: \_\_\_\_\_ FEIN: \_\_\_\_\_

AS REGISTERED WITH THE FLORIDA DIVISION OF CORPORATIONS

Business Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

IF APPLICABLE - LIST FICTITIOUS NAME; DOING BUSINESS AS (DBA); ALSO KNOWN AS NAME (AKA)

Applicant's Address of Record: \_\_\_\_\_

INCLUDE APARTMENT OR SUITE NUMBER

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Scope of Business or Trade: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

**SECTION 5.** List all certified or registered licenses issued pursuant to Chapter 489, F.S. held by the applicant, or the certified or registered license numbers held by the qualifier for the corporation or LLC listed on this application of which the applicant is a corporate officer: \_\_\_\_\_

**SECTION 6.** If you have submitted an electronic payment for this application, write the transaction confirmation number in the following space: \_\_\_\_\_

**SECTION 7.** Are you affiliated with any corporation (including LLC) other than the corporation (including LLC) to which this application applies?  Yes  No

**IF YES, PLEASE LIST THE NAME(S) AND FEIN(S) OF THE AFFILIATED CORPORATION(S) OR LLC(S):**

**NAME:** \_\_\_\_\_ **FEIN:** \_\_\_\_\_

**SECTION 8.** If your corporation or LLC is engaged in the construction industry, you must provide the required proof of ownership in the corporation or LLC.

- A. To be eligible for a construction industry exemption as an officer of a corporation, the applicant must be a shareholder, owning at least 10% of the stock of the corporation. **A COPY OF A STOCK CERTIFICATE EVIDENCING THE REQUIRED OWNERSHIP MUST BE ATTACHED.**
- B. To be eligible for a construction industry exemption as a member of a limited liability company, the applicant must confirm ownership of at least 10% of the company. **THE REQUIRED OWNERSHIP MAY BE ESTABLISHED BY PRODUCTION OF DOCUMENTATION REFLECTING THE REQUIRED OWNERSHIP, OR BY SUBMITTING A STATEMENT ATTESTING TO THE REQUIRED OWNERSHIP.**

**THIS APPLICATION IS CONTINUED ON PAGE 2**

**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.

\_\_\_\_\_  
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.

\_\_\_\_\_  
APPLICANT'S SIGNATURE

\_\_\_\_\_  
DATE SIGNED

NOTARY STATE OF FLORIDA, COUNTY OF \_\_\_\_\_

Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, by \_\_\_\_\_

Personally Known \_\_\_\_\_ OR Produced Identification \_\_\_\_\_ Type of Identification  
Produced \_\_\_\_\_

NOTARY SIGNATURE \_\_\_\_\_ My Commission Expires \_\_\_\_\_

Please mail or submit your completed application, application fee, and any required attachments to the district office nearest your place of business.

4415 Metro Parkway, Suite 300  
Ft. Myers FL 33916  
Telephone (239) 938-1840

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

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

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

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 70<sup>th</sup> Ave., Suite # 116  
Plantation FL 33317  
Telephone (954) 321-2906

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

401 NW 2<sup>nd</sup> 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."