

DIVISION OF WORKERS' COMPENSATION
BUREAU OF MONITORING AND AUDIT
SELF-INSURANCE SECTION

SERVICE COMPANY APPLICATION

NAME OF APPLICANT

APPLICANT IS A Corporation Individual Proprietor Partnership Other(exp)

ADDRESS OF HOME OFFICE (Street, City, State, Zip Code)

ADDRESS OF FLORIDA BRANCH OFFICES

NAMES AND ADDRESS OF OWNERS, PARTNERS OR CORPORATE OFFICERS

NAME OF RESIDENT AGENT

ADDRESS OF RESIDENT AGENT

IS APPLICANT A SUBSIDIARY? YES NO (if YES Answer the following:)

NAME OF PARENT COMPANY	TELEPHONE NO. (Area - Exchange)
------------------------	---------------------------------

ADDRESS OF PARENT COMPANY (Street, City, State, Zip Code)

I Certify that the information submitted supporting this application is true and correct to the best of my knowledge. The applicant agrees to abide by the provisions of Rule 4L-5.112, .113, .114, F.A.C., and all other applicable rules and the Workers' Compensation Law (Chapter 440, F.S.).

SIGNATURE

TITLE

DATE

INSTRUCTIONS:

1. Attach two (2) letters of reference in accordance with Rule 4L-5.113.
2. Attach summary data and resumes of your personnel in accordance with the provision of Rule 4L-5.113. Include the residence and business address of your personnel on each resume submitted.
3. Attach a list of all self-insured employers and funds with which you have contracted or intend to contract. Indicate what services are to be provided (e.g., claims, safety, underwriting or all).