

<b>AGENCY NAME AND ADDRESS</b> Unique Risk Management and Insurance Services LLC 23052 Alicia Pkwy Suite H378 Mission Viejo CA 92692		<b>COMPANY:</b> UNDERWRITER: APPLICANT NAME: Mold Ladies LLC OFFICE PHONE: 5053858519 MOBILE PHONE: MAILING ADDRESS (including ZIP + 4 or Canadian Postal Code) 1536 S Missouri Ave Clearwater FL 33756-2237	
<b>PRODUCER NAME:</b> <b>CS REPRESENTATIVE NAME:</b> OFFICE PHONE (A/C. No. Ext): 949-305-5577 MOBILE PHONE: FAX (A/C. No.): 949-305-5077 E-MAIL ADDRESS: scott@uniquerisk.com CODE: SUB CODE: AGENCY CUSTOMER ID:		E-MAIL ADDRESS: SOLE PROPRIETOR <input type="checkbox"/> CORPORATION <input checked="" type="checkbox"/> LLC <input type="checkbox"/> TRUST <input type="checkbox"/> UNINCORPORATED ASSOCIATION PARTNERSHIP <input type="checkbox"/> SUBCHAPTER "S" CORP <input type="checkbox"/> JOINT VENTURE <input type="checkbox"/> OTHER:	
CREDIT BUREAU NAME: FEDERAL EMPLOYER ID NUMBER 88-3069365		YRS IN BUS: NEW SIC: NAICS: WEBSITE ADDRESS: ID NUMBER: OTHER RATING BUREAU ID OR STATE EMPLOYER REGISTRATION NUMBER	

<b>STATUS OF SUBMISSION</b> <input checked="" type="checkbox"/> QUOTE <input type="checkbox"/> ISSUE POLICY <input type="checkbox"/> BOUND (Give date and/or attach copy) <input type="checkbox"/> ASSIGNED RISK (Attach ACORD 133)		<b>BILLING / AUDIT INFORMATION</b> BILLING PLAN <input type="checkbox"/> AGENCY BILL <input checked="" type="checkbox"/> DIRECT BILL		PAYMENT PLAN <input type="checkbox"/> ANNUAL <input type="checkbox"/> <input type="checkbox"/> SEMI-ANNUAL <input type="checkbox"/> QUARTERLY % DOWN:		AUDIT <input checked="" type="checkbox"/> AT EXPIRATION <input type="checkbox"/> MONTHLY <input type="checkbox"/> SEMI-ANNUAL <input type="checkbox"/> <input type="checkbox"/> QUARTERLY	
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LOC #	HIGHEST FLOOR	STREET, CITY, COUNTY, STATE, ZIP CODE
1	1	1536 Missouri Ave Clearwater, FL 33756

<b>POLICY INFORMATION</b> PROPOSED EFF DATE: ASAP PROPOSED EXP DATE: RATING EFFECTIVE DATE (if applicable): ANNIVERSARY RATING DATE (if applicable): PARTICIPATING: <input type="checkbox"/> NON-PARTICIPATING: <input type="checkbox"/> RETRO PLAN:		PART 1 - WORKERS COMPENSATION (States) FL		PART 2 - EMPLOYER'S LIABILITY \$ 1,000,000 EACH ACCIDENT \$ 1,000,000 DISEASE-POLICY LIMIT \$ 1,000,000 DISEASE-EACH EMPLOYEE		PART 3 - OTHER STATES INS DEDUCTIBLES (N / A in WI) MEDICAL INDEMNITY		AMOUNT / % (N / A in WI) OTHER COVERAGES U.S.L. & H. VOLUNTARY COMP FOREIGN COV MANAGED CARE OPTION	
DIVIDEND PLAN/SAFETY GROUP		ADDITIONAL COMPANY INFORMATION							
SPECIFY ADDITIONAL COVERAGES / ENDORSEMENTS (Attach ACORD 101, Additional Remarks Schedule, if more space is required)									

<b>TOTAL ESTIMATED ANNUAL PREMIUM - ALL STATES</b>		
TOTAL ESTIMATED ANNUAL PREMIUM ALL STATES \$	TOTAL MINIMUM PREMIUM ALL STATES \$	TOTAL DEPOSIT PREMIUM ALL STATES \$

<b>CONTACT INFORMATION</b>				
TYPE	NAME	OFFICE PHONE	MOBILE PHONE	E-MAIL
INSPECTION	Sherry Faust	505-385-8519		
ACCTNG RECORD				
CLAIMS INFO				

<b>INDIVIDUALS INCLUDED / EXCLUDED</b> PARTNERS, OWNERS, OFFICERS, RELATIVES (Must be employed by business operations) TO BE INCLUDED OR EXCLUDED (Remuneration/Payroll to be included must be part of rating information section.) Exclusions or waivers in California must meet the requirements of Cal. Labor Code §§3351 and 3352.									
STATE	LOC #	NAME	DATE OF BIRTH	TITLE/RELATIONSHIP	OWNER-SHIP %	DUTIES	INC/EXC	CLASS CODE	REMUNERATION/PAYROLL
FL	1	Sherry Faust		Owner	51		EXC		
FL	1	Alex Ritchie		GM	20		EXC		
FL	1	Roland			20		EXC		
FL	1	Alicia Riordan		VP	6		EXC		



**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	ANNUAL PREMIUM	MOD	# CLAIMS	AMOUNT PAID	RESERVE
	CO: POL #:					
	CO: POL #:					
	CO: POL #:					
	CO: POL #:					
	CO: POL #:					

**NATURE OF BUSINESS / DESCRIPTION OF OPERATIONS**

GIVE COMMENTS AND DESCRIPTIONS OF BUSINESS, OPERATIONS AND PRODUCTS: 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.

Devin Rich - Lead - 3% Excluded  
Mold Remediation Services

**GENERAL INFORMATION**

EXPLAIN ALL "YES" RESPONSES	Y / N
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT / WATERCRAFT?	N
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)	Y
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?	N
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?	N
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?	N
6. ARE SUB-CONTRACTORS USED? (If "YES", give % of work subcontracted)	N
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INSURANCE? (If "YES", payroll for this work must be included in the State Rating Worksheet on Page 2)	N
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?	N
9. ANY GROUP TRANSPORTATION PROVIDED?	N
10. ANY SEASONAL EMPLOYEES?	N
11. IS THERE ANY VOLUNTEER OR DONATED LABOR? (If "YES", please specify)	N
12. DO EMPLOYEES TRAVEL OUT OF STATE? (If "YES", indicate state(s) of travel and frequency)	N
13. ARE ATHLETIC TEAMS SPONSORED?	N
14. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?	N
15. ANY OTHER INSURANCE WITH THIS INSURER?	N
16. ANY PRIOR COVERAGE DECLINED / CANCELLED / NON-RENEWED IN THE LAST THREE (3) YEARS?	N

**GENERAL INFORMATION (continued)**

AGENCY CUSTOMER ID: \_\_\_\_\_

EXPLAIN ALL "YES" RESPONSES	Y / N
17. ARE EMPLOYEE HEALTH PLANS PROVIDED?	N
18. DO ANY EMPLOYEES PERFORM WORK FOR OTHER BUSINESSES OR SUBSIDIARIES?	N
19. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?	N
20. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME? If "YES", # of Employees: <u>  N  </u>	N
21. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST FIVE (5) YEARS? (If "YES", please specify)	N
22. ANY UNDISPUTED AND UNPAID WORKERS COMPENSATION PREMIUM DUE FROM YOU OR ANY COMMONLY MANAGED OR OWNED ENTERPRISES? IF YES, EXPLAIN INCLUDING ENTITY NAME(S) AND POLICY NUMBER(S).	N

**SIGNATURE**

Copy of the Notice of Information Practices (Privacy) has been given to the applicant. (Not required in all states, contact your agent or broker for your state's requirements.)			
<p>PERSONAL INFORMATION MAY BE COLLECTED FROM PERSONS OTHER THAN THE INDIVIDUAL OR INDIVIDUALS PROPOSED FOR COVERAGE. SUCH INFORMATION AS WELL AS OTHER PERSONAL OR PRIVILEGED INFORMATION SUBSEQUENTLY COLLECTED BY THE INSURANCE INSTITUTION OR AGENT MAY IN CERTAIN CIRCUMSTANCES BE DISCLOSED TO THIRD PARTIES WITHOUT AUTHORIZATION. A RIGHT OF ACCESS AND CORRECTION EXISTS WITH RESPECT TO ALL PERSONAL INFORMATION COLLECTED. UPON REQUEST, A MORE DETAILED NOTICE OF YOUR RIGHTS AND OUR PRACTICES REGARDING PERSONAL INFORMATION WILL BE FURNISHED.</p>			
(Not applicable in AZ, CA, DE, KS, MA, MN, ND, NY, OR, VA, or WV. Specific ACORD 38s are available for applicants in these states.)		(Applicant's Initials): _____	
<p>THE UNDERSIGNED IS AN AUTHORIZED REPRESENTATIVE OF THE APPLICANT AND REPRESENTS THAT REASONABLE INQUIRY HAS BEEN MADE TO OBTAIN THE ANSWERS TO QUESTIONS ON THIS APPLICATION. HE/SHE REPRESENTS THAT THE ANSWERS ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF HIS/HER KNOWLEDGE.</p>			
APPLICANT'S SIGNATURE (Must be Officer, Owner or Partner)	DATE	PRODUCER'S SIGNATURE	NATIONAL PRODUCER NUMBER