WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY): 08/01/2024

AGENCY NAME AND ADDRESS	
Cline Agency Insurance Brokers 12400 Wilshire Blvd Ste 280 Los Angeles CA 90025 www.clineagency.com	COMPANY: Unassigned UNDERWRITER: APPLICANT NAME: Surfside III Condominium Owners Association OFFICE PHONE: MOBILE PHONE:
PRODUCER NAME: Rocco Espino	MAILING ADDRESS (including ZIP + 4 or Canadian Postal Code): c/o Lordon Management, 1275 Center Court Drive, Covina CA 91724
CS REPRESENTATIVE NAME: Rocco Espino	YRS IN BUS: 42
OFFICE PHONE (A/C, No, Ext): (800) 966-9566	SIC:
MOBILE PHONE:	NAICS:
FAX (A/C, No): (800) 736-3830	WEBSITE ADDRESS:
E-MAIL ADDRESS: rocco@clineagency.com	E-MAIL ADDRESS: insurance@mylordon.com
CODE: SUB CODE:	[ ] SOLE PROPRIETOR [X] CORPORATION [ ] LLC [ ] TRUST [ ] UNINCORPORATED ASSOCIATION [ ] PARTNERSHIP [ ] SUBCHAPTER "S" CORP [ ] JOINT VENTURE [ ] OTHER:
AGENCY CUSTOMER ID: 317201	CREDIT BUREAU NAME: ID NUMBER:
	FEDERAL EMPLOYER ID NUMBER: 953063708 / NCCI RISK ID NUMBER: / OTHER RATING BUREAU ID OR STATE EMPLOYER REGISTRATION NUMBER:

STATUS OF SUBMISSION

- [X] QUOTE
- [ ] ISSUE POLICY
- [ ] BOUND (Give date and/or attach copy)
- [ ] ASSIGNED RISK (Attach ACORD 133)

BILLING / AUDIT INFORMATION

BILLING PLAN	PAYMENT PLAN	AUDIT
[ ] AGENCY BILL	[X] ANNUAL	[ ] AT EXPIRATION
[X] DIRECT BILL	[ ] SEMI-ANNUAL	[ ] MONTHLY
	[ ] QUARTERLY % DOWN:	[ ] SEMI-ANNUAL
		[ ] QUARTERLY

LOCATIONS

LOC #	HIGHEST FLOOR	STREET, CITY, COUNTY, STATE, ZIP CODE
		Multiple, Seawind Way, Sunfish Way Port Hueneme 93041

POLICY INFORMATION

PROPOSED EFF DATE	PROPOSED EXP DATE	RATING EFFECTIVE DATE (if applicable)	ANNIVERSARY RATING DATE (if applicable)	PARTICIPATING / NON-PARTICIPATING	RETRO PLAN
09/05/2024	09/05/2025			[ ] PARTICIPATING [ ] NON-PARTICIPATING	

PART 1 - WORKERS COMPENSATION (States)	PART 2 - EMPLOYER'S LIABILITY	PART 3 - OTHER STATES INS	DEDUCTIBLES (N / A in WI)	AMOUNT / % (N / A in WI)	OTHER COVERAGES
	$ 1,000,000 EACH ACCIDENT		[ ] MEDICAL		[ ] U.S.L. & H. [ ] MANAGED CARE OPTION
	$ 1,000,000 DISEASE-POLICY LIMIT		[ ] INDEMNITY		[X] VOLUNTARY COMP
	$ 1,000,000 DISEASE-EACH EMPLOYEE				[ ] FOREIGN COV

DIVIDEND PLAN/SAFETY GROUP:

ADDITIONAL COMPANY INFORMATION:

SPECIFY ADDITIONAL COVERAGES / ENDORSEMENTS (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

TOTAL ESTIMATED ANNUAL PREMIUM - ALL STATES

TOTAL ESTIMATED ANNUAL PREMIUM ALL STATES	TOTAL MINIMUM PREMIUM ALL STATES	TOTAL DEPOSIT PREMIUM ALL STATES
$	$	$

CONTACT INFORMATION

TYPE	NAME	OFFICE PHONE	MOBILE PHONE	E-MAIL
INSPECTION	Madison Bauer	(626) 967-7921		insurance@mylordon.com
ACCTNG RECORD	Madison Bauer	(626) 967-7921		insurance@mylordon.com
CLAIMS INFO	Madison Bauer	(626) 967-7921		insurance@mylordon.com

INDIVIDUALS INCLUDED / EXCLUDED

PARTNERS, 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 in Missouri must meet the requirements of Section 287.090 RSMo.

STATE	LOC #	NAME	DATE OF BIRTH	TITLE/ RELATIONSHIP	OWNER- SHIP %	DUTIES	INC/EXC	CLASS CODE	REMUNERATION/PAYROLL

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