Florida dbpr Department of Business & Professional Regulation

Division of Regulation
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FLORIDA FARM LABOR PROGRAM
WORKERS' COMPENSATION INFORMATION
(Workers' Compensation Coverage Provided by Contractor's Employer)

_____ _____
Name of Contractor/Corporation Social Security or License Number

_____
Street, Rural Route or Post Office Box

_____
City, State and Zip Code

Effective this date _____, I, _____

_____
NAME, ADDRESS, AND PHONE NUMBER OF EMPLOYER

will pay the premium for Workers' Compensation Insurance on you and your crew members as long as you are in our employment. **I understand that this coverage will also be used to cover the transportation of workers.** Our policy number is _____. The policy period is from _____ to _____. Your employment with us should last until approximately _____.

Must be a specific date (MM/DD/YY)

_____
Employer Signature

_____
Title of Signer

TO BE COMPLETED BY THE INSURANCE CARRIER OR CARRIER'S DULY AUTHORIZED AGENT

I HEREBY CERTIFY THE ABOVE STATEMENT IS CORRECT, AND THAT THE POLICY COVERS THE TRANSPORTATION OF WORKERS.

_____ _____
Name of Insurance Agency Signature of Insurance Representative

_____ _____
Street Address or Post Office Box Date

_____
City, State and Zip Code