STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

BOND NO. _____

KNOW ALL MEN BY THESE PRESENTS THAT _____ of _____ as Principal and _____ a surety bond company organized under the laws of the State of _____ and licensed to do business in the State of Florida as Surety, are held and firmly bound unto the Agency for Health Care administration in the total penal sum of _____ lawful money of the United States of America, for which sum well and truly to be paid said Principal and Surety bind themselves, their heirs, executors, administrators, successors and assigns, jointly and severally firmly by these presents:

A. WHEREAS, the above named Principal is an assisted living facility as defined in Chapter 400, Part III, Florida Statutes, and, as such, is a licensee under Chapter 400, Part III, Florida Statutes, and

B. WHEREAS, Chapter 400, Part III, Florida Statutes require each assisted living facility whose owner, operator, staff or representative thereof services as representative payee or is granted power of attorney for a resident shall file a surety bond with the Agency for Health Care Administration in an amount equal to twice the average monthly aggregate income or personal funds due to residents or expendable from their account, plus the value of any other property of the resident, which is in fact under the control of the person having the power of attorney.

NOW, THEREFORE, the condition of this obligation is such that if the above named Principal shall: (1) well and truly hold separately and in trust all residents' funds deposited with Principal as assisted living facility and (2) shall administer said funds on behalf of said residents in the manner directed by Chapter 400, Part III, Florida Statutes, and (3) shall render true and complete accounts to the residents, the depositors, and the Obligee when requested, and (4) upon termination of each said deposit, shall account for all funds received thereunder, expended and held on hand, then this obligation shall be null and void, otherwise to remain in full force and effect.

This bond is executed and accepted subject to the following conditions: (1) The agency for Health Care Administration or, with the written consent of the Director of each Agency, any aggrieved resident or depositor, may maintain in his own name, an action on this bond or recover for principal's alleged breaches of the condition hereof, in any court of competent jurisdiction in the State of Florida. (2) This bond shall be effective as of 12:01 A. M. of _____ _____, and shall continue in full force and effect until _____.

IN WITNESS WHEREOF, the parties hereto have affixed their hands and seals this _____ day of _____, _____

_____ _____

Principal's Representative

Upon issuance of renewal, forward original to AHCA-ALF Unit, 2727 Mahan Drive, Tallahassee, Florida, 32308. Upon cancellation or nonrenewal, please advise this office at least 30 days in advance giving reason for such action. The name and address of the licensed facility should appear on all correspondence with this office.

Surety Bond Application

AGENCY NAME: _____ AGENCY CONTACT: _____

AGENCY PHONE: _____ AGENCY FAX: _____ AGENCY EMAIL: _____

AGENCY ADDRESS: _____ City: _____ State: _____ Zip: _____

CURRENT OR EXPIRING QUOTE WE ARE LOOKING TO BEAT? _____

NAME OF PREVIOUS SURETY COMPANY WRITING THE BOND? _____

SECTION I: BOND APPLIED FOR

Type of Bond: _____ Effective Date: _____ Expiration Date: _____

Type of Company **CORP**☐ **LLC**☐ **DBA**☐ **PARTNERSHIP** ☐ Bond Amount: _____

(Obligee): _____

Obligee Address _____

SECTION II: GENERAL INFORMATION

Applicant's Name: _____ Spouse Name: _____

SS#: _____ Spouse SS#: _____ Home Phone: ( ) _____

Residence Address: _____ City: _____ State: _____ Zip: _____

Business Name: _____

Business Phone: ( ) _____ Business Fax: ( ) _____ E-mail: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Date Business BEGAN under present Individual or Firm Name: _____ BUSINESS TAX ID: _____

HAS ANY COMPANY REFUSED TO ISSUE BONDS FOR ANY PURPOSE? YES ☐ NO☐ DO YOU HAVE ANY LIENS, CLAIMS OR JUDGMENTS AGAINST YOU? YES ☐ NO☐

HAS APPLICANT EVER FAILED IN BUSINESS? YES ☐ NO☐ HAS APPLICANT EVER FILED BANKRUPTCY? YES ☐ NO☐

IF YES TO ANY, PLEASE EXPLAIN ON A SEPERATE SHEET OF PAPER

SECTION III: ADDITIONAL OWNERS OR PARTNERS AS REQUIRED

NAME: _____ SPOUSE NAME: _____

SS#: _____ SPOUSE SS#: _____ PHONE: _____

HOME ADDRESS: _____ City: _____ State: _____ Zip: _____

PERSONAL FINANCIALS *(IF MORE THAN ONE OWNER, EACH HAS TO FILL OUT THIS APPLICATION)*

STATEMENT OF ASSETS AND LIABILITIES AS OF

ASSETS		LIABILITIES	
CASH IN BANK		NOTES PAYABLE TO BANKS	
CASH ON HAND		NOTES TO OTHERS (excl. of equipment)	
STOCKS AND BONDS		ACCOUNTS PAYABLE	
ACCOUNTS RECEIVABLE		FEDERAL & STATE INCOME TAX DUE	
NOTES RECEIVABLE		ALL OTHER TAXES	
INVENTORY		ACCRUALS, PAYROLLS, ETC.	
CASH VALUE LIFE INSURANCE			
EQUIPMENT		DUE ON EQUIPMENT	
REAL ESTATE		DUE ON REAL ESTATE	
OTHER ASSETS		OTHER LIABILITIES	
		CAPITAL STOCK (if a corporation)	
		SURPLUS AND UNDIVIDED PROFITS	
TOTAL ASSETS		**TOTAL LIABILITIES**	
		NET WORTH	

Name of Owners	Name and Title of Officers	% OWNERSHIP IN COMPANY

COMPLETION OF THIS FORM CONSTITUTES PERMISSION FOR WORLDWIDE INSURANCE SPECIALISTS INC. TO OBTAIN CONSUMER INFORMATION WHICH WILL BE USED TO DETERMINE BONDING ELIGIBILITY. THIS INFORMATION WILL BE HELD IN THE STRICTEST CONFIDENCE
NO PREMIUM FINANCING WILL BE ACCEPTED AS PREMIUM IS EARNED IN FULL.

Worldwide Insurance Specialists, Inc
2424 W. Missouri AVE
Phoenix, AZ 85015

Toll Free: (888) 518-8011
Local (602) 749-0702
Fax: (602) 674-8235

E-Mail WWIS@WWISINC.COM