STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION
MEDICAID PROVIDER SURETY BOND

MEDICAID PROVIDER NUMBER or **TAX ID** _____ **BOND NUMBER** _____

Know all men by these presents that

_____ d/b/a _____
(Provider's Name)

with its place of business at _____
(Provider's Physical Address)

City of _____, County of _____, State of _____, as principal,

and _____, a corporation organized and existing under the laws of
(Surety Name)

the State of _____, with its principal place of business at _____
(Surety Address)

City of _____, County of _____, State of _____ and licensed to transact a surety business in the State of Florida, as surety, are indebted to the State of Florida, Agency for Health Care Administration (AHCA), in the penal sum of Fifty Thousand Dollars ($50,000), for which payment principal and surety bind ourselves and our legal representatives and successors, jointly and severally.

The condition of this obligation is that principal is a Medicaid provider as defined in §409.901(11), Florida Statutes (Fla. Stat.), and is required by the Agency, pursuant to §409.907(7), Fla. Stat., to post a surety bond in the amount of $50,000 to insure compliance with the attached provider agreement, pursuant to §409.907, Fla. Stat.

If principal and all of principal's agents and employees faithfully conform to and abide by the provisions of the above statute, implementing regulations and bulletins, together with all amendatory and supplementary acts, now and hereafter enacted, and if principal honestly and faithfully applies funds received, and faithfully and honestly performs all obligations and undertakings made pursuant to the provisions of such statute in the conduct of providing Medicaid services by principal and by principal's agents and employees, then this obligation shall be null and void; otherwise, it shall be in full force and effect.

1. The total aggregate liability of the surety shall be limited to the sum of $50,000 Dollars.

2. This bond and the obligation under the bond shall be deemed to run continuously, and shall remain in full force and effect for one year until and unless the bond is terminated and canceled in the manner provided, the Medicaid provider agreement expires, or as otherwise provided by law.

3. The Agency, acting through the Secretary, reserves the right, at any time, to terminate this bond, except as to any liability already incurred or accrued, by written notice of such termination to the surety delivered or mailed by certified or registered mail. On expiration of the period designated in such notice, which period shall be not less than sixty (60) days from the time the notice was mailed, this bond shall terminate and be of no further force or effect except as to any liability incurred or accrued prior to such termination.

4. Surety reserves the right to terminate this bond at any time, such termination to be effected by surety's giving sixty (60) days written notice, including reason, by certified or registered mail to: The principal and EDS Provider Enrollment, 2671 Executive Center Circle, Suite 100, Tallahassee, FL 32301. The liability of surety on this bond shall cease sixty (60) days after receipt of the termination notice by Agency and principal, or on the filing and acceptance of a new bond whichever first occurs; and the bond shall terminate and be of no further force or effect, except as to any liability, debt, or other obligation incurred or accrued prior to the effective date of such termination. The principal insured under the bond shall, within thirty (30) days of the filing of the notice of termination, provide EDS Provider Enrollment with a replacement bond.

Bond forms change; this is for educational purposes only.

5. In the event principal and surety, or either of them, is served with notice of any action brought against principal or surety under this bond, written notice of the filing of such action shall be immediately given by principal or surety, as each is served with notice of the action to: EDS Provider Enrollment, 2671 Executive Center Circle, Suite 100, Tallahassee, FL 32301.

6. In the event any actions or proceedings are initiated with respect to this bond, the parties agree that the venue shall be Leon County, State of Florida.

7. Should any proceedings be necessary to enforce this bond, AHCA shall be allowed to recover attorney fees, in addition to other sums found due.

8. It is agreed that this bond shall be governed by and construed in accordance with the laws of the State of Florida.

9. Neither this bond nor the obligation of this bond, nor any interest in the bond, may be assigned without the prior, express, and written consent of surety.

10. No right of action shall accrue on account of this bond for the use or benefit of any individual, partnership, corporation, or other entity, other than AHCA.

The premium for which this bond is written is _____ Dollars (_____)

In witness whereof, each party to this bond has caused it to be executed at the place and on the date indicated below.

MEDICAID PROVIDER {
By: _____
(Authorized Corporate Officer)
Capacity: As _____

AND

SURETY COMPANY {
By: _____
(Authorized Corporate Officer)
Capacity: As _____

OR

RESIDENT AGENT {
By: _____
(Florida Resident Agent of Surety Company)
_____
(Resident Agent's Street Address)
_____
(City, State, and ZIP Code)

SIGNED and SEALED in the presence of: _____ (Witness) and _____ (Witness)

Executed at _____, Florida, this _____ day of _____, _____ .

NOTE: If a Florida Resident Agent signs in lieu of the Surety Company Officer then a properly certified copy of the Agent's Power of Attorney must be attached to this bond.

Bond forms change; this is for educational purposes only.

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.

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