CYE ENTERPRISES, INC.

1605 Rowe Avenue
Jacksonville, FL 32208
Phone: (904) 224-8224
Fax: (904) 224-8227

Subcontractor/Vendor Pre-Qualification Instructions and Supporting Documents Checklist

- ☐ 1. Subcontractor Pre-Qualification Form – Fill form
- ☐ 2. W-9 – Fill form and sign
- ☐ 3. Insurance Certificate – Provide a copy of your current coverage limits

  All CYE subcontractors are required to carry the minimums below upon award of contract. At that time, a waiver of subrogation and additional insured endorsements shall be applied to general liability and auto coverage.

  i. Comprehensive General Liability including completed operations
     - $1,000,000 Each Occurrence
     - $1,000,000 any one person or organization
     - $2,000,000 Products/Completed Operations Aggregate
     - $2,000,000 General Aggregate

  ii. Comprehensive Automobile Liability

  Bodily Injury
     - $200,000 Each Person
     - $500,000 Each Occurrence

  Property Damage
     - $20,000 Each Occurrence

  iii. Worker's Compensation and Employers Liability
     - $100,000

- ☐ 4. OSHA forms 300A and 300 – Provide data for the **most recent three years**

  Complete the OSHA 300 and OSHA 300A pages, one for each of the past three years; 2017, 2018 and 2019.

- ☐ 5. Experience Modification Rate (EMR) – Provide letter or NCCI document for the **past three years**

  Verification is to be obtained from your worker's compensation insurance agent. It can be in the form of an NCCI document (like the sample attached) or in letter format on your agent's letterhead. Your agent will need to provide your EMR for, at least, the past three years.

- ☐ 6. DART Rate Letter – Provide signed letter similar to the sample attached

  This is a self-generated letter produced on your company letterhead. The data needed to calculate the DART rate can be found on your latest completed year's OSHA 300, 300A forms. See the attached sample for more information.

- ☐ 7. Reference letter from bonding company, if applicable – Letter must contain your single and aggregate project limits
- ☐ 8. Material manufacturer certifications, if applicable
- ☐ 9. Construction or trade-specific license(s), if applicable
- ☐ 10. Safety Program/Manual documentation, if available

Submit all documents to Anna Rodgers, Contract Administrator:

Email to (preferred):
arodgers@cyeinc.com

Fax to:
904-647-2056

Mail to:
Anna Rodgers
1605 Rowe Avenue
Jacksonville, FL 32208

For more information, contact Anna Rodgers at: 904-647-2056

CYE Enterprises Inc.
1605 Rowe Avenue
Jacksonville, FL 32208
Telephone 904-224-8224 *Fax* 904-224-8227

SUBCONTRACTOR PRE-QUALIFICATION FORM

Date _____

Company Name _____

Address _____

_____

City _____ ***State*** _____ ***Zip*** _____

Phone # _____ ***Fax #*** _____

Cage Code _____

Estimating Contact _____

Email _____

Past Performance Contact _____

Email _____

Web Site Address _____

Date Established _____

Type of Business _____

Contracting License # (s) - (If Applicable) _____

Types of Projects ***Federal*** ☐ ***State*** ☐ ***Commercial*** ☐ ***Residential*** ☐

Description of Services You Provide

_____

Geographic Service Area _____

Number of Employees: _____

Does your company have a safety program ***Yes*** ☐ ***No*** ☐

If yes, is it a written safety program ***Yes*** ☐ ***No*** ☐

Do you have a substance abuse program ***Yes*** ☐ ***No*** ☐

Do you carry liability Insurance ***Yes*** ☐ ***No*** ☐

(Attach copy of Certificate of Insurance for evidence of limits)

Do you carry Worker's Compensation Insurance ***Yes*** ☐ ***No*** ☐

EMR (Experience Modification Rating) _____

(EMR can be obtained by contacting your Worker's Comp policy agent)

Have you had any OSHA Violations? **Yes** ☐ **No** ☐

If yes, Please describe violation, and include date of occurrence and penalty information.

_____

BANK REFERENCES

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Contact _____

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Contact _____

SUPPLIER REFERENCES

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Contact _____

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Contact _____

PAST PERFORMANCE REFERENCES

Project Title _____

Location _____

Contract # _____

Phone _____ Fax _____

Point of Contact & Title _____ email: _____

Project Title _____

Location _____

Contract # _____

Phone _____ Fax _____

Point of Contact & Title _____ email: _____

BONDING

DOES YOUR COMPANY HAVE A BONDING PROGRAM?

Yes ☐ **No** ☐

Bonding Company Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Agent _____

Bonding Limits **Single** _____ **Aggregate** _____

ADDTL PAST PERFORMANCE REFERENCES

Project Title _____

Location _____

Contract # _____

Phone _____ Fax _____

Point of Contact & Title _____ email: _____

Project Title _____

Location _____

Contract # _____

Phone _____ Fax _____

Point of Contact & Title _____ email: _____

CONSTRUCTION CREWS AND SUPERINTENDENTS

Number of In-House Crews _____

Number of Field Employees _____

Superintendent #1 Name _____

Years of Service as Superintendent _____

Superintendent #2 Name _____

Years of Service as Superintendent _____

Superintendent #3 Name _____

Years of Service as Superintendent _____

ADDTL INFORMATION ABOUT YOUR FIRM

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person** ► **Date** ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 01/01/2020

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME: *Insurance Agent Name*	
Insurance Agency 123 Main St. Anytown, USA 12345	PHONE (A/C, No, Ext): (123) 555-1212	FAX (A/C, No): (123) 555-1213
	E-MAIL ADDRESS: agent@yourinsurance.com	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : Sample Insurance Co.	
INSURED	INSURER B :	
Your Company 111 Main St Anytown, USA 12345	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY			123456789	01/01/2020	01/01/2021	EACH OCCURRENCE	$ 1,000,000
	CLAIMS-MADE [X] OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$ 1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 2,000,000
	POLICY [ ] PRO-JECT [ ] LOC						PRODUCTS - COMP/OP AGG	$ 2,000,000
	OTHER:							$
A	AUTOMOBILE LIABILITY			123456789	01/01/2020	01/01/2021	COMBINED SINGLE LIMIT (Ea accident)	$
	X ANY AUTO						BODILY INJURY (Per person)	$ 200,000
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$ 500,000
	HIRED AUTOS / NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$ 20,000
								$
	UMBRELLA LIAB [ ] OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB [ ] CLAIMS-MADE						AGGREGATE	$
	DED [ ] RETENTION $							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N			123456789	01/01/2020	01/01/2021	PER STATUTE [ ] OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [ ] N / A (Mandatory in NH)						E.L. EACH ACCIDENT	$ 100,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

CYE Enterprises, Inc.
1605 Rowe Avenue
Jacksonville, FL 32208

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Agent Signature

OSHA's Form 300 (Rev. 01/2004)

Log of Work-Related Injuries and Illnesses

Note: You can type input into this form and save it. Because the forms in this recordkeeping package are "fillable/writable" PDF documents, you can type into the input form fields and then save your inputs using the free Adobe PDF Reader. In addition, the forms are programmed to auto-calculate as appropriate.

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

Year 20 ___

U.S. Department of Labor

Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

You must record information about every work-related death and about every work-related injury or illness that involves loss of consciousness, restricted work activity or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that meet any of the specific recording criteria listed in 29 CFR Part 1904.8 through 1904.12. Feel free to use two lines for a single case if you need to. You must complete an Injury and Illness Incident Report (OSHA Form 301) or equivalent form for each injury or illness recorded on this form. If you're not sure whether a case is recordable, call your local OSHA office for help.

Establishment name ______________________

City ______________ State ________

	Identify the person			Describe the case			Classify the case — SELECT ONLY ONE box for each case based on the most serious outcome for that case:				Enter the number of days the injured or ill worker was:		Select the "Injury" column or choose one type of illness: (M)					
	(A) Case no.	(B) Employee's name	(C) Job title (*e.g., Welder*)	(D) Date of injury or onset of illness (*e.g., 2/10*)	(E) Where the event occurred (*e.g., Loading dock north end*)	(F) Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill (*e.g., Second degree burns on right forearm from acetylene torch*)	(G) Death	(H) Days away from work	(I) Remained at Work: Job transfer or restriction	(J) Remained at Work: Other record-able cases	(K) Away from work	(L) On job transfer or restriction	(1) Injury	(2) Skin disorder	(3) Respiratory condition	(4) Poisoning	(5) Hearing loss	(6) All other illnesses
Reset				___ / ___ month / day							___ days	___ days						
Reset				___ / ___ month / day							___ days	___ days						
Reset				___ / ___ month / day							___ days	___ days						
Reset				___ / ___ month / day							___ days	___ days						
Reset				___ / ___ month / day							___ days	___ days						
Reset				___ / ___ month / day							___ days	___ days						
Reset				___ / ___ month / day							___ days	___ days						
Reset				___ / ___ month / day							___ days	___ days						
Reset				___ / ___ month / day							___ days	___ days						
Reset				___ / ___ month / day							___ days	___ days						
						Page totals ▶	___	___	___	___	___	___	Injury (1)	Skin disorder (2)	Respiratory condition (3)	Poisoning (4)	Hearing loss (5)	All other illnesses (6)

Save Input | Add a Form Page

OSHA's Form 300A (Rev. 01/2004)

Summary of Work-Related Injuries and Illnesses

Note: You can type input into this form and save it.
Because the forms in this recordkeeping package are "fillable/writable" PDF documents, you can type into the input form fields and then save your inputs using the free Adobe PDF Reader.

Year 20 ___

U.S. Department of Labor
Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

All establishments covered by Part 1904 must complete this Summary page, even if no work-related injuries or illnesses occurred during the year. Remember to review the Log to verify that the entries are complete and accurate before completing this summary.

Using the Log, count the individual entries you made for each category. Then write the totals below, making sure you've added the entries from every page of the Log. If you had no cases, write "0."

Employees, former employees, and their representatives have the right to review the OSHA Form 300 in its entirety. They also have limited access to the OSHA Form 301 or its equivalent. See 29 CFR Part 1904.35, in OSHA's recordkeeping rule, for further details on the access provisions for these forms.

Number of Cases

Total number of deaths	Total number of cases with days away from work	Total number of cases with job transfer or restriction	Total number of other recordable cases
_____	_____	_____	_____
(G)	(H)	(I)	(J)

Number of Days

Total number of days away from work	Total number of days of job transfer or restriction
_____	_____
(K)	(L)

Injury and Illness Types

Total number of . . .	(M)		
(1) Injuries	_____	(4) Poisonings	_____
(2) Skin disorders	_____	(5) Hearing loss	_____
(3) Respiratory conditions	_____	(6) All other illnesses	_____

Post this Summary page from February 1 to April 30 of the year following the year covered by the form.

Establishment information

Your establishment name _____

Street _____

City _____ State _____ Zip _____

Industry description (*e.g., Manufacture of motor truck trailers*)

_____

Standard Industrial Classification (SIC), if known (*e.g., 3715*)

_____

OR

North American Industrial Classification (NAICS), if known (e.g., 336212)

_____

Employment information *(If you don't have these figures, see the Worksheet on the next page to estimate.)*

Annual average number of employees _____

Total hours worked by all employees last year _____

Sign here

Knowingly falsifying this document may result in a fine.

I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete.

_____ _____

Company executive Title

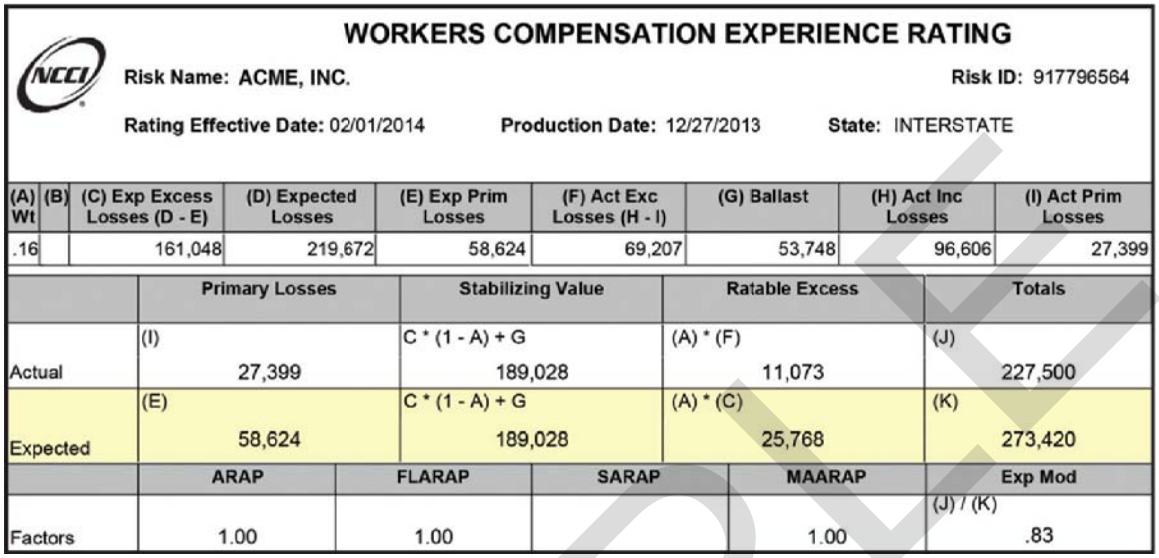
Phone _____ - _____ - _____ Date _____ / _____ / _____

Save Input

WORKERS COMPENSATION EXPERIENCE RATING

Risk Name: ACME, INC. **Risk ID:** 917796564

Rating Effective Date: 01/01/2019 **Production Date:** 11/27/2018 **State:** INTERSTATE



WORKERS COMPENSATION EXPERIENCE RATING

Risk Name: ACME, INC. Risk ID: 917796564

Rating Effective Date: 02/01/2014 Production Date: 12/27/2013 State: INTERSTATE

(A) Wt	(B)	(C) Exp Excess Losses (D - E)	(D) Expected Losses	(E) Exp Prim Losses	(F) Act Exc Losses (H - I)	(G) Ballast	(H) Act Inc Losses	(I) Act Prim Losses
.16		161,048	219,672	58,624	69,207	53,748	96,606	27,399

	Primary Losses	Stabilizing Value	Ratable Excess	Totals
Actual	(I) 27,399	C * (1 - A) + G 189,028	(A) * (F) 11,073	(J) 227,500
Expected	(E) 58,624	C * (1 - A) + G 189,028	(A) * (C) 25,768	(K) 273,420

	ARAP	FLARAP	SARAP	MAARAP	Exp Mod
Factors	1.00	1.00		1.00	(J) / (K) .83

ANY COMPANY, INC.
123 Main Street
Anytown, USA 12345

1 January 2019

CYE Enterprises, Inc.
1605 Rowe Avenue
Jacksonville, FL 32208

Project Title: Sample Project

Subject: Any Company, Inc. DART Rate

Number of All Employee Labor Hours Worked Fiscal Year 2019	95,000

DART Incidents

Total No. of **CASES** of non-fatal work-related injury and illness cases with:	
Days away from work (Column H on OSHA 300)	1
Job transfer or restricted work activity only (Column I on OSHA 300)	0
TOTAL DART Incidents – Add Above	1

DART Rate = [Total DART incidents x 200,000] ÷ Total of All Employee Labor Hours

Worked **DART RATE Fiscal Year 2019 =** 2.10

Sincerely,

Bob Smith

Bob Smith
Project Manager