



WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY)

AGENCY		COMPANY				UNDERWRITER			
PHONE (A/C. No. Ext):		APPLICANT NAME							
FAX (A/C. No.):		MAILING ADDRESS (including ZIP code)				E-MAIL ADDRESS			
E-MAIL ADDRESS:		YRS IN BUS	SIC	INDIVIDUAL	CORPORATION	LLC	OTHER:		
CODE:		SUB CODE:		CREDIT BUREAU NAME:		ID NUMBER:		OTHER RATING BUREAU ID OR STATE EMPLOYER REGISTRATION NUMBER	
AGENCY CUSTOMER ID		FEDERAL EMPLOYER ID NUMBER			NCCI ID NUMBER				

STATUS OF SUBMISSION**BILLING/AUDIT INFORMATION**

<input type="checkbox"/> QUOTE	<input type="checkbox"/> ISSUE POLICY	BILLING PLAN		PAYMENT PLAN		AUDIT	
<input type="checkbox"/> BOUND (Give date and/or attach copy)	<input type="checkbox"/> AGENCY BILL	<input type="checkbox"/> ANNUAL	<input type="checkbox"/> OTHER:	<input type="checkbox"/> AT EXPIRATION	<input type="checkbox"/> MONTHLY		
<input type="checkbox"/> ASSIGNED RISK (Attach ACORD 133)	<input type="checkbox"/> DIRECT BILL	<input type="checkbox"/> SEMI-ANNUAL	<input type="checkbox"/> QUARTERLY	<input type="checkbox"/> SEMI-ANNUAL	<input type="checkbox"/> OTHER:		
				<input type="checkbox"/> QUARTERLY	<input type="checkbox"/> % DOWN:	<input type="checkbox"/> QUARTERLY	

LOCATIONS

LOC #	STREET, CITY, COUNTY, STATE, ZIP CODE

POLICY INFORMATION

PROPOSED EFF DATE	PROPOSED EXP DATE	NORMAL ANNIVERSARY RATING DATE	PARTICIPATING	RETRO PLAN		
			NON-PARTICIPATING			
PART 1 - WORKERS COMPENSATION (States)	PART 2 - EMPLOYER'S LIABILITY		PART 3 - OTHER STATES INS	DEDUCTIBLES	AMOUNT/%	OTHER COVERAGES
	\$	EACH ACCIDENT		MEDICAL		U.S.L. & H. VOLUNTARY COMP
	\$	DISEASE-POLICY LIMIT		INDEMNITY		FOREIGN COV
\$	DISEASE-EACH EMPLOYEE					MANAGED CARE OPTION
DIVIDEND PLAN/SAFETY GROUP		ADDITIONAL COMPANY INFORMATION				

RATING INFORMATION

STATE	LOC #	CLASS CODE	DESCR CODE	CATEGORIES, DUTIES, CLASSIFICATIONS	# EMPLOYEES		ESTIMATED ANNUAL REMUNERATION	RATE	ESTIMATED ANNUAL PREMIUM
					FULL TIME	PART TIME			

STATE:	FACTOR	FACTORED PREMIUM	FACTOR	FACTORED PREMIUM	SPECIFY ADDITIONAL COVERAGES / ENDORSEMENTS	
TOTAL		\$	EXPENSE CONSTANT	N/A		\$
INCREASED LIMITS		\$	TAXES / ASSESSMENTS	N/A		\$
DEDUCTIBLE		\$				\$
		\$	ESTIMATED ANNUAL PREMIUM	N/A		\$
EXPERIENCE OR MERIT MODIFICATION		\$				
LOSS CONSTANT	N/A	\$				
ASSIGNED RISK SURCHARGE		\$				
ARAP		\$				
SCHEDULE RATING		\$				
CCPAP		\$	TOTAL EST ANNUAL PREMIUM	N/A	\$	
STANDARD PREMIUM		\$	MINIMUM PREMIUM	\$		
PREMIUM DISCOUNT		\$	DEPOSIT PREMIUM	\$		

INDIVIDUALS INCLUDED/EXCLUDED

PARTNERS, OFFICERS, RELATIVES TO BE INCLUDED OR EXCLUDED. (Remuneration to be included must be part of rating information section.)									
STATE	LOC #	NAME	DATE OF BIRTH	TITLE/ RELATIONSHIP	OWNER- SHIP %	DUTIES	INC/EXC	CLASS CODE	REMUNERATION

PRIOR CARRIER INFORMATION/LOSS HISTORY

PROVIDE INFORMATION FOR THE PAST 5 YEARS AND USE THE REMARKS SECTION FOR LOSS DETAILS							LOSS RUN ATTACHED
YEAR	CARRIER & POLICY NUMBER	ANNUAL PREMIUM	MOD	# CLAIMS	AMOUNT PAID	RESERVE	
	CO: POL #:						
	CO: POL #:						
	CO: POL #:						
	CO: POL #:						
	CO: POL #:						

NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS

GIVE COMMENTS AND DESCRIPTIONS OF BUSINESS, OPERATIONS AND PRODUCTS: MANUFACTURING-- RAW MATERIALS, PROCESSES, PRODUCT, EQUIPMENT, CONTRACTOR-- TYPE OF WORK, SUB-CONTRACTS. MERCANTILE--MERCHANDISE, CUSTOMERS, DELIVERIES. SERVICE--TYPE, LOCATION. FARM--ACREAGE, ANIMALS, MACHINERY, SUB-CONTRACTS.

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	YES	NO	EXPLAIN ALL "YES" RESPONSES	YES	NO
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT/WATERCRAFT?			18. ANY PRIOR COVERAGE DECLINED/ CANCELLED/NON-RENEWED (Last 3 years)?		
2. DO/HAVE PAST, PRESENT OR DISCONTINUED OPERATIONS INVOLVE(D) STORING, TREATING, DISCHARGING, APPLYING, DISPOSING, OR TRANSPORTING OF HAZARDOUS MATERIAL? (e.g. landfills, wastes, fuel tanks, etc)			19. ARE EMPLOYEE HEALTH PLANS PROVIDED?		
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?			20. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS/SUBSIDIARY?		
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?			21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?		
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?			22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME?		
6. ARE SUB-CONTRACTORS USED? (IF YES, GIVE % OF WORK SUBCONTRACTED)			23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST 5 YEARS?		
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INS.?			24. ANY UNDISPUTED AND UNPAID WORKERS COMPENSATION PREMIUM DUE FROM YOU OR ANY COMMONLY MANAGED OR OWNED ENTERPRISES? IF YES, EXPLAIN INCLUDING ENTITTY NAME(S) AND POLICY NUMBERS(S).		
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?			CONTACT INFORMATION		
9. ANY GROUP TRANSPORTATION PROVIDED?			IN- SPECTION	PHONE:	
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?				NAME:	
11. ANY SEASONAL EMPLOYEES?			ACCTNG RECORD	E-MAIL:	
12. IS THERE ANY VOLUNTEER OR DONATED LABOR?				PHONE:	
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?				NAME:	
14. DO EMPLOYEES TRAVEL OUT OF STATE?			CLAIMS INFO	E-MAIL:	
15. ARE ATHLETIC TEAMS SPONSORED?				PHONE:	
16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?				NAME:	
17. ANY OTHER INSURANCE WITH THIS INSURER?				E-MAIL:	

APPLICABLE IN TENNESSEE: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO ANY PARTY TO A WORKERS COMPENSATION TRANSACTION FOR THE PURPOSE OF COMMITTING FRAUD. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS. ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, HI, NE, OH, OK, OR, TN or VT; in DC, LA, ME and VA, insurance benefits may also be denied)

REMARKS (Attach additional sheets if more space is required)

APPLICANT'S SIGNATURE	DATE	PRODUCER'S SIGNATURE	NATIONAL PRODUCER NUMBER
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