



WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY)

AGENCY		COMPANY			UNDERWRITER		
1 APPLICANT NAME							
2 MAILING ADDRESS (including ZIP + 4)					E-MAIL ADDRESS		
PHONE (A/C, No, Ext):		3 YRS IN BUS		SIC	NAICS	4 INDIVIDUAL	
FAX (A/C, No):						CORPORATION	
E-MAIL ADDRESS:						LLC	
CODE:		SUB CODE:		CREDIT BUREAU NAME:		ID NUMBER:	
AGENCY CUSTOMER ID		5 FEDERAL EMPLOYER ID NUMBER		NCCI ID NUMBER		OTHER RATING BUREAU ID OR STATE EMPLOYER REGISTRATION NUMBER	

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

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

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

8 RATING INFORMATION											
STATE	LOC #	9 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		\$	

10 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

11 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 #:					

12 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.

13 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 ENTITY NAME(S) AND POLICY NUMBERS(S).		
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?			14 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?			E-MAIL:		
15. ARE ATHLETIC TEAMS SPONSORED?			CLAIMS INFO	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)

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