



WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY)

AGENCY NAME AND ADDRESS		COMPANY:	
PRODUCER NAME:		UNDERWRITER:	
CS REPRESENTATIVE NAME:		APPLICANT NAME:	
OFFICE PHONE (A/C. No. Ext):		OFFICE PHONE:	MOBILE PHONE:
MOBILE PHONE:		MAILING ADDRESS (including ZIP + 4 or Canadian Postal Code)	
FAX (A/C. No.):		YRS IN BUS:	
E-MAIL ADDRESS:		SIC:	
CODE: SUB CODE:		NAICS:	
AGENCY CUSTOMER ID:		WEBSITE ADDRESS:	
E-MAIL ADDRESS:		E-MAIL ADDRESS:	
SOLE PROPRIETOR <input type="checkbox"/>		CORPORATION <input type="checkbox"/>	LLC <input type="checkbox"/>
PARTNERSHIP <input type="checkbox"/>		SUBCHAPTER "S" CORP <input type="checkbox"/>	TRUST <input type="checkbox"/>
CREDIT BUREAU NAME:		ID NUMBER:	
FEDERAL EMPLOYER ID NUMBER		NCCI RISK 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	BILLING PLAN	PAYMENT PLAN
<input type="checkbox"/> BOUND (Give date and/or attach copy)	<input type="checkbox"/> AGENCY BILL	<input type="checkbox"/> ANNUAL <input type="checkbox"/>	<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"/> SEMI-ANNUAL <input type="checkbox"/>
		<input type="checkbox"/> QUARTERLY % DOWN:	<input type="checkbox"/> QUARTERLY

LOCATIONS		
LOC #	HIGHEST FLOOR	STREET, CITY, COUNTY, STATE, ZIP CODE

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 (N / A in WI)		AMOUNT / % (N / A in WI)	
		\$ 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							
SPECIFY ADDITIONAL COVERAGES / ENDORSEMENTS (Attach ACORD 101, Additional Remarks Schedule, if more space is required)									

TOTAL ESTIMATED ANNUAL PREMIUM - ALL STATES		
TOTAL ESTIMATED ANNUAL PREMIUM ALL STATES	TOTAL MINIMUM PREMIUM ALL STATES	TOTAL DEPOSIT PREMIUM ALL STATES
\$	\$	\$

CONTACT INFORMATION				
TYPE	NAME	OFFICE PHONE	MOBILE PHONE	E-MAIL
INSPECTION				
ACCTNG RECORD				
CLAIMS INFO				

INDIVIDUALS INCLUDED / EXCLUDED									
PARTNERS, OFFICERS, RELATIVES (Must be employed by business operations) TO BE INCLUDED OR EXCLUDED (Remuneration/Payroll to be included must be part of rating information section.) Exclusions in Missouri must meet the requirements of Section 287.090 RSMo.									
STATE	LOC #	NAME	DATE OF BIRTH	TITLE/ RELATIONSHIP	OWNER-SHIP %	DUTIES	INC/EXC	CLASS CODE	REMUNERATION/PAYROLL

STATE RATING WORKSHEET

FOR MULTIPLE STATES, ATTACH AN ADDITIONAL PAGE 2 OF THIS FORM

RATING INFORMATION - STATE:

LOC #	CLASS CODE	DESCR CODE	CATEGORIES, DUTIES, CLASSIFICATIONS	# EMPLOYEES		SIC	NAICS	ESTIMATED ANNUAL REMUNERATION/ PAYROLL	RATE	ESTIMATED ANNUAL MANUAL PREMIUM
				FULL TIME	PART TIME					

PREMIUM

STATE:	FACTOR	FACTORED PREMIUM		FACTOR	FACTORED PREMIUM
TOTAL	N / A	\$			\$
INCREASED LIMITS		\$	SCHEDULE RATING *		\$
DEDUCTIBLE *		\$	CCPAP		\$
		\$	STANDARD PREMIUM		\$
EXPERIENCE OR MERIT MODIFICATION		\$	PREMIUM DISCOUNT		\$
		\$	EXPENSE CONSTANT	N / A	\$
ASSIGNED RISK SURCHARGE *		\$	TAXES / ASSESSMENTS *	N / A	\$
ARAP *		\$			\$
* N / A in Wisconsin					
TOTAL ESTIMATED ANNUAL PREMIUM		MINIMUM PREMIUM	DEPOSIT PREMIUM		
\$		\$	\$		

REMARKS (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

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	Y / N
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT / WATERCRAFT?	<input type="checkbox"/>
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)	<input type="checkbox"/>
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?	<input type="checkbox"/>
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?	<input type="checkbox"/>
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?	<input type="checkbox"/>
6. ARE SUB-CONTRACTORS USED? (If "YES", give % of work subcontracted)	<input type="checkbox"/>
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INSURANCE? (If "YES", payroll for this work must be included in the State Rating Worksheet on Page 2)	<input type="checkbox"/>
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?	<input type="checkbox"/>
9. ANY GROUP TRANSPORTATION PROVIDED?	<input type="checkbox"/>
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?	<input type="checkbox"/>
11. ANY SEASONAL EMPLOYEES?	<input type="checkbox"/>
12. IS THERE ANY VOLUNTEER OR DONATED LABOR? (If "YES", please specify)	<input type="checkbox"/>

GENERAL INFORMATION (continued)

EXPLAIN ALL "YES" RESPONSES	Y / N
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?	<input type="checkbox"/>
14. DO EMPLOYEES TRAVEL OUT OF STATE? (If "YES", indicate state(s) of travel and frequency)	<input type="checkbox"/>
15. ARE ATHLETIC TEAMS SPONSORED?	<input type="checkbox"/>
16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?	<input type="checkbox"/>
17. ANY OTHER INSURANCE WITH THIS INSURER?	<input type="checkbox"/>
18. ANY PRIOR COVERAGE DECLINED / CANCELLED / NON-RENEWED IN THE LAST THREE (3) YEARS? (Missouri Applicants - Do not answer this question)	<input type="checkbox"/>
19. ARE EMPLOYEE HEALTH PLANS PROVIDED?	<input type="checkbox"/>
20. DO ANY EMPLOYEES PERFORM WORK FOR OTHER BUSINESSES OR SUBSIDIARIES?	<input type="checkbox"/>
21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?	<input type="checkbox"/>
22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME? If "YES", # of Employees: _____	<input type="checkbox"/>
23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST FIVE (5) YEARS? (If "YES", please specify)	<input type="checkbox"/>
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 NUMBER(S).	<input type="checkbox"/>

REMARKS (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

APPLICABLE IN TENNESSEE AND VERMONT: 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, DC, FL, HI, MA, MN, NE, OH, OK, OR, VT or WA; in LA, ME, TN and VA, insurance benefits may also be denied)

IN THE DISTRICT OF COLUMBIA, WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES.

IN MASSACHUSETTS, NEBRASKA, OREGON AND VERMONT, 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, MAY BE COMMITTING A FRAUDULENT INSURANCE ACT, WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO CRIMINAL AND CIVIL PENALTIES.

IN WASHINGTON, IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

APPLICANT'S SIGNATURE (Must be Officer, Owner or Partner)	DATE	PRODUCER'S SIGNATURE	NATIONAL PRODUCER NUMBER
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