

# ACORD™ WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY)

AGENCY PHONE (A/C, No, Ext): FAX (A/C, No):	COMPANY			UNDERWRITER		
	APPLICANT NAME			INTERNET ADDRESS		
	MAILING ADDRESS (including ZIP code)					
YRS IN BUS		SIC	INDIVIDUAL	CORPORATION	LLC	
			PARTNERSHIP	SUBCHAPTER "S" CORP	OTHER:	
CODE:	SUB CODE:	CREDIT BUREAU NAME:			ID NUMBER:	
AGENCY CUSTOMER ID		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	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"/> SEMI-ANNUAL	<input type="checkbox"/> OTHER:	
			<input type="checkbox"/> QUARTERLY	<input type="checkbox"/> % DOWN:	<input type="checkbox"/> QUARTERLY		

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

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

SPECIFY ADDITIONAL COVERAGES/ENDORSEMENTS		FACTOR	FACTORED PREMIUM			
	TOTAL		\$			
	INCREASED LIMITS		\$			
	DEDUCTIBLE		\$			
			\$			
	EXPERIENCE MODIFICATION		\$			
	LOSS CONSTANT	N/A	\$			
	ASSIGNED RISK SURCHARGE		\$			
	ARAP		\$			
			\$			
PREMIUM DISCOUNT		\$				
EXPENSE CONSTANT	N/A	\$				
		\$				
MINIMUM PREMIUM	\$	DEPOSIT PREMIUM	\$	TOTAL EST ANNUAL PREMIUM	N/A	\$

**INDIVIDUALS INCLUDED/EXCLUDED**

PARTNERS, OFFICERS, RELATIVES TO BE INCLUDED OR EXCLUDED. (Remuneration to be included must be part of rating information section.)

#	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?			16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?		
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)			17. ANY OTHER INSURANCE WITH THIS INSURER?		
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?			18. ANY PRIOR COVERAGE DECLINED/ CANCELLED/NON-RENEWED (Last 3 years)?		
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?			19. ARE EMPLOYEE HEALTH PLANS PROVIDED?		
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?			20. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS/SUBSIDIARY?		
6. ARE SUB-CONTRACTORS USED? (IF YES, GIVE % OF WORK SUBCONTRACTED)			21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?		
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INS.?			22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME?		
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?			23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST 5 YEARS?		
9. ANY GROUP TRANSPORTATION PROVIDED?			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).		
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?			<b>CONTACT INFORMATION</b>		
11. ANY SEASONAL EMPLOYEES?			IN- SPECTION	PHONE: NAME:	
12. IS THERE ANY VOLUNTEER OR DONATED LABOR?			ACCTNG RECORD	PHONE: NAME:	
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?			CLAIMS INFO	PHONE: NAME:	
14. DO EMPLOYEES TRAVEL OUT OF STATE?			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.		
15. ARE ATHLETIC TEAMS SPONSORED?			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					
APPLICANT'S SIGNATURE	DATE	PRODUCER'S SIGNATURE	NATIONAL PRODUCER NUMBER		