

ACORD. WORKERS COMPENSATION APPLICATION DATE (MM/DD/YY)

PRODUCER <input type="checkbox"/> PHONE (A/C No. Ext): CODE: SUB CODE: AGENCY CUSTOMER ID	COMPANY APPLICANT NAME MAILING ADDRESS (including ZIP code) YRS IN BUS <input type="checkbox"/> SIC <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> CORPORATION <input type="checkbox"/> OTHER: <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> SUBCHAPTER "S" CORP <input type="checkbox"/>	UNDERWRITER FEDERAL EMPLOYER ID NUMBER <input type="checkbox"/> NCCI ID NUMBER <input type="checkbox"/> OTHER RATING BUREAU ID NUMBER <input type="checkbox"/>
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QUOTE <input type="checkbox"/> ISSUE POLICY <input type="checkbox"/> BOUND (Give date and/or attach copy) <input type="checkbox"/> ASSIGNED RISK (Attach ACORD 133) <input type="checkbox"/>	BILLING PLAN <input type="checkbox"/> AGENCY BILL <input type="checkbox"/> DIRECT BILL	PAYMENT PLAN <input type="checkbox"/> ANNUAL <input type="checkbox"/> SEMI-ANNUAL <input type="checkbox"/> QUARTERLY % DOWN: <input type="checkbox"/>	AUDIT <input type="checkbox"/> AT EXPIRATION <input type="checkbox"/> SEMI-ANNUAL <input type="checkbox"/> QUARTERLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> OTHER:
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LOCATIONS

STREET, CITY, COUNTY, STATE, ZIP CODE

PROPOSED EXP DATE (MM/DD/YY)	PROPOSED EXP DATE (MM/DD/YY)	NORMAL ANNIVERSARY RATING DATE	PARTICIPATING	RETRO PLAN
			NON-PARTICIPATING	
PART 1 - WORKERS COMPENSATION (States)	PART 2 - EMPLOYER'S LIABILITY \$ EACH ACCIDENT \$ DISEASE-POLICY LIMIT \$ DISEASE-EACH EMPLOYEE	DEDUCTIBLES <input type="checkbox"/> MEDICAL <input type="checkbox"/> INDEMNITY	OTHER COVERAGES <input type="checkbox"/> U.S.L. & H. <input type="checkbox"/> VOLUNTARY COMPENSATION	

DIVIDEND PLANS/SAFETY GROUP ADDITIONAL COMPANY INFORMATION

STATE	LOC	CLASS CODE	COMPANY USE	CATEGORIES, DUTIES, CLASSIFICATIONS	# OF EMPLOYEES	ESTIMATED ANNUAL REMUNERATION	RATE	ESTIMATED ANNUAL PREMIUM

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

MINIMUM PREMIUM	\$	DEPOSIT PREMIUM	\$	TOTAL EST ANNUAL PREMIUM	\$
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INDIVIDUALS INCLUDED/EXCLUDED

OWNERS, 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-EMP %	DUTIES	INC/EXC	CLASS CODE	REMUNERATION

LOSS CARRIER INFORMATION/LOSS HISTORY

PROVIDE INFORMATION FOR THE PAST 5 YEARS AND USE THE REMARKS SECTION FOR LOSS DETAILS

YEAR	CARRIER & POLICY NUMBER	ANNUAL PREMIUM	MOD	# CLAIMS	LOSS RUN ATTACHED	AMOUNT PAID	RESERVE
	CO: POL #:						
	CO: POL #:						
	CO: POL #:						
	CO: POL #:						
	CO: POL #:						
	CO: POL #:						

CURRENT BUSINESS DESCRIPTION OF OPERATIONS

MAKE 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.

SPECIAL INFORMATION

PLAIN ALL "YES" RESPONSES	YES	NO	EXPLAIN ALL "YES" RESPONSES	YES	NO
DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT/WATERCRAFT?			15. ARE ATHLETIC TEAMS SPONSORED?		
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)			16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?		
ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?			17. ANY OTHER INSURANCE WITH THIS INSURER?		
ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?			18. ANY PRIOR COVERAGE DECLINED/ CANCELLED/NON-RENEWED (Last 3 years)?		
IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?			18. ARE EMPLOYEE HEALTH PLANS PROVIDED?		
ARE SUB-CONTRACTORS USED?			20. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS/SUBSIDIARY?		
ANY WORK SUBLET WITHOUT CERTIFICATES OF INS.?			21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?		
IS A FORMAL SAFETY PROGRAM IN OPERATION?			22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME?		
ANY GROUP TRANSPORTATION PROVIDED?			CONTACT INFORMATION		
ANY EMPLOYEES UNDER 18 OR OVER 80 YEARS OF AGE?			INSPECTION	PHONE:	
ANY PART TIME OR SEASONAL EMPLOYEES?			ACCTNG RECORD	NAME:	
IS THERE ANY VOLUNTEER OR DONATED LABOR?			CLAIMS INFO	PHONE:	
ANY EMPLOYEES WITH PHYSICAL HANDICAPS?				NAME:	
DO EMPLOYEES TRAVEL OUT OF STATE?					

MARKS

APPLICANT'S SIGNATURE _____ PRODUCER'S SIGNATURE _____