

ACORDTM WORKERS COMPENSATION APPLICATION

DATE

| | | | | |
|---|--------------------------------------|----------------------------|----------------|--|
| PRODUCER 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 |
| | | | PARTNERSHIP | SUBCHAPTER "S" CORP |
| | | | | LIMITED 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"/> 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"/> OTHER: | <input type="checkbox"/> OTHER: |
| | | | QUARTERLY | QUARTERLY |
| | | | % DOWN: | |

| LOCATIONS | |
|-----------|---------------------------------------|
| # | STREET, CITY, COUNTY, STATE, ZIP CODE |
| 1 | |
| 2 | |
| 3 | |

| | | | | |
|---|--------------------------------------|----------------------------------|----------------------------|---------------------|
| 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/% |
| \$ | EACH ACCIDENT | | MEDICAL | |
| \$ | DISEASE-POLICY LIMIT | | INDEMNITY | |
| \$ | DISEASE-EACH EMPLOYEE | | | |
| DIVIDEND PLAN/SAFETY GROUP | ADDITIONAL COMPANY INFORMATION | | | |
| | | | OTHER COVERAGES | MANAGED CARE OPTION |
| | | | U.S.L. & H. VOLUNTARY COMP | |
| | | | FOREIGN COV | |

| 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 | | | | | | | | | \$ |
| ASSIGNED RISK SURCHARGE | | | | | | | | | \$ |
| ARAP | | | | | | | | | \$ |
| | | | | | | | | | \$ |
| PREMIUM DISCOUNT | | | | | | | | | \$ |
| EXPENSE CONSTANT | | | | | | | | | \$ |
| | | | | | | | | | \$ |
| MINIMUM PREMIUM | \$ | | | DEPOSIT PREMIUM | \$ | | TOTAL EST ANNUAL PREMIUM | \$ | \$ |

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 |
| 1 | | | | | | | | |
| 2 | | | | | | | | |
| 3 | | | | | | | | |
| 4 | | | | | | | | |
| 5 | Social Sec # on all Owners | | | | | | | |

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)? | | NOT APPLICABLE IN MO |
| 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? | | | CONTACT INFORMATION | | |
| 11. ANY SEASONAL EMPLOYEES? | | | IN- SPECTION | PHONE: | |
| 12. IS THERE ANY VOLUNTEER OR DONATED LABOR? | | | NAME: | | |
| 13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS? | | | ACCTNG RECORD | PHONE: | |
| 14. DO EMPLOYEES TRAVEL OUT OF STATE? | | | NAME: | | |
| 15. ARE ATHLETIC TEAMS SPONSORED? | | | CLAIMS INFO | PHONE: | |
| | | | NAME: | | |

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, VT; IN DC, LA, ME AND VA, INSURANCE BENEFITS MAY ALSO BE DENIED)

REMARKS

APPLICANT'S SIGNATURE _____ PRODUCER'S SIGNATURE _____
Insurance Shop