

Applicant's Representative _____ Address _____ Effective date _____	<input type="checkbox"/> New application <input type="checkbox"/> Renewal of policy number
Quote needed by _____	

1) **Legal name of applicant** (and subsidiaries if applicable) _____

2) **Mailing address** _____

FEDERAL EMPLOYER NUMBER	NCCI INTERSTATE/INTRASTATE RISK ID NUMBER	OTHER RATING BUREAU ID NUMBER
STATE EMPLOYER UNEMPLOYMENT INSURANCE ACCOUNT ID NUMBER(S)		

4) **Type of entity?** Individual Partnership Corporation Subchapter "S" Corp Other _____

5) **Years in business?** _____

6) **Description of operations, processes and products of applicant and subsidiaries** (Attach copy of current and comprehensive loss prevention inspection reports, product brochure, and annual report or 10-K report) _____

7) **Number of employees to be covered** (Include full-time, part-time and leased.) _____

8) **Provide listing of locations to be covered** (Attach supplemental page if additional space is required.)

ADDRESS	SUBSIDIARY (IF APPLICABLE)	BRIEF DESCRIPTION OF OPERATIONS
A. _____	_____	_____
B. _____	_____	_____
C. _____	_____	_____

9) **Coverage desired**

A. **Part One—Workers' Compensation Insurance—States to be covered** _____

B. **Part Two—Employers Liability Insurance—Limit desired:**

Bodily Injury by Accident \$ _____ each accident Bodily Injury by Accident \$ _____ each accident

Bodily Injury by Disease \$ _____ policy limit Bodily Injury by Disease \$ _____ policy limit

Bodily Injury by Disease \$ _____ each employee Bodily Injury by Disease \$ _____ each employee

C. **Part Three—Other States Insurance—Specify states if any and describe circumstances** _____

D. **Deductible amount(s) desired** _____

E. **Does applicant desire Aggregate Stop Loss coverage?** yes no

10) **Specify additional coverages or endorsements desired** _____

15) Vehicle information

A. Does applicant own or lease vehicles which haul or transport applicant's goods or products, or the goods or products of others?
 yes no

If "yes," Vehicle Supplemental Application must be completed. If "no," complete sections B and C below.

B. Provide the number of owned or leased vehicles for the following and indicate the average number of employees occupying each vehicle.

TYPE OF VEHICLE	NUMBER OF UNITS	AVERAGE NUMBER OF EMPLOYEES
1. Passenger cars		
2. Vans		
3. Light & Medium trucks		
4. Heavy & X-Heavy trucks		
5. Truck tractors		
6. Trailers		

TYPE OF VEHICLE	NUMBER OF UNITS	AVERAGE NUMBER OF EMPLOYEES
7. Police Cars		
8. Fire trucks		
9. Ambulance		
10. Motorcycles		
11. Buses		
12. *Other		

**Golf Carts, ATV's, Trams, etc.*

C. Does the applicant provide transportation of employees to and or from any work site or work location? yes no If "yes," provide a listing of vehicles and, for each, (1) seating capacity, (2) average number of employees per trip, (3) average radius per trip and (4) average number of daily trips.

16) Special exposures (Check the appropriate box which reflects the actual and/or anticipated exposures associated with the applicant's operations.

Provide details for any "yes" response on page 4.)

	YES	NO
A. Own, lease or charter any aircraft? (If "yes", Aircraft Supplemental Application must be completed.)	<input type="checkbox"/>	<input type="checkbox"/>
B. Own, lease or charter any watercraft? (If "yes", Watercraft Supplemental Application must be completed.)	<input type="checkbox"/>	<input type="checkbox"/>
C. Load, unload, repair or construct watercraft or vessels including work performed on barges or docks?	<input type="checkbox"/>	<input type="checkbox"/>
D. Operations or employees subject to the Longshoremen's and Harbor Workers' Act, Jones Act or Federal Employer's Liability Act?	<input type="checkbox"/>	<input type="checkbox"/>
E. Own, operate or maintain a railroad or own, lease, operate or repair railroad equipment?	<input type="checkbox"/>	<input type="checkbox"/>
F. Foreign operations or employees who travel to foreign countries?	<input type="checkbox"/>	<input type="checkbox"/>
G. Occupational disease exposures? (Include asbestos, silica dusts, toxic, injurious or hazardous substances, compounds or chemicals, caustics, fumes, noise, radiation, communicable diseases and any other O.D. exposures.) If "yes", also describe measures taken to control.	<input type="checkbox"/>	<input type="checkbox"/>
H. Operations which have resulted in carpal tunnel syndrome, repetitive motion or cumulative trauma claims?	<input type="checkbox"/>	<input type="checkbox"/>
I. Manufacture, produce, refine, store, distribute or transport gases, gasoline or flammables?	<input type="checkbox"/>	<input type="checkbox"/>
J. Manufacture, handle, transport, distribute or store explosives or explosive substances?	<input type="checkbox"/>	<input type="checkbox"/>
K. Underground, tunneling, mining, cofferdam or sub aqueous operations.	<input type="checkbox"/>	<input type="checkbox"/>
L. Wrecking, dismantling, or demolition work?	<input type="checkbox"/>	<input type="checkbox"/>
M. Operations subcontracted to others? If "yes", what are the operations and who is responsible for the workers' compensation coverage?	<input type="checkbox"/>	<input type="checkbox"/>
N. Operations involving exposure to heights?	<input type="checkbox"/>	<input type="checkbox"/>
O. Operations involving exposure to burns?	<input type="checkbox"/>	<input type="checkbox"/>
P. Volunteer or donated labor to be covered? If "yes", indicate the type of work performed and number of volunteer hours for each type of work in Item 14 of Application. (If applicant is a health care facility, a Hospital/Health Care Supplemental Application must be completed.)	<input type="checkbox"/>	<input type="checkbox"/>
Q. Leased employees? If "yes", what are their duties and who is responsible for their workers' compensation coverage? Attach copy of employee lease agreement.	<input type="checkbox"/>	<input type="checkbox"/>

C. Is information taken from loss runs? yes no If "no," provide source. _____

D. Are loss runs submitted with application? yes no If "no," are loss runs available upon demand? yes no

This is NOT a binder of coverage. The application must be signed by the applicant or the applicant's representative. The applicant represents that all statements made in this application are complete and true and that all material facts have been fully disclosed.

FRAUD WARNING STATEMENTS

Colorado

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

New Jersey

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New York

Any person who knowingly and with intent to defraud any insurance company or other 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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.

All Other States

Any person who knowingly and with intent to defraud any insurance company or other 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 such person to criminal and civil penalties.

Name of Applicant and subsidiaries _____

Applicant's Representative's: _____

Title: _____

Date: _____

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