# LARGE DEDUCTIBLE WORKERS' COMPENSATION APPLICATION

**Applicant's Representative:** _____ ☐ **New application**
**Address:** _____ ☐ **Renewal of policy number**
**Effective date:** _____ **Quote needed by:** _____ _____

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

_____

_____

**2) Mailing address:** _____

_____

**3) 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, annual report or 10 K report, and copy of self insured application filed with the state)**:** _____

_____

**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 – Others 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:** _____

_____

**11) Individuals included/excluded:**

**Partners, officers, relatives to be included or excluded. (Remuneration to be included in question 14 below.)**

| # | NAME | INCLUDED/ EXCLUDED | DATE OF BIRTH | TITLE/ RELATIONSHIP | OWNERSHIP % | DUTIES | CLASS CODE | REMUNERATION |
|---|---|---|---|---|---|---|---|---|
| 1 | | ☐ INCL ☐ EXCL | | | | | | |
| 2 | | ☐ INCL ☐ EXCL | | | | | | |
| 3 | | ☐ INCL ☐ EXCL | | | | | | |
| 4 | | ☐ INCL ☐ EXCL | | | | | | |
| 5 | | ☐ INCL ☐ EXCL | | | | | | |

**12) Name of Third Party Administrator:** _____

**13) General Information**

A. Name of Loss Control Provider: _____
Contact name and telephone number: _____
Attach details of types and frequency of Loss Control services that will be provided: _____

_____

| | | YES | NO |
|---|---|---|---|
| B. | Does applicant have a formal safety program? (If "yes", attach copy) | ☐ | ☐ |
| C. | Any Light Duty or Return to Work Program? | ☐ | ☐ |
| D. | Are employee health plans provided? | ☐ | ☐ |
| E. | Are physical examinations required after offer of employment is made? | ☐ | ☐ |
| F. | Any drug testing program? | ☐ | ☐ |
| G. | Any incentive program to reward accident-free performance? | ☐ | ☐ |
| H. | Do employees receive any supplemental benefits in addition to W. C. benefits? | ☐ | ☐ |

***Provide details for any "yes" responses on a supplemental page.*

**14) Provide the following information regarding each state or jurisdiction to be covered** (Attach supplemental page if additional space is required)**:**

| STATE | W.C. CODE NO. | CLASSIFICATION | NO. OF EMPLOYEES | ESTIMATED ANNUAL PAYROLL OR MANHOURS | CURRENT MANUAL RATES | MANUAL PREMIUM |
|---|---|---|---|---|---|---|
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| | | **TOTAL** | | | | |

# LARGE DEDUCTIBLE WORKERS' COMPENSATION APPLICATION

**Experience Modification** _____ **Effective Date Of Experience Modification** _____ **Manual Rate Effective Date** _____

**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 | TYPE OF VEHICLE | NUMBER OF UNITS | AVERAGE NUMBER OF EMPLOYEES |
|---|---|---|---|---|---|
| 1. Passenger cars | | | 7. Police cars | | |
| 2. Vans | | | 8. Fire trucks | | |
| 3. Light & Medium trucks | | | 9. Ambulance | | |
| 4. Heavy & X-Heavy trucks | | | 10. Motorcycles | | |
| 5. Truck tractors | | | 11. Buses | | |
| 6. Trailers | | | 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 applicants operations and 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) | ☐ | ☐ |
| B. | Own, lease or charter any watercraft? (If "yes", Watercraft Supplemental Application must be completed) | ☐ | ☐ |
| C. | Load, unload, repair or construct watercraft or vessels including work performed on barges or docks? | ☐ | ☐ |
| D. | Operations or employees subject to the Longshoremen's and Harbor Workers' Act, Jones Act or Federal Employer's Liability Act? | ☐ | ☐ |
| E. | Own, operate or maintain a railroad or own, lease, operate or repair railroad equipment? | ☐ | ☐ |
| F. | Foreign operations or employees who travel to foreign countries? | ☐ | ☐ |
| 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. | ☐ | ☐ |
| H. | Operations that have resulted in carpal tunnel syndrome, repetitive motion or cumulative trauma claims? | ☐ | ☐ |
| I. | Manufacture, produce, refine, store, distribute or transport gases, gasoline or flammables? | ☐ | ☐ |
| J. | Manufacture, handle, transport, distribute or store explosives or explosive substances? | ☐ | ☐ |
| K. | Underground, tunneling, mining, cofferdam or sub aqueous operations? | ☐ | ☐ |
| L. | Wrecking, dismantling, or demolition work? | ☐ | ☐ |
| M. | Operations subcontracted to others? If "yes", what are the operations and who is responsible for the workers; compensation coverage? | ☐ | ☐ |
| N. | Operations involving exposure to heights? | ☐ | ☐ |
| O. | Operations involving exposure to burns? | ☐ | ☐ |
| 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.) | ☐ | ☐ |
| Q. | Leased employees? If "yes", what are their duties and who is responsible for their workers' compensation coverage? Attach copy of employee lease agreement. | ☐ | ☐ |
| R. | Any OSHA violations? | ☐ | ☐ |
| S. | Any substantial or unusual changes in operations that are planned or have taken place in the last five years? | ☐ | ☐ |

T. Workers' compensation coverage cancelled or non-renewed in last five years? ☐ ☐

Provide details for any "yes" responses for special exposures (Attach supplemental page if additional space is required):

**17) Loss Experience** (Attach supplemental page if additional space is required):

A. Provide five year loss history for each state to be included in proposed coverage. (Summarize loss experience even though submitting loss runs. Break out losses by year. Valuation must be within last six months.)

| STATE | POLICY PERIOD MM/DD/YY | TOTAL AUDITED PAYROLLS OR MANHOURS | EXP. MOD. | INDEMNITY PAID | INDEMNITY RESERVE | MEDICAL PAID | MEDICAL RESERVE | CLAIMS EXPENSE | TOTAL INCURRED | VALUATION DATE MM/DD/YY |
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B. Provide the following information concerning all death and permanent total disability claims and all claims with total incurred costs in excess of $50,000 in the last five years.

| STATE | DATE OF LOSS | NO. OF EMP. INVOLVED | CLAIMANTS NAME(S) | DESCRIPTION OF LOSS AND NATURE OF INJURY OR DISEASE | TOTAL PAID | TOTAL RESERVE | TOTAL INCURRED | OPEN OR CLOSED |
|---|---|---|---|---|---|---|---|---|
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Please attach another sheet if necessary.

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 Signature: _____

_____

(Please type name, title, and company of submitting broker)

Date: _____