

WORKERS COMPENSATION INSURANCE APPLICATION

Legal Entity Name: _____ Tax ID number: _____
Contact Name: _____ Title: _____
Business Phone: _____ Email: _____
Fax: _____ Website: _____

Mailing Address: _____
City: _____ State: _____ Zip code: _____

Premises Location (if more than one advise in REMARKS section): _____
City: _____ State: _____ Zip code: _____

Nature of Business (detailed description of operations): _____
Year business started: _____

Prior Insurance Carrier: _____
Policy Number: _____ Effective dates (M/Y): _____

Is company canceling coverage? ☐ yes ☐ no
Please explain if yes: _____
Total premium \$ _____ Any claims in the last 5 years? ☐ yes ☐ no

Employee payroll figures:

	No. of Full Time	No. of Part Time	Annual Payroll Remuneration
Office Staff	_____	_____	_____
Executive Director(s)	_____	_____	_____
Nurse(s)	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you engaged in any other type of business?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are sub-contractors used? (If yes, _____% of work subcontracted.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any work sublet without certificate of insurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is a written safety program in operation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any group transportation provided?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any employees under 16 or over 60 years of age?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any seasonal employees?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there any volunteer or donated labor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any employees with physical handicaps?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do employees travel out of state?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are athletic teams sponsored?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are physicals required after offers of employment are made?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any prior coverage declined, cancelled, non-renewed (last 3 years)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are employee health plans provided?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there a labor interchange with any other business/subsidiary?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you lease employees to or from other employers?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any tax lines or bankruptcy within the last 5 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any undisputed and unpaid workers compensation premium due from you or any commonly managed or owned enterprises	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do any employees predominantly work at home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you received any offers of voluntary coverage? Indicate the number of Insurance companies that have refused the applicant coverage in the last 60 days	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Explain all yes answers:

Has there been previous workers compensation insurance coverage in this state?

☐ Yes ☐ No

In any other state?

☐ Yes ☐ No

Which state? _____

If NO to the prior two questions, was this due to:

☐ New Business

☐ Number of Employees

☐ Self-Insured Group

☐ Other (Explain):

Is there any unpaid workers compensation premium due or in dispute? from you or any commonly managed or owned enterprises?

☐ yes

☐ no

If Yes, explain including entity names and policy numbers. _____

Has there been a name change, consolidation, merger or ownership change during the past five years?

☐ yes

☐ no

If yes, give previous name and date change in REMARKS area below.

Do you lease workers from a labor contractor?

☐ Yes

☐ No

Are you seeking to cover the leased workers?

☐ Yes

☐ No

Do you provide temporary labor services to other employers?

☐ Yes

☐ No

Do you have a franchise or licensing agreement?

☐ Yes

☐ No

Do you or your employees regularly operate from a base terminal which is used to load, unload, store or transfer freight?

☐ Yes

☐ No

(if Yes, please provide a list of terminal addresses)

Any person knowingly and with intent to defraud any insurance company or other person, files an application for Insurance containing false information or conceals information concerning any fact material thereto, for the purpose of misleading, commits a fraudulent insurance act, which is a crime.

Signature

Date

REMARKS

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.