

ACORDTM WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY)

AGENCY	PHONE (A/C, No, Ext):	COMPANY		UNDERWRITER	
	FAX (A/C, No):			INTERNET ADDRESS	
	MAILING ADDRESS (including ZIP code)		APPLICANT NAME		
			YRS IN BUS SIC INDIVIDUAL CORPORATION LLC PARTNERSHIP SUBCHAPTER "S" 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	<input type="checkbox"/> BILLING PLAN	<input type="checkbox"/> PAYMENT PLAN	<input type="checkbox"/> AUDIT
<input type="checkbox"/> BOUND (Give date and/or attach copy)	<input type="checkbox"/> AGENCY BILL	<input type="checkbox"/> ANNUAL	<input type="checkbox"/> OTHER:	<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"/> % DOWN:	<input type="checkbox"/> SEMI-ANNUAL
		<input type="checkbox"/> QUARTERLY		<input type="checkbox"/> QUARTERLY
				<input type="checkbox"/> MONTHLY
				<input type="checkbox"/> OTHER:

LOCATIONS

#	STREET, CITY, COUNTY, STATE, ZIP CODE

POLICY INFORMATION

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		<input type="checkbox"/> MEDICAL	<input type="checkbox"/> U.S.L. & H.
	\$ DISEASE-POLICY LIMIT		<input type="checkbox"/> INDEMNITY	<input type="checkbox"/> VOLUNTARY COMP
	\$ DISEASE-EACH EMPLOYEE			<input type="checkbox"/> FOREIGN COV
DIVIDEND PLAN/SAFETY GROUP	ADDITIONAL COMPANY INFORMATION			
				MANAGED CARE OPTION

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	N/A	\$
ASSIGNED RISK SURCHARGE		\$
ARAP		\$
PREMIUM DISCOUNT		\$
EXPENSE CONSTANT	N/A	\$
		\$
MINIMUM PREMIUM	\$	
DEPOSIT PREMIUM	\$	
TOTAL EST ANNUAL PREMIUM	N/A	\$

ACORD 130 (2002/09)

PLEASE COMPLETE REVERSE SIDE

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[illegible][illegible]

<p>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.</p>
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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 ENTITIY NAME(S) AND POLICY NUMBERS(S).			
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?				CONTACT INFORMATION IN- SPECTION PHONE: NAME:			
11. ANY SEASONAL EMPLOYEES?							
12. IS THERE ANY VOLUNTEER OR DONATED LABOR?				ACCTNG RECORD PHONE: NAME:			
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?							
14. DO EMPLOYEES TRAVEL OUT OF STATE?				CLAIMS INFO PHONE: NAME:			
15. ARE ATHLETIC TEAMS SPONSORED?							
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, TN or VT; in DC, LA, ME and VA, insurance benefits may also be denied)							
REMARKS							
APPLICANT'S SIGNATURE		DATE		PRODUCER'S SIGNATURE		NATIONAL PRODUCER NUMBER	

ADDITIONAL LOCATION/ RATING INFORMATION

LOCATIONS

#	STREET, CITY, COUNTY, STATE, ZIP

RATING INFORMATION

STATE	LOC	CLASS CODE	COMPANY USE	CATEGORIES/DUTIES/CLASSIFICATIONS	# EMPLOYEES		ESTIMATED ANNUAL REMUNERATION	RATE	ESTIMATED ANNUAL PREMIUM
					FULL TIME	PART TIME			