

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	Y/N
1a. IS THE APPLICANT A SUBSIDIARY OF ANOTHER ENTITY ?	<input type="checkbox"/>
1b. DOES THE APPLICANT HAVE ANY SUBSIDIARIES?	<input type="checkbox"/>
2. IS A FORMAL SAFETY PROGRAM IN OPERATION?	<input type="checkbox"/>
3. ANY EXPOSURE TO FLAMMABLES, EXPLOSIVES, CHEMICALS?	<input type="checkbox"/>
4. ANY CATASTROPHE EXPOSURE?	<input type="checkbox"/>
5. ANY OTHER INSURANCE WITH THIS COMPANY OR BEING SUBMITTED?	<input type="checkbox"/>
6. ANY POLICY OR COVERAGE DECLINED, CANCELLED OR NON-RENEWED DURING THE PRIOR THREE (3) YEARS? (Not applicable in MO)	<input type="checkbox"/>
7. ANY PAST LOSSES OR CLAIMS RELATING TO SEXUAL ABUSE OR MOLESTATION ALLEGATIONS, DISCRIMINATION OR NEGLIGENT HIRING?	<input type="checkbox"/>
8. DURING THE LAST FIVE YEARS (TEN IN RI), HAS ANY APPLICANT BEEN INDICTED FOR OR CONVICTED OF ANY DEGREE OF THE CRIME OF FRAUD, BRIBERY, ARSON OR ANY OTHER ARSON-RELATED CRIME IN CONNECTION WITH THIS OR ANY OTHER PROPERTY? (In RI, this question must be answered by any applicant for property insurance. Failure to disclose the existence of an arson conviction is a misdemeanor punishable by a sentence of up to one year of imprisonment).	<input type="checkbox"/>
9. ANY UNCORRECTED FIRE CODE VIOLATIONS?	<input type="checkbox"/>
10. ANY BANKRUPTCIES, TAX OR CREDIT LIENS AGAINST THE APPLICANT IN THE PAST FIVE (5) YEARS?	<input type="checkbox"/>
11. HAS BUSINESS BEEN PLACED IN A TRUST? IF "YES", NAME OF TRUST:	<input type="checkbox"/>
12. ANY FOREIGN OPERATIONS, FOREIGN PRODUCTS DISTRIBUTED IN USA, OR US PRODUCTS SOLD/DISTRIBUTED IN FOREIGN COUNTRIES? (If "YES", attach ACORD 815 for Liability Exposure and/or ACORD 816 for Property Exposure)	<input type="checkbox"/>

REMARKS/PROCESSING INSTRUCTIONS (Attach additional sheets if more space is required)

COPY OF THE NOTICE OF INFORMATION PRACTICES (PRIVACY) HAS BEEN GIVEN TO THE APPLICANT. (Not applicable in all states, consult your agent or broker for your state's requirements.)

NOTICE OF INSURANCE INFORMATION PRACTICES - PERSONAL INFORMATION ABOUT YOU, INCLUDING INFORMATION FROM A CREDIT REPORT, MAY BE COLLECTED FROM PERSONS OTHER THAN YOU IN CONNECTION WITH THIS APPLICATION FOR INSURANCE AND SUBSEQUENT POLICY RENEWALS. SUCH INFORMATION AS WELL AS OTHER PERSONAL AND PRIVILEGED INFORMATION COLLECTED BY US OR OUR AGENTS MAY IN CERTAIN CIRCUMSTANCES BE DISCLOSED TO THIRD PARTIES WITHOUT YOUR AUTHORIZATION. YOU HAVE THE RIGHT TO REVIEW YOUR PERSONAL INFORMATION IN OUR FILES AND CAN REQUEST CORRECTION OF ANY INACCURACIES. A MORE DETAILED DESCRIPTION OF YOUR RIGHTS AND OUR PRACTICES REGARDING SUCH INFORMATION IS AVAILABLE UPON REQUEST. CONTACT YOUR AGENT OR BROKER FOR INSTRUCTIONS ON HOW TO SUBMIT A REQUEST TO US.

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, FL, HI, MA, NE, OH, OK, OR, or VT; in DC, LA, ME, TN, VA and WA, insurance benefits may also be denied)

IN 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.

THE UNDERSIGNED IS AN AUTHORIZED REPRESENTATIVE OF THE APPLICANT AND REPRESENTS THAT REASONABLE ENQUIRY HAS BEEN MADE TO OBTAIN THE ANSWERS TO QUESTIONS ON THIS APPLICATION. HE/SHE REPRESENTS THAT THE ANSWERS ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF HIS/HER KNOWLEDGE.

PRODUCER'S SIGNATURE	PRODUCER'S NAME (Please Print)	STATE PRODUCER LICENSE NO (Required in Florida)
APPLICANT'S SIGNATURE	DATE	NATIONAL PRODUCER NUMBER

PRIOR CARRIER INFORMATION

LINE	CATEGORY	CLAIMS MADE		OCCURRENCE		CLAIMS MADE		OCCURRENCE		CLAIMS MADE		OCCURRENCE		CLAIMS MADE		OCCURRENCE	
GENERAL LIABILITY	CARRIER																
	POLICY NUMBER																
	POLICY TYPE																
	RETRO DATE																
	EFF-EXP DATE																
	GENERAL AGGREGATE																
	PRODUCTS COMP OP AGGREGATE																
	PERSONAL & ADV INJ																
	EACH OCCURRENCE																
	FIRE DAMAGE																
	MEDICAL EXPENSE																
	BODILY INJURY	OCCURRENCE															
		AGGREGATE															
	PROPERTY DAMAGE	OCCURRENCE															
		AGGREGATE															
COMBINED SINGLE LIMIT																	
MODIFICATION FACTOR																	
TOTAL PREMIUM																	
AUTOMOBILE	CARRIER																
	POLICY NUMBER																
	POLICY TYPE																
	EFF-EXP DATE																
	COMBINED SINGLE LIMIT																
	BODILY INJURY	EA PERSON															
		EA ACCIDENT															
	PROPERTY DAMAGE																
	MODIFICATION FACTOR																
	TOTAL PREMIUM																
PROPERTY	CARRIER																
	POLICY NUMBER																
	POLICY TYPE																
	EFF-EXP DATE																
	BUILDING	AMT															
	PERS PROP	AMT															
	MODIFICATION FACTOR																
TOTAL PREMIUM																	
PROPERTY	CARRIER																
	POLICY NUMBER																
	POLICY TYPE																
	EFF-EXP DATE																
	LIMIT																
	MODIFICATION FACTOR																
	TOTAL PREMIUM																

LOSS HISTORY

ENTER ALL CLAIMS OR LOSSES (REGARDLESS OF FAULT AND WHETHER OR NOT INSURED) OR OCCURRENCES THAT MAY GIVE RISE TO CLAIMS FOR THE PRIOR 5 YEARS (3 YEARS IN KS & NY)

DATE OF OCCURRENCE	LINE	TYPE/DESCRIPTION OF OCCURRENCE OR CLAIM	DATE OF CLAIM	AMOUNT PAID	AMOUNT RESERVED	CHK HERE IF NONE	SEE ATTACHED LOSS SUMMARY	CLAIM STATUS
							OPEN	CLSD

REMARKS	NOTE: FIDELITY REQUIRES A FIVE YEAR LOSS HISTORY	ATTACHMENTS



WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY)

AGENCY NAME AND ADDRESS	COMPANY:	
	UNDERWRITER:	
	APPLICANT NAME:	
	OFFICE PHONE:	MOBILE PHONE:
PRODUCER NAME:	MAILING ADDRESS (including ZIP + 4 or Canadian Postal Code)	
	YRS IN BUS:	
CS REPRESENTATIVE NAME:	SIC:	
OFFICE PHONE (A/C. No. Ext)	NAICS:	
MOBILE PHONE:	WEBSITE ADDRESS:	
FAX (A/C. No.):	E-MAIL ADDRESS:	
E-MAIL ADDRESS:	SOLE PROPRIETOR	CORPORATION
CODE:	PARTNERSHIP	SUBCHAPTER "S" CORP
SUB CODE:	LLC	TRUST
AGENCY CUSTOMER ID:	JOINT VENTURE	OTHER
	CREDIT BUREAU NAME:	ID NUMBER:
	FEDERAL EMPLOYER ID NUMBER	NCCI RISK 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"/> MONTHLY	<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"/> QUARTERLY	<input type="checkbox"/> SEMI-ANNUAL
		<input type="checkbox"/> QUARTERLY	% DOWN:	<input type="checkbox"/> QUARTERLY

LOCATIONS

LOC #	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		MEDICAL	OTHER COVERAGES
	\$ DISEASE-POLICY LIMIT		INDEMNITY	U.S.L. & H. VOLUNTARY COMP
	\$ DISEASE-EACH EMPLOYEE			FOREIGN COV
DIVIDEND PLAN/SAFETY GROUP	ADDITIONAL COMPANY INFORMATION			
SPECIFY ADDITIONAL COVERAGES / ENDORSEMENTS				

TOTAL ESTIMATED ANNUAL PREMIUM - ALL STATES

TOTAL ESTIMATED ANNUAL PREMIUM ALL STATES	TOTAL MINIMUM PREMIUM ALL STATES	TOTAL DEPOSIT PREMIUM ALL STATES
\$	\$	\$

CONTACT INFORMATION

TYPE	NAME	OFFICE PHONE	MOBILE PHONE	E-MAIL
INSPECTION				
ACCTNG RECORD				
CLAIMS INFO				

INDIVIDUALS INCLUDED/EXCLUDED

PARTNERS, OFFICERS, RELATIVES (Must be employed by business operations) TO BE INCLUDED OR EXCLUDED (Remuneration/Payroll to be included must be part of rating information section.)									
STATE	LOC #	NAME	DATE OF BIRTH	TITLE/RELATIONSHIP	OWNER-SHIP %	DUTIES	INC/EXC	CLASS CODE	REMUNERATION/PAYROLL

PRIOR CARRIER INFORMATION/LOSS HISTORY

AGENCY CUSTOMER ID: _____

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
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT/WATERCRAFT?	<input type="checkbox"/>	<input type="checkbox"/>
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)	<input type="checkbox"/>	<input type="checkbox"/>
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?	<input type="checkbox"/>	<input type="checkbox"/>
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?	<input type="checkbox"/>	<input type="checkbox"/>
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?	<input type="checkbox"/>	<input type="checkbox"/>
6. ARE SUB-CONTRACTORS USED? (If "YES", give % of work subcontracted)	<input type="checkbox"/>	<input type="checkbox"/>
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INSURANCE? (If "YES", payroll for this work must be included in the State Rating Worksheet on Page 2)	<input type="checkbox"/>	<input type="checkbox"/>
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?	<input type="checkbox"/>	<input type="checkbox"/>
9. ANY GROUP TRANSPORTATION PROVIDED?	<input type="checkbox"/>	<input type="checkbox"/>
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?	<input type="checkbox"/>	<input type="checkbox"/>
11. ANY SEASONAL EMPLOYEES?	<input type="checkbox"/>	<input type="checkbox"/>
12. IS THERE ANY VOLUNTEER OR DONATED LABOR? (If "YES", please specify)	<input type="checkbox"/>	<input type="checkbox"/>

GENERAL INFORMATION (continued)

EXPLAIN ALL "YES" RESPONSES	YES	NO
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?	<input type="checkbox"/>	<input type="checkbox"/>
14. DO EMPLOYEES TRAVEL OUT OF STATE? (If "YES", indicate state(s) of travel and frequency)	<input type="checkbox"/>	<input type="checkbox"/>
15. ARE ATHLETIC TEAMS SPONSORED?	<input type="checkbox"/>	<input type="checkbox"/>
16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?	<input type="checkbox"/>	<input type="checkbox"/>
17. ANY OTHER INSURANCE WITH THIS INSURER?	<input type="checkbox"/>	<input type="checkbox"/>
18. ANY PRIOR COVERAGE DECLINED/ CANCELLED/NON-RENEWED IN THE LAST THREE (3) YEARS? (Not applicable in MO)	<input type="checkbox"/>	<input type="checkbox"/>
19. ARE EMPLOYEE HEALTH PLANS PROVIDED?	<input type="checkbox"/>	<input type="checkbox"/>
20. DO ANY EMPLOYEES PERFORM WORK FOR OTHER BUSINESSES OR SUBSIDIARIES?	<input type="checkbox"/>	<input type="checkbox"/>
21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?	<input type="checkbox"/>	<input type="checkbox"/>
22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME? If "YES", # of Employees: _____	<input type="checkbox"/>	<input type="checkbox"/>
23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST FIVE (5) YEARS? (If "YES", please specify)	<input type="checkbox"/>	<input type="checkbox"/>
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).	<input type="checkbox"/>	<input type="checkbox"/>

REMARKS (Attach additional sheets if more space is required)

APPLICABLE IN TENNESSEE AND VERMONT: 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, FL, HI, MA, NE, OH, OK, OR, TN or VT; in DC, LA, ME, VA and WA, insurance benefits may also be denied)

APPLICANT'S SIGNATURE (Must be Officer, Owner or Partner)	DATE	PRODUCER'S SIGNATURE	NATIONAL PRODUCER NUMBER
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