

ACORD™ WORKERS COMPENSATION APPLICATION

DATE

PRODUCER	PHONE (A/C, No, Ext): 888.611.7467 FAX (A/C, No): 888.583.3110	COMPANY Insurance Shop Comp Carriers	UNDERWRITER	
The Insurance Shop, LLC WorkersCompensationShop.com 3809 South Providence Road Ste A Columbia, MO 65203		APPLICANT NAME		
		MAILING ADDRESS (Including ZIP code)		
		YRS IN BUS	SIC	INDIVIDUAL
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
		PARTNERSHIP	SUBCHAPTER "S" CORP	OTHER:

STATUS OF SUBMISSION		BILLING/AUDIT INFORMATION					
<input checked="" 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"/> ASSIGNED RISK (Attach ACORD 133)	<input checked="" type="checkbox"/> AGENCY BILL	<input type="checkbox"/> DIRECT BILL	<input type="checkbox"/> ANNUAL	<input type="checkbox"/> SEMI-ANNUAL	<input type="checkbox"/> QUARTERLY	<input type="checkbox"/> OTHER: % DOWN:
		<input type="checkbox"/> AT EXPIRATION	<input type="checkbox"/> SEMI-ANNUAL	<input type="checkbox"/> QUARTERLY	<input type="checkbox"/> MONTHLY <input type="checkbox"/> OTHER:		

LOCATIONS	
#	STREET, CITY, COUNTY, STATE, ZIP CODE
1	
2	
3	

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/%	OTHER COVERAGES
	\$ 500,000 EACH ACCIDENT		MEDICAL		U.S.L. & H. VOLUNTARY COMP
	\$ 500,000 DISEASE-POLICY LIMIT		INDEMNITY		MANAGED CARE OPTION
	\$ 500,000 DISEASE-EACH EMPLOYEE				FOREIGN COV
DIVIDEND PLAN/SAFETY GROUP	ADDITIONAL COMPANY INFORMATION				

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	\$
		ASSIGNED RISK SURCHARGE	\$
		ARAP	\$
			\$
		PREMIUM DISCOUNT	\$
		EXPENSE CONSTANT	\$
			\$
MINIMUM PREMIUM	\$	DEPOSIT PREMIUM	\$
		TOTAL EST ANNUAL PREMIUM	0 \$ 0

INDIVIDUALS INCLUDED/EXCLUDED

PARTNERS, OFFICERS, RELATIVES TO BE INCLUDED OR EXCLUDED. (Remuneration to be included must be part of rating information section.)								
#	NAME	DATE OF BIRTH	TITLE/ RELATIONSHIP	OWNER- SHIP %	DUTIES	INC/EXC	CLASS CODE	REMUNERATION
1								
2								
3								
4								
5	Social Sec # on all Owners							

PRIOR CARRIER INFORMATION/LOSS HISTORY

PROVIDE INFORMATION FOR THE PAST 5 YEARS AND USE THE REMARKS SECTION FOR LOSS DETAILS							<input checked="" type="checkbox"/> 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	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 ENTITY NAME(S) AND POLICY NUMBERS(S).		
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?			CONTACT INFORMATION		
11. ANY SEASONAL EMPLOYEES?			IN-SPECTION PHONE:		
12. IS THERE ANY VOLUNTEER OR DONATED LABOR?			NAME:		
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?			ACCTNG RECORD PHONE:		
14. DO EMPLOYEES TRAVEL OUT OF STATE?			NAME:		
15. ARE ATHLETIC TEAMS SPONSORED?			CLAIMS INFO PHONE:		
			NAME:		

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, VT; IN DC, LA, ME AND VA, INSURANCE BENEFITS MAY ALSO BE DENIED)

REMARKS

APPLICANT'S SIGNATURE	PRODUCER'S SIGNATURE The Insurance Shop, LLC
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