WORKERS COMPENSATION APPLICATION

APPLICANT INFORMATION

Named Insured:					
Mailing Address:					
City:		**State:**		**Zip:**	
Contact Person:		**Telephone #:**			
Email Address:		**Website Address:**			
Corporate Entity is: ☐ Corporation ☐ Individual ☐ Partnership ☐ Joint Venture ☐ Other (Please attach description)					
What Year was the Entity Founded:					
FEDERAL EMPLOYER ID #:		**NCCI RISK ID #:**			

LOCATIONS

LOC #	STREET	CITY	STATE	ZIP

POLICY INFORMATION

EFFECTIVE DATE:		**EXPIRATION DATE:**		**ANNIVERSARY RATING DATE:**	
EMPLOYER'S LIABILITY LIMITS:	$	EACH ACCIDENT LIMIT			
	$	DISEASE-POLICY LIMIT			
	$	DISEASE-EACH EMPLOYEE LIMIT			
DEDUCTIBLES:	$	MEDICAL			
	$	INDEMNITY			
COVERED STATES:		**DIVIDEND PLAN/SAFETY GROUP:**			
OTHER COVERAGES: ☐ U.S.L.&H. ☐ Voluntary Comp ☐ Foreign Coverage ☐ Managed Care					
TOTAL CURRENT ANNUAL PREMIUM ALL STATES:					
SPECIFY ADDITIONAL COVERAGE/ENDORSEMENTS REQUIRED:					

INCLUDED/EXCLUDED INDIVIDUALS

PARTNERS, OFFICERS, RELATIVES TO BE INCLUDED OR EXCLUDED (Must be employed by business operations)

STATE	LOC #	NAME	DOB	TITLE	OWNERSHIP %	DUTIES	INC/EXC	CLASS CODE	PAYROLL

RATING INFORMATION

STATE	CLASS CODE	DESCRIPTION/CLASSIFICATION	EMPLOYEES		SIC	NAICS	ESTIMATED ANNUAL PAYROLL
			FULL TIME	PART TIME			

IF ADDITIONAL SPACE IS REQUIRED ATTACH ADDITIONAL PAGE 2 OF THIS APPLICATION

REMARKS

GENERAL INFORMATION

Does the insured have any operations, payroll or anticipated work anywhere within the state of NY?	☐YES ☐NO
Does the applicant have any exposure to USL&H, FELA or other Federal Act?	☐YES ☐NO
Does the insured lease any employees or utilize any leased labor?	☐YES ☐NO
Do the insured's operations include any trenching or work more than ten (10) feet below ground surface?	☐YES ☐NO
Do the insured's operations include any exposure or work taking place over two (2) stories, or sixty (60) feet, above the ground, including on scaffolding?	☐YES ☐NO
Does the insured utilize sub-contractors without a written contract and certificates of insurance?	☐YES ☐NO
Is the insured operating within fifty (50) feet of any railroad?	☐YES ☐NO
Does any one location have more than 100 employees?	☐YES ☐NO
Has the insured ever been cited by OSHA?	☐YES ☐NO
Has the insured been in business for at least three (3) years without a lapse in Workers Compensation coverage?	☐YES ☐NO
Does the insured require a written application for employment that includes questions regarding any pre-employment accidents and any pre-existing medical conditions?	☐YES ☐NO
Does the insured require candidate physicals after an offer of employment has been made?	☐YES ☐NO
Do principals of the insured act as supervisors on job sites?	☐YES ☐NO
Is any work performed on barges, vessels, docks, piers, bridges or over navigable waters?	☐YES ☐NO
Is the average tenure of employees at least one year?	☐YES ☐NO
Does the applicant own, operate or lease any aircraft or watercraft?	☐YES ☐NO
Are there any tax liens or bankruptcies within the prior five (5) years?	☐YES ☐NO
Does the insured utilize a written Safety Plan that details the proper procedures for worksite emergencies?	☐YES ☐NO
Does the insured have a safety professional (CIH/CSP) sign-off on their Health/Safety programs?	☐YES ☐NO
For how long does the insured retain personnel, workplace and ambient air monitoring results?	

ABATEMENT INFORMATION

Has the insured instituted the new Respiratory Protection Standard provisions and provided the correct PPE based upon the hazards associated with each specific worksite?		☐YES ☐NO
Has all hazard-specific training provided to personnel incorporated the proper use of PPE and respiratory equipment and afforded annual fit testing for respirators and refresher training for both PPE and respirators?		☐YES ☐NO
Is the abatement license holder for the company an employee of the insured?		☐YES ☐NO
Does the insured's Health/Safety Plan detail the procedures for each hazard which might be encountered during work activities?		☐YES ☐NO
Who is the insured's corporate Respiratory Program Administrator?	NAME:	
	TITLE:	
	CONTACT #:	

CONSULTING INFORMATION

Is the consulting or laboratory professional who qualifies the services and exposures an employee of the insured?	☐YES ☐NO
Does the insured limit the scope of services depending on the type of substances, materials or wastes a worksite contains?	☐YES ☐NO
Please describe any "Accreditations" held by the insured:	
What type and level of certification and training is required of the insured's employees:	

CLAIMS INFORMATION:

Have any claims been made against you or reported under any Workers Compensation policy?	☐YES ☐NO
Are you aware of any fact, circumstance or situation that could reasonably result in a claim being made against you, or any other entity, for which coverage is being sought?	☐YES ☐NO
If "**YES**", please describe or provide attached reference:	

FRAUD WARNING: APPLICABLE TO ALL STATES

Any person who knowing 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.

WARRANTY STATEMENT

The undersigned authorized officer of the applicant declares that the statements set forth herein are true. The undersigned authorized officer agrees that if the information supplied on the application changes between the date of the application and the effective date of the insurance, he/she (undersigned) will immediately notify the insurer of such changes, and the insurer may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance. Signing of this application does not bind the applicant or the insurer to complete the insurance.

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

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SIGNATURE OF OWNER OR OFFICER OF APPLICANT:	
PRINTED NAME & TITLE OF SIGNATORY:	
DATE OF SIGNATURE:	

AGENT/BROKERAGE:	
LICENSE NUMBER:	
ADDRESS OF AGENCY/BROKERAGE:	
CONTACT PERSON & TELEPHONE:	