# WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY): 11/05/2020

AGENCY NAME AND ADDRESS: [redacted]

COMPANY: [redacted]

UNDERWRITER:

APPLICANT NAME: [redacted]

OFFICE PHONE:

MOBILE PHONE:

MAILING ADDRESS (including ZIP + 4 or Canadian Postal Code): [redacted]

YRS IN BUS:

SIC:

NAICS:

WEBSITE ADDRESS:

PRODUCER NAME: [redacted]

CS REPRESENTATIVE NAME:

OFFICE PHONE (A/C, No, Ext):

MOBILE PHONE:

FAX (A/C, No): [redacted]

E-MAIL ADDRESS:

E-MAIL ADDRESS:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | SOLE PROPRIETOR | | CORPORATION | X | LLC | | TRUST | | UNINCORPORATED ASSOCIATION |
| | PARTNERSHIP | | SUBCHAPTER "S" CORP | | JOINT VENTURE | | OTHER: | | |

CODE: [redacted] SUB CODE:

AGENCY CUSTOMER ID: [redacted]

CREDIT BUREAU NAME:

ID NUMBER:

FEDERAL EMPLOYER ID NUMBER: [redacted]

NCCI RISK ID NUMBER

OTHER RATING BUREAU ID OR STATE EMPLOYER REGISTRATION NUMBER

## STATUS OF SUBMISSION

- [ ] QUOTE
- [ ] ISSUE POLICY
- [ ] BOUND (Give date and/or attach copy)
- [ ] ASSIGNED RISK (Attach ACORD 133)

## BILLING / AUDIT INFORMATION

**BILLING PLAN**
- [ ] AGENCY BILL
- [ ] DIRECT BILL

**PAYMENT PLAN**
- [ ] ANNUAL
- [X] 7 pmts
- [ ] SEMI-ANNUAL
- [ ] QUARTERLY

% DOWN: 25.00

**AUDIT**
- [X] AT EXPIRATION
- [ ] MONTHLY
- [ ] SEMI-ANNUAL
- [ ] QUARTERLY

## LOCATIONS

| LOC # | HIGHEST FLOOR | STREET, CITY, COUNTY, STATE, ZIP CODE |
|---|---|---|
| 1 | | [redacted] |
| | | |
| | | |

## POLICY INFORMATION

| PROPOSED EFF DATE | PROPOSED EXP DATE | NORMAL ANNIVERSARY RATING DATE | | RETRO PLAN |
|---|---|---|---|---|
| 12/26/2024 | 12/26/2024 | | [ ] PARTICIPATING<br>[ ] NON-PARTICIPATING | |

**PART 1 - WORKERS COMPENSATION (States):** PA

**PART 2 - EMPLOYER'S LIABILITY**

| | | |
|---|---|---|
| $ | 500,000 | EACH ACCIDENT |
| $ | 500,000 | DISEASE-POLICY LIMIT |
| $ | 500,000 | DISEASE-EACH EMPLOYEE |

**PART 3 - OTHER STATES INS**

| DEDUCTIBLES (N / A in WI) | | AMOUNT / % (N / A in WI) | OTHER COVERAGES | | |
|---|---|---|---|---|---|
| [ ] | MEDICAL | | [ ] | U.S.L. & H. | [ ] MANAGED CARE OPTION |
| [ ] | INDEMNITY | | [ ] | VOLUNTARY COMP | |
| | | | [ ] | FOREIGN COV | |

DIVIDEND PLAN/SAFETY GROUP

ADDITIONAL COMPANY INFORMATION

SPECIFY ADDITIONAL COVERAGES / ENDORSEMENTS (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

## TOTAL ESTIMATED ANNUAL PREMIUM - ALL STATES

| TOTAL ESTIMATED ANNUAL PREMIUM ALL STATES | TOTAL MINIMUM PREMIUM ALL STATES | TOTAL DEPOSIT PREMIUM ALL STATES |
|---|---|---|
| $ 9,613.00 | $ 233.00 | $ 9,440.00 |

## 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.) Exclusions in Missouri must meet the requirements of Section 287.090 RSMo.

| STATE | LOC # | NAME | DATE OF BIRTH | TITLE/ RELATIONSHIP | OWNER-SHIP % | DUTIES | INC/EXC | CLASS CODE | REMUNERATION/PAYROLL |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| | | | | | | | | | |
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