

AGENCY NAME AND ADDRESS		COMPANY:	
PRODUCER NAME:		UNDERWRITER:	
CS REPRESENTATIVE NAME:		APPLICANT NAME:	
OFFICE PHONE (A/C. No. Ext):		OFFICE PHONE:	MOBILE PHONE:
MOBILE PHONE:		MAILING ADDRESS (including ZIP + 4 or Canadian Postal Code)	
FAX (A/C. No.):		YRS IN BUS:	
E-MAIL ADDRESS:		SIC:	
CODE: SUB CODE:		NAICS:	
AGENCY CUSTOMER ID:		WEBSITE ADDRESS:	
E-MAIL ADDRESS:		<input type="checkbox"/> SOLE PROPRIETOR <input type="checkbox"/> CORPORATION <input type="checkbox"/> LLC <input type="checkbox"/> TRUST <input type="checkbox"/> UNINCORPORATED ASSOCIATION <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> SUBCHAPTER "S" CORP <input type="checkbox"/> JOINT VENTURE <input type="checkbox"/> 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	<input type="checkbox"/> BILLING PLAN	<input type="checkbox"/> PAYMENT PLAN
<input type="checkbox"/> BOUND (Give date and/or attach copy)	<input type="checkbox"/> AGENCY BILL	<input type="checkbox"/> ANNUAL	<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"/> MONTHLY
		<input type="checkbox"/> QUARTERLY	<input type="checkbox"/> QUARTERLY
		% DOWN:	

LOCATIONS		
LOC #	HIGHEST FLOOR	STREET, CITY, COUNTY, STATE, ZIP CODE

POLICY INFORMATION		RATING EFFECTIVE DATE (if applicable)	ANNIVERSARY RATING DATE (if applicable)	PARTICIPATING	RETRO PLAN
PROPOSED EFF DATE	PROPOSED EXP DATE			<input type="checkbox"/> PARTICIPATING	<input type="checkbox"/> RETRO PLAN
				<input type="checkbox"/> NON-PARTICIPATING	
PART 1 - WORKERS COMPENSATION (States)	PART 2 - EMPLOYER'S LIABILITY	PART 3 - OTHER STATES INS	DEDUCTIBLES (N / A in WI)	AMOUNT / % (N / A in WI)	OTHER COVERAGES
	\$ EACH ACCIDENT		<input type="checkbox"/> MEDICAL		<input type="checkbox"/> U.S.L. & H. VOLUNTARY COMP
	\$ DISEASE-POLICY LIMIT		<input type="checkbox"/> INDEMNITY		<input type="checkbox"/> FOREIGN COV
	\$ DISEASE-EACH EMPLOYEE				<input type="checkbox"/> MANAGED CARE OPTION
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
\$	\$	\$

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

INDIVIDUALS INCLUDED / EXCLUDED									
PARTNERS, OWNERS, 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 or waivers in California must meet the requirements of Cal. Labor Code §§3351 and 3352.									
STATE	LOC #	NAME	DATE OF BIRTH	TITLE/ RELATIONSHIP	OWNER-SHIP %	DUTIES	INC/EXC	CLASS CODE	REMUNERATION/PAYROLL

STATE RATING WORKSHEET

FOR MULTIPLE STATES, ATTACH AN ADDITIONAL PAGE 2 OF THIS FORM

RATING INFORMATION - STATE:

LOC #	CLASS CODE	DESCR CODE	CATEGORIES, DUTIES, CLASSIFICATIONS	# EMPLOYEES		SIC	NAICS	ESTIMATED ANNUAL REMUNERATION/PAYROLL	RATE	ESTIMATED ANNUAL MANUAL PREMIUM
				FULL TIME	PART TIME					

PREMIUM

STATE:	FACTOR	FACTORED PREMIUM		FACTOR	FACTORED PREMIUM
TOTAL	N / A	\$			\$
INCREASED LIMITS		\$	SCHEDULE RATING *		\$
DEDUCTIBLE *		\$	CCPAP		\$
EXPERIENCE OR MERIT MODIFICATION		\$	STANDARD PREMIUM		\$
TERRORISM	N / A	\$	PREMIUM DISCOUNT		\$
CATASTROPHE	N / A	\$	EXPENSE CONSTANT	N / A	\$
ASSIGNED RISK SURCHARGE *		\$	TAXES / ASSESSMENTS *	N / A	\$
ARAP *		\$			\$

* N / A in Wisconsin

TOTAL ESTIMATED ANNUAL PREMIUM \$	MINIMUM PREMIUM \$	DEPOSIT PREMIUM \$
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REMARKS (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

PRIOR CARRIER INFORMATION / LOSS HISTORY

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	Y / N
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT / WATERCRAFT?	
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)	
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?	
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?	
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?	
6. ARE SUB-CONTRACTORS USED? (If "YES", give % of work subcontracted)	
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)	
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?	
9. ANY GROUP TRANSPORTATION PROVIDED?	
10. ANY SEASONAL EMPLOYEES?	
11. IS THERE ANY VOLUNTEER OR DONATED LABOR? (If "YES", please specify)	
12. DO EMPLOYEES TRAVEL OUT OF STATE? (If "YES", indicate state(s) of travel and frequency)	
13. ARE ATHLETIC TEAMS SPONSORED?	
14. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?	
15. ANY OTHER INSURANCE WITH THIS INSURER?	
16. ANY PRIOR COVERAGE DECLINED / CANCELLED / NON-RENEWED IN THE LAST THREE (3) YEARS?	

GENERAL INFORMATION (continued)

AGENCY CUSTOMER ID: _____

EXPLAIN ALL "YES" RESPONSES	Y / N
17. ARE EMPLOYEE HEALTH PLANS PROVIDED?	
18. DO ANY EMPLOYEES PERFORM WORK FOR OTHER BUSINESSES OR SUBSIDIARIES?	
19. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?	
20. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME? If "YES", # of Employees: _____	
21. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST FIVE (5) YEARS? (If "YES", please specify)	
22. 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).	

SIGNATURE

Copy of the Notice of Information Practices (Privacy) has been given to the applicant. (Not required in all states, contact your agent or broker for your state's requirements.)			
<p>PERSONAL INFORMATION MAY BE COLLECTED FROM PERSONS OTHER THAN THE INDIVIDUAL OR INDIVIDUALS PROPOSED FOR COVERAGE. SUCH INFORMATION AS WELL AS OTHER PERSONAL OR PRIVILEGED INFORMATION SUBSEQUENTLY COLLECTED BY THE INSURANCE INSTITUTION OR AGENT MAY IN CERTAIN CIRCUMSTANCES BE DISCLOSED TO THIRD PARTIES WITHOUT AUTHORIZATION. A RIGHT OF ACCESS AND CORRECTION EXISTS WITH RESPECT TO ALL PERSONAL INFORMATION COLLECTED. UPON REQUEST, A MORE DETAILED NOTICE OF YOUR RIGHTS AND OUR PRACTICES REGARDING PERSONAL INFORMATION WILL BE FURNISHED.</p>			
(Not applicable in AZ, CA, DE, KS, MA, MN, ND, NY, OR, VA, or WV. Specific ACORD 38s are available for applicants in these states.)			(Applicant's Initials): _____
<p>THE UNDERSIGNED IS AN AUTHORIZED REPRESENTATIVE OF THE APPLICANT AND REPRESENTS THAT REASONABLE INQUIRY 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.</p>			
APPLICANT'S SIGNATURE (Must be Officer, Owner or Partner)	DATE	PRODUCER'S SIGNATURE	NATIONAL PRODUCER NUMBER