



INSURANCE CO.
Peoria, Illinois

**PRIMARY EMPLOYERS INDEMNITY
EXCESS EMPLOYERS INDEMNITY**

Application

Agent:	Please indicate coverage desired: <input type="checkbox"/> Primary Employers Indemnity (PEI) <input type="checkbox"/> Excess Employers Indemnity (EEI)
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APPLICANT INFORMATION

Name			
Mailing Address			
<input type="checkbox"/> Individual	<input type="checkbox"/> Corporation	<input type="checkbox"/> LLC	Yrs. In Business
<input type="checkbox"/> Partnership	<input type="checkbox"/> Joint Venture	<input type="checkbox"/> Other	

LOCATION INFORMATION

#	Street, City, County, State, Zip Code	Number Of Employees
1		
2		
3		

NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS

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WC ACT REJECTION

Please indicate the date you have rejected or will reject the WC Act.	
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CURRENT COVERAGE INFORMATION

Carrier	
Policy Period	
Employee / Occurrence Limits	
SIR / Deductible	
Aggregate Limits / Reinstatements	
Rate per \$100 payroll / Premium	

GENERAL INFORMATION

#	Explain "Yes" Answers on separate sheet	Yes	No	#	Explain "Yes" Answers on separate sheet	Yes	No
1.	Have you filed for bankruptcy in the last 5 years?			9.	Do you mfg., store, sell, handle or transport any chemicals?		
2.	Do you have any employees subject to the USL & HW Act, Jones Act or FELA?			10.	Do you mfg., store, sell, handle or transport any drug or pharmaceuticals?		
3.	Do you own, lease or charter any watercraft?			11.	Do you mfg., store, sell, handle or transport any explosives?		
4.	Do you own, lease or charter any aircraft?			12.	Do you mfg., store, sell, handle or transport any gasoline or fuel oils?		
5.	Do you provide transportation for employees to or from the workplace?			13.	Do you mfg., store, sell, handle or transport any hazardous materials?		
6.	Do you use any donated or volunteer labor?			14.	Do you mfg., store, sell, handle or transport any nuclear materials?		
7.	Do you use any temporary or leased employees?			15.	Do you mfg., store, sell, handle or transport asbestos or asbestos products?		
8.	Do you use subcontractors?			16.	Do you require employees to drive their own vehicles for your business?		

AUTOMOBILE INFORMATION (indicate the number of autos owned, leased or operated or the number of dealer tags by type)

Radius of Use	PPT	Light Comml.	Med. Comml.	Hvy. Comml.	X-Hvy. Comml.	Tractors
0 to 50 Miles						
51 to 200 Miles						
Over 200 Miles						

RATING INFORMATION

Classification	NCCI Code	Part-time EE's	Full-time EE's	Estimated Annual Payroll

If included for coverage, partners payroll is subject to a maximum of \$30,200 and executive officers payroll is subject to a maximum of \$62,400 annually.

LOSS INFORMATION – Valued as of _____ (first dollar aggregate losses for the last 5 years.)

Year	Medical Incurred	Indemnity Incurred	Total Incurred	No. of Claims	Annual Payroll or No. of Employees

Please provide details of each loss exceeding either the SIR or \$50,000, whichever is less, on a separate sheet of paper. Details should include the data of loss, a brief description of the accident, the number of employees involved and the amount incurred.

VOLUNTARY BENEFIT PLAN (indicate limits and/or amounts)

	A D & D		Disability		Medical		
Maximum Limit/Amount							
% of AWW payable/No. of weeks payable			/				
Incurral Period							
#	Explain "Yes" Answers on a separate sheet	Yes	No	#	Explain "Yes" Answers on a separate sheet	Yes	No
1.	Is your Plan mandatory for all employees?			3.	Does your Plan include provisions for medical case management?		
2.	Does your Plan include designated medical providers?			4.	Does your Plan include a "light duty" program?		

CLAIM ADMINISTRATION

Name of Third Party Administrator (TPA) that will be handling claims within the SIR?	TPA
Name of telephone number of the employee handling claims within your organization if no TPA is used?	Name Telephone

SAFETY PROGRAM

#	Explain "Yes" Answers on a separate sheet	Yes	No	#	Explain "Yes" Answers on a separate sheet	Yes	No
1.	Do you have a written safety manual?			7.	Do you conduct periodic self-inspections?		
2.	Do you have a safety incentive program?			8.	Do you conduct accident investigations?		
3.	Do you have an Alcohol/Drug testing program?			9.	Do you keep records of all safety activities?		
4.	Do you have a safety director?			10.	Have you had any OSHA violations in the last 5 years?		
5.	Do you have a safety committee?			11.	Do you have an outside safety consultant on retainer?		
6.	Do you have an employee training program?						

PEI COVERAGE REQUESTED

Limits of Indemnity	Any One Employee	Any One Occurrence
A D & D, Disability, Medical Expense, OD / CT & EL Coverage		\$
Self-Insured Retention		
A D & D, Disability, Medical Expense, OD / CT & EL Coverage:		\$
	% of AWW Payable	Max. AWW Payable
Disability Sublimits	%	\$
	Medical Expense	Disability
Maximum Benefit Period (260 week maximum)	weeks	weeks

E EI COVERAGE REQUESTED

Limits of Indemnity	Any One Employee	Any One Occurrence
Bodily Injury	\$	\$
Occupational Disease & Cumulative Trauma	\$	
Self-Insured Retentions		
Bodily Injury		\$
Occupational Disease & Cumulative Trauma	\$	\$

E EI Reinstatements (BI Only): Unlimited 2 Free 1 Free 2 Paid 1 Paid

COVERAGE AMENDMENTS

#	Explain "Yes" Answers on a separate sheet	Yes	No	#	Explain "Yes" Answers on a separate sheet	Yes	No
1.	Are executive officers to be excluded? (If yes, provide names on a separate sheet)			4.	Are Waivers of Subrogation required?		
2.	Are aircraft exposures to be excluded?			5.	Is the Suppl. EL Endorsement to be included? (EEI coverage only)		
3.	Is Occupational Disease to be excluded?						

This is not a Workers Compensation policy. You do not become a subscriber to the Workers Compensation system by purchasing this policy. You lose those benefits that would accrue under the Workers Compensation Act. By signing this application you warrant that you will comply with the Workers Compensation Law as it pertains to non-subscribers and that the required notices will be filed and posted.

By signing this application you confirm that you have been provided with and inspected a specimen copy of the Primary Employers Indemnity and/or Excess Employers Indemnity policy(ies). We recommend that you consult with your legal advisor to ensure that you fully understand the coverage provided. You also agree that, should coverage be issued based upon this application, that this application shall become a material and integral part of the policy and the statements made herein shall be construed as your representations and warranties. You acknowledge that the coverage applied for will be underwritten by an insurer not licensed o transact insurance in the State of Texas and the policy will be issued and delivered as a surplus lines coverage pursuant to the Texas insurance statutes.

Any person who knowingly and with intent to defraud any insurance company or other person files a statement 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.

Authorized Signatory of Applicant

Title

Date