

Corporate Risk Services, LLC
5502 Walsh Lane, Ste 103
Rogers, AR 72758
(479) 271-7475 Fax (479) 271-7141

INDIVIDUAL
SELF-INSURANCE
APPLICATION FOR EXCESS
WORKERS' COMPENSATION
COVERAGE

New Application Effective Date: _____

Renewal of Policy Number: _____ To Be Quoted By: _____

1. Name of Applicant (as shown on self-insurance permit): _____

2. Address: _____ Zip: _____

3. Applicant Phone Number: _____

4. CFO: _____ Phone: _____

E-Mail: _____

Main Contact: _____ Phone: _____

E-Mail: _____

5. Federal Employers Identification Number: _____

6. Describe operations to be covered; subsidiaries to be covered if any. (Attach copy of current and comprehensive engineering inspection reports, annual report, or 10k report and products brochure.)

7. Describe any substantial or unusual changes in operations that are planned or have taken place in the past five years:

8. Date qualified as a self-insured: _____

9. States to be self-insured: _____

10. Are there other states or jurisdictions included for self-insurance that would not be covered by the insurance requested by this application? Yes No

If yes, list: _____

11. Do any employees receive supplemental benefits in addition to workers' compensation benefits? Yes No

12. Provide details of any OSHA or State OSHA violation within the past 5 years: _____

13. Does the applicant have any employees who may be subject to the Longshoremen and Harbor Workers Act, Jones Act or Federal Employee's Liability Act? (Unless endorsed, our policy does NOT include federal acts coverage.) Yes No

If yes, describe: _____

14. Do the operations of the applicant include volunteer or donated labor? Yes No

If yes, describe: _____

15. Does applicant have any foreign operations or employees who travel to foreign countries? Yes No
 If yes, describe: _____
16. Does the applicant outsource or utilize contract staffing for any job function(s)? Yes No
 If yes, describe both the functions performed and total number of individuals involved: _____
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- Does the staffing company provide workers' compensation coverage? Yes No
 What measures are taken to confirm that the staffing company is providing workers' compensation coverage? _____
17. Does the applicant use any nanotechnology in their operations or research? Yes No
 If so, please explain: _____
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18. Is applicant engaged in the manufacture, production, refining, storage, distribution, or transportation of gases, gasoline or flammables? Yes No
 If yes, describe: _____
19. Are there any occupational disease exposures involved in the applicant's operations? (asbestos; silica; dusts; toxic, injurious or hazardous chemicals; caustics, fumes, radiation, communicable diseases and any other O.D. exposures) If yes, describe steps taken to control: Yes No

20. Does applicant perform any underground, subaqueous, or tunneling operations? Yes No
 If yes, describe: _____
21. Do the operations of the applicant include wrecking or demolition of structures? Yes No
 If yes, describe: _____
22. Do the operations of the applicant involve exposure to heights? Yes No
 If yes, describe: _____
23. Does applicant now (or have future plans to) own, lease or charter watercraft? Yes No
 If yes, describe watercraft, use, number of crew members, passenger capacity and whether craft is owned, leased, or chartered. _____
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24. Does applicant own, lease, or charter aircraft? *(If yes, Aircraft Questionnaire must be completed.)* Yes No
25. Complete the following information on owned or leased vehicles:
- a. Number of: passenger cars _____ trucks _____ tractors _____
- b. Number of commercial vehicles owned by: applicant _____ owner-operator _____
- c. Is applicant responsible for W.C. coverage on owner-operators? Yes No
 If no, does applicant obtain certificate of W.C. insurance from such operators? Yes No
- d. With respect to commercial vehicles:
1. States in which vehicles operate: _____
2. Average number of persons in each unit: _____
3. Does applicant transport chemicals, hazardous materials, explosives, explosive material, flammable material, or any petroleum products? Yes No
 If yes, provide full details: _____
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26 Does applicant provide any transportation for employees to or from the workplace? Yes No
 If yes, describe the type of conveyance, frequency of trips and number of employees
 (total number and number per conveyance involved): _____

27 Policy Coverages and Limits.

Current Carrier: _____

Type of Coverage: _____

Present Program:

SPECIFIC EXCESS LIMIT	EMPLOYERS LIABILITY LIMIT	SELF-INSURED RETENTION	RATE	AGGREGATE EXCESS LIMIT	AGGREGATE LOSS FUND %	CURRENT ESTIMATED LOSS FUND	MINIMUM TERM LOSS FUND

Coverage Desired:

SPECIFIC EXCESS LIMIT	EMPLOYERS LIABILITY LIMIT	SELF-INSURED RETENTION	AGGREGATE EXCESS LIMIT	AGGREGATE LOSS FUND %

28 Gross Payroll Distribution by Classification Code.

a. Projected payroll. Provide the following information regarding each state or jurisdiction:
 (If more space is needed, use a separate page.)

Please Note: Prospective and historical payrolls and worker hours are required for the state of Washington.
 Both capped and uncapped payrolls are required for the state of Nevada.

		POLICY PERIOD:						
STATE	W.C. CODE	CLASSIFICATION	PROSPECTIVE YEAR	1st PRIOR	2nd PRIOR	3rd PRIOR	4th PRIOR	5th PRIOR
Totals:								

b. Is there any significant change to the payroll distribution by classification code in the last five years? Yes No

c. If yes, describe reason for change(s): _____

- b. Are claims handled to conclusion? If no, give details. Yes No
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- c. What is normal length of service contract? _____
- d. Does applicant agree to let the excess carrier know about any changes in the service company or in the kind or amount of services to be performed by the service company? Yes No
- e. Do you have an alternative duty return to work program in place for all departments? Yes No
- f. Do you provide in-house medical attention for first aid injuries? Yes No
- g. If so, who provides the treatment? _____
- h. Do you have a process in place in which all injuries are internally investigated and reported to your claim servicing company within 24 hours? Yes No
- i. Do you conduct regular or quarterly claim reviews with your claim servicing company? Yes No
- j. Check the following managed care programs that apply to your program:
- PPO contracted pricing other _____
- fee scheduling nurse case management

Florida Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

New Jersey Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New York Any person who knowingly 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.

Louisiana Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Other States Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement is guilty of insurance fraud.

Date

Applicant's Signature

Title

Print Applicant's Name

Print Applicant's Title