EXCESS WORKERS' COMPENSATION APPLICATION

Must be accompanied by an Employee Concentration Supplement

APPLICANT

First Named Insured					
Physical Address		Mailing Address			
City		City			
State		Zip Code		State		Zip Code	
Application Type		Expiring Policy #		Effective Date	

Name of Additional Named Insured:

Website Address:

Provide a description of operations, processes and products:
(Attach a copy of current and comprehensive loss prevention inspection reports, product brochure, annual report or 10-K report, and copy of certificate of approval to self-insure issued by the state)

Add Additional

** If applicant is a health care facility, a Hospital/Health Care Supplemental Application must be completed.

	State/Jurisdictions
Provide the date that the applicant qualified as a self-insured:	
In which States or Jurisdictions will the applicant operate as a qualified Self-Insured?	

Add Additional

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THIRD PARTY ADMINISTRATOR INFORMATION (If requesting approval for self-administration, please attach an Approved Service Organization Application.)

Name of Third Party Administrator:

Address		City			
Contact Name		State		Zip Code	
Phone Number		Email			

Has service company accepted responsibility for providing specific excess claim reporting and follow-up detail to excess carrier?	
How long are claims to be handled by the TPA?	
How many years has the service company had a service contract with the applicant?	
If less than seven years, will loss runs include all prior TPA open and closed claims?	
Is the service contract concurrent with the policy period?	

Loss runs concurrent with policy period must be provided on a quarterly basis.

THIRD PARTY ADMINISTRATOR INFORMATION (If requesting approval for self-administration, please attach an Approved Service Organization Application.)

Name of Third Party Administrator:

Address		City			
Contact Name		State		Zip Code	
Phone Number		Email			

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Add Additional

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LOSS PREVENTION SERVICE

Name of Service Provider or Consulting Firm:

Name of Main Contact at Service Company:

Phone Number:

Add Additional

Name of Safety Manager/Coordinator:

Phone Number:

Does applicant agree to provide copies of loss prevention reports upon request?

Check the box next to each item that is a component of the applicant's current safety program:

☐	Self-Inspections	☐	Third Party Inspections	☐	Industrial Hygiene Surveys
☐	Ergonomic Evaluations	☐	Safety Committee Meetings	☐	Job Hazard Analysis
☐	Drug/Alcohol Testing	☐	Incident Investigation Process	☐	Return to Work Program
☐	Safety Accountability	☐	Safety Manager on Staff	☐	Injury Management Process
☐	Orientation Safety Training	☐	Ongoing Safety Training	☐	Hazard Communication/GHS

CURRENT PROGRAM

Name of present workers' compensation carrier (primary or excess):

If fully insured, describe type of plan (i.e. retro, dividend, large deductible):

Complete the following if presently self-insured:

STATE	SELF-INSURED RETENTION	SPECIFIC EXCESS LIMIT	EMPLOYER'S LIABILITY LIMIT	LOSS FUND %	AGGREGATE EXCESS LIMIT	MINIMUM TERM LOSS FUND

Add Row

Complete the following for the desired coverage (indicate all alternatives to be considered):

STATE	SELF-INSURED RETENTION	SPECIFIC EXCESS LIMIT	EMPLOYER'S LIABILITY LIMIT	LOSS FUND %	AGGREGATE EXCESS LIMIT	MINIMUM TERM LOSS FUND

Add Row

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Provide the following information regarding each state or jurisdiction to be covered:

STATE	W.C. CLASS CODE	CLASSIFICATION	NO. OF EMPLOYEES	ESTIMATED ANNUAL PAYROLL	ESTIMATED ANNUAL MANHOURS
		Totals			

Add Row

Specify additional coverage or endorsements desired:

Vehicle Information

A. Does applicant own or lease vehicles that haul or transport applicant's goods or products?

B. Does applicant own or lease vehicles that haul or transport the goods or products of others?

C. Does applicant own or lease vehicles for any of the following purposes: Police, Fire Protection, Ambulance Service, Street Maintenance?

D. Does the applicant use horses on company business?

E. Does the applicant use motorcycles on company business?

F. Does the applicant provide transportation of employees to, and/or from, any work site/work location?

G. Does applicant own or lease more than 25 vehicles?

H. Are 10 or more non-employer owned vehicles used by employees on company business?

***If "yes" to any of the above, complete the Vehicle Supplemental Application and skip the grid below.*

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Special Exposures- Select the appropriate answer that reflects the actual and/or anticipated exposures associated with the applicant's operations. Does the applicant:

A.	Own, lease or charter any aircraft? **(If "yes", Aircraft Supplemental Application must be completed.)**	
B.	Have employees that travel on aircraft other than commercial aircraft? **(If "yes," Aircraft Supplemental Application must be completed.)**	
C.	Own, lease or charter any watercraft? **(If "yes", Watercraft Supplemental Application must be completed.)**	
D.	Load, unload, repair or construct watercraft or vessels including work performed on barges or docks?	
E.	Have operations or employees subject to the Longshoremen's and Harbor Workers' Act, Jones Act or Federal Employer's Liability Act?	
F.	Own, operate or maintain a railroad or own, lease, operate or repair railroad equipment?	
G.	Have foreign operations or employees who travel to foreign countries?	
H.	Have occupational disease exposures now or in the past? (Includes asbestos, silica dusts, toxic, injurious or hazardous substances, compounds or chemicals, caustics, fumes, noise, radiation, communicable diseases and any other O.D. exposures.) If "yes", also describe measures taken to control.	
I.	Have operations involving nanotechnology?	
J.	Manufacture, produce, refine, store, distribute or transport gases, gasoline or flammables?	
K.	Manufacture, handle, transport, distribute or store explosives or explosive substances?	
L.	Have underground, tunneling, mining, cofferdam or subaqueous operations?	
M.	Perform wrecking, dismantling or demolition work?	
N.	Have operations subcontracted to others? If "yes", what are the operations and who is responsible for the workers' compensation coverage (use the text box below)?	
O.	Does the applicant require certificates of insurance?	
P.	Have operations involving exposure to heights?	
Q.	Have operations involving exposure to burns or explosions?	
R.	Subject to OSHA's Process Safety Management Standard for Highly Hazardous Materials?	
S.	Have employees that are leased or loaned from other organizations? If "yes", what are their duties and who is responsible for their workers' compensation coverage? Attach copy of employee lease agreement.	
T.	Lease or loan employees to other organizations? If "yes", what are their duties and who is responsible for their workers' compensation coverage? Attach copy of employee lease agreement.	
U.	Have any OSHA violations in the past 10 years?	
V.	Have any substantial or unusual changes in operations that are planned or have taken place in the last five years?	
W.	Have workers' compensation coverage that was cancelled or non-renewed in last seven years?	
X.	Anticipate providing any employees for volunteer disaster relief such as earthquake or hurricane relief?	
Y.	Have any volunteer or donated labor to be covered? If "yes", please provide a list of all volunteer duties and number of hours below.	
Z.	Do employees receive supplemental benefits in addition to statutory workers' compensation benefits?	

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Provide details for any "yes" responses for special exposures (attach supplemental page if additional space is required)	

Loss Experience -Provide at least a seven year loss history for each State to be included in proposal coverage. Please provide 10 years for best possible terms.

(Summarize loss experience even though submitting loss runs. Loss runs must be sumitted with the application. Break out losses by policy year. Loss runs must be currently valued.)

Beginning Policy Period MO/DAY/YEAR					Ending Policy Period MO/DAY/YEAR			
State	Total Audited Payrolls or Manhours for WA exposures	Indemnity Paid	Indemnity Reserve	Medical Paid	Medical Reserve	Claims Expense	Total Incurred	Valuation Date
Beginning Policy Period MO/DAY/YEAR					Ending Policy Period MO/DAY/YEAR			
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FRAUD WARNING STATEMENTS

Colorado

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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.

Kentucky

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Maryland

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

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.

Ohio

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 a false or deceptive statement is guilty of insurance fraud.

Oregon

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and maybe subject to fines and confinement in prison. In order for the Company to deny a claim on the basis of misstatements, misrepresentations, omissions or concealments on the Employer's part, the Company must show that: (1) the misinformation is material to the content of the policy; (2) the Company relied upon the misinformation; and (3) the information was either: (a) material to the risk assumed by the Company; or (b) provided fraudulently.

For remedies other than the denial of a claim, misstatements, misrepresentations, omissions or concealments on the Employer's part must either be fraudulent or material to the Company's interests.

With regard to fire insurance, in order to trigger the right to remedy, material misrepresentations must be willful or intentional. Misstatements, misrepresentations, omissions or concealments on the Employer's part are not fraudulent unless they are made with the intent to knowingly defraud.

All Other States

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

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This is NOT a binder of coverage. The application must be signed by the applicant or the applicant's representative. The applicant represents that all statements made in this application are complete and true and that all material facts have been fully disclosed.

Applicant's Representative		Date:	

Save Form

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