Workers' Compensation
Application Transmittal Sheet

Please submit this form with your new business application to: Colleen Lahna at clahna@massagent.com or by fax to (508) 634-2930

Named Insured:_____

Requested Effective Date:_____

To speed things along, please check option below:

☐ Provide quote and wait for request to bind.

☐ Quote is not needed. Please bind coverage and provide binder reflecting, policy number, effective date, carrier and premium information.

***Please complete the following information. This will be the avenue in which Number One Insurance Agency will contact you regarding the above-mentioned insured.

Agency Contact Name:_____

Contact's Email:_____

Agency Name:_____

Address:_____

_____

Agency Phone:_____

Agency Fax:_____

Thank you for your interest in the Number One Insurance Agency's Workers' Compensation Program.

Please contact Colleen Lahna with any questions regarding the submission process at (508) 634-7361 or clahna@massagent.com.

COMPLETION INSTRUCTIONS

Required Fields & Notes for Workers' Compensation Application

Be sure to complete the following fields:

- Agency, phone, fax & email if available
- Applicant Name
- Mailing Address
- Yrs in Business
- Type of business: Individual, Corp, etc.
- FEIN
- Location addresses
- Proposed Effective Date
- Part 2 – Employer's Liability Limits
- Under Rating Information be sure to include by location:
  class code, phraseology, # employees & payroll

Example:	01 8810	Clerical	1FT / 2PT	$50,000*
	01 8742	Outside Salesperson	1FT / 0PT	$80,000*
	02 8810	Clerical	1PT	$20,000*

*These figures should include the payroll for any "included" officers and owners.
It should be the entire "included" payroll for the business.

The section including Mod, ARAP, Loss Constant – you do not need to complete.
Our quote proposal will provide this information for you.

- Under Individuals Included/Excluded Area
  All owners and officers must be listed if included or not!
  We need name, title, % of ownership, if they are being Included or Excluded, Class Code and Payroll.
  - Sole Proprietors/Partners/LLC Members: Automatically EXCLUDED!
    To include need signed request on insured's letterhead asking to be included.
  - Corporations: Automatically INCLUDES all "active" officers.
    To exclude – must have at least 25% of ownership and Approved DIA Form 153.
  - See the General Information: Officers/Owner Information for more details.

- If prior carrier existed, please complete carrier, policy number & premium, if available.

- If no coverage was provided previously, please note why, for example: New Business, Adding Employees.

- Provide a detailed description of business outlining duties of all staff. Please list website of insured, if available.

- All General Information Questions must be answered.
  All YES questions must be explained under Remarks!

- Contact information: Name and phone number must be listed.

- We require the producer to sign the application and require that all producers receive a signature from the insured for your agency records. Our alternative market will require a completed Acord 130 signed by both the insured and the agent.

WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY)

AGENCY NAME AND ADDRESS	COMPANY:
	UNDERWRITER:
	APPLICANT NAME:
	OFFICE PHONE: / MOBILE PHONE:
	MAILING ADDRESS (including ZIP + 4 or Canadian Postal Code) / YRS IN BUS:
	SIC:
PRODUCER NAME:	NAICS:
CS REPRESENTATIVE NAME:	WEBSITE ADDRESS:
OFFICE PHONE (A/C, No, Ext)	E-MAIL ADDRESS:
MOBILE PHONE:	☐ SOLE PROPRIETOR ☐ CORPORATION ☐ LLC ☐ TRUST
FAX (A/C, No):	☐ PARTNERSHIP ☐ SUBCHAPTER "S" CORP ☐ JOINT VENTURE ☐ OTHER
E-MAIL ADDRESS:	CREDIT BUREAU NAME: / ID NUMBER:
CODE: SUB CODE:	FEDERAL EMPLOYER ID NUMBER / NCCI RISK ID NUMBER / OTHER RATING BUREAU ID OR STATE EMPLOYER REGISTRATION NUMBER
AGENCY CUSTOMER ID:	

STATUS OF SUBMISSION

☐ QUOTE ☐ ISSUE POLICY

☐ BOUND (Give date and/or attach copy)

☐ ASSIGNED RISK (Attach ACORD 133)

BILLING/AUDIT INFORMATION

BILLING PLAN	PAYMENT PLAN	AUDIT
☐ AGENCY BILL	☐ ANNUAL ☐	☐ AT EXPIRATION ☐ MONTHLY
☐ DIRECT BILL	☐ SEMI-ANNUAL	☐ SEMI-ANNUAL ☐
	☐ QUARTERLY % DOWN:	☐ QUARTERLY

LOCATIONS

LOC #	STREET, CITY, COUNTY, STATE, ZIP CODE

POLICY INFORMATION

PROPOSED EFF DATE	PROPOSED EXP DATE	NORMAL ANNIVERSARY RATING DATE	☐ PARTICIPATING ☐ NON-PARTICIPATING	RETRO PLAN

PART 1 - WORKERS COMPENSATION (States)	PART 2 - EMPLOYER'S LIABILITY	PART 3 - OTHER STATES INS	DEDUCTIBLES	AMOUNT/%	OTHER COVERAGES
	$ EACH ACCIDENT		☐ MEDICAL		☐ U.S.L. & H. ☐ MANAGED CARE OPTION
	$ DISEASE-POLICY LIMIT		☐ INDEMNITY		☐ VOLUNTARY COMP ☐
	$ DISEASE-EACH EMPLOYEE		☐		☐ FOREIGN COV ☐

DIVIDEND PLAN/SAFETY GROUP	ADDITIONAL COMPANY INFORMATION

SPECIFY ADDITIONAL COVERAGES / ENDORSEMENTS

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, 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.)

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

STATE RATING SHEET # _____ **OF** _____ **SHEETS** **AGENCY CUSTOMER ID:** _____

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 FULL TIME	# EMPLOYEES PART TIME	SIC	NAICS	ESTIMATED ANNUAL REMUNERATION/ PAYROLL	RATE	ESTIMATED ANNUAL MANUAL PREMIUM

PREMIUM

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

TOTAL ESTIMATED ANNUAL PREMIUM	MINIMUM PREMIUM	DEPOSIT PREMIUM
$	$	$

REMARKS

AGENCY CUSTOMER ID: _____

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	YES	NO
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 EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?	☐	☐
11. ANY SEASONAL EMPLOYEES?	☐	☐
12. IS THERE ANY VOLUNTEER OR DONATED LABOR? (If "YES", please specify)	☐	☐

AGENCY CUSTOMER ID: _____

GENERAL INFORMATION (continued)

EXPLAIN ALL "YES" RESPONSES	YES	NO
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?	☐	☐
14. DO EMPLOYEES TRAVEL OUT OF STATE? (If "YES", indicate state(s) of travel and frequency)	☐	☐
15. ARE ATHLETIC TEAMS SPONSORED?	☐	☐
16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?	☐	☐
17. ANY OTHER INSURANCE WITH THIS INSURER?	☐	☐
18. ANY PRIOR COVERAGE DECLINED/ CANCELLED/NON-RENEWED IN THE LAST THREE (3) YEARS? (Not applicable in MO)	☐	☐
19. ARE EMPLOYEE HEALTH PLANS PROVIDED?	☐	☐
20. DO ANY EMPLOYEES PERFORM WORK FOR OTHER BUSINESSES OR SUBSIDIARIES?	☐	☐
21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?	☐	☐
22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME? If "YES", # of Employees: _____	☐	☐
23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST FIVE (5) YEARS? (If "YES", please specify)	☐	☐
24. 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).	☐	☐

REMARKS (Attach additional sheets if more space is required)

APPLICABLE IN TENNESSEE AND VERMONT: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO ANY PARTY TO A WORKERS COMPENSATION TRANSACTION FOR THE PURPOSE OF COMMITTING FRAUD. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 SUBJECTS THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, FL, HI, MA, NE, OH, OK, OR, TN or VT; in DC, LA, ME, VA and WA, insurance benefits may also be denied)

APPLICANT'S SIGNATURE (Must be Officer, Owner or Partner)	DATE	PRODUCER'S SIGNATURE	NATIONAL PRODUCER NUMBER