

Workers' Compensation Application (Acord 130) Transmittal Sheet

Forward new business submissions with this completed form to
Michelle St. Angelo at mstangelo@massagent.com or contact her for questions at 508-634-7364

Named Insured: _____

Requested Effective Date: _____

Select Quote/Binding Option:

- Provide a quote and wait for request to bind.
- Quote is NOT needed. Please bind coverage and provide binder.

Agency Contact Name _____

Contact's Email: _____

Agency City/Town: _____

Application Instructions:

On application be sure to complete/include the below information:

- Agency Name, Address, Phone & Email
- Applicant/Client Name (include DBA) , Phone Number (**required**) & Mailing Address
- Yrs. in Business
- Type of Business: Individual, Corp, etc.
- FEIN
- Proposed Effective Date
- Part 1 – States
- Part 2 – Employer's Liability Limits
- Detailed description of business outlining duties of all staff and website.
- Complete ALL General Information questions and explain any YES answers under Remarks!
- Rating Information by location: Class Code, Phraseology, # Employees, Payroll

Owners & Officers Included / Excluded:

- All owners and officers must be listed, whether included or NOT!
- Provide Title, Ownership %, request to Include/Exclude, Class Code, and Payroll.
- **Sole Proprietors, Partners/LLC Members are AUTOMATICALLY EXCLUDED!**
 - **To Include:** provide signed "Letter of Inclusion" on insured's letterhead.
 - Minimum/Maximum Payroll is \$61,700 effective October 1, 2021.
- **Corporations AUTOMATICALLY INCLUDE all "active" officers**
 - **To Exclude:** must have at least 25% ownership and Approved DIA Form 153.
 - Minimum Payroll: \$14,040 / Maximum Payroll: \$70,200 effective October 1, 2021.

Prior Coverage:

- Provide prior carrier(s) if applicable.
- Provide reasons if no prior coverage (e.g., new business, adding employees)

4 Years Loss Runs:

- Required by The Hartford and Norfolk & Dedham if there were any claims within past three (3) years.
- Alternative Market requires

Signatures:

- Insured AND agent signatures required on the application.



WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY)

AGENCY NAME AND ADDRESS	COMPANY:	
	UNDERWRITER:	
PRODUCER NAME:	APPLICANT NAME:	
	OFFICE PHONE:	MOBILE PHONE:
CS REPRESENTATIVE NAME:	MAILING ADDRESS (including ZIP + 4 or Canadian Postal Code)	YRS IN BUS:
OFFICE PHONE (A/C. No. Ext)	SIC:	
MOBILE PHONE:	NAICS:	
FAX (A/C. No.):	WEBSITE ADDRESS:	
E-MAIL ADDRESS:	E-MAIL ADDRESS:	
CODE: SUB CODE:	CREDIT BUREAU NAME:	ID NUMBER:
AGENCY CUSTOMER ID:	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	BILLING PLAN	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"/> MONTHLY
<input type="checkbox"/> ASSIGNED RISK (Attach ACORD 133)	<input type="checkbox"/> DIRECT BILL	<input type="checkbox"/> SEMI-ANNUAL	<input type="checkbox"/> SEMI-ANNUAL <input type="checkbox"/>
		<input type="checkbox"/> QUARTERLY % DOWN:	<input type="checkbox"/> QUARTERLY

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

POLICY INFORMATION				
PROPOSED EFF DATE	PROPOSED EXP DATE	NORMAL ANNIVERSARY RATING DATE	PARTICIPATING	RETRO PLAN
			NON-PARTICIPATING	
PART 1 - WORKERS COMPENSATION (States)	PART 2 - EMPLOYER'S LIABILITY	PART 3 - OTHER STATES INS	DEDUCTIBLES	AMOUNT/%
	\$ EACH ACCIDENT		MEDICAL	OTHER COVERAGES
	\$ DISEASE-POLICY LIMIT		INDEMNITY	U.S.L. & H. 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

PRIOR CARRIER INFORMATION/LOSS HISTORY

AGENCY CUSTOMER ID: _____

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?	<input type="checkbox"/>	<input type="checkbox"/>
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)	<input type="checkbox"/>	<input type="checkbox"/>
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?	<input type="checkbox"/>	<input type="checkbox"/>
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?	<input type="checkbox"/>	<input type="checkbox"/>
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?	<input type="checkbox"/>	<input type="checkbox"/>
6. ARE SUB-CONTRACTORS USED? (If "YES", give % of work subcontracted)	<input type="checkbox"/>	<input type="checkbox"/>
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)	<input type="checkbox"/>	<input type="checkbox"/>
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?	<input type="checkbox"/>	<input type="checkbox"/>
9. ANY GROUP TRANSPORTATION PROVIDED?	<input type="checkbox"/>	<input type="checkbox"/>
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?	<input type="checkbox"/>	<input type="checkbox"/>
11. ANY SEASONAL EMPLOYEES?	<input type="checkbox"/>	<input type="checkbox"/>
12. IS THERE ANY VOLUNTEER OR DONATED LABOR? (If "YES", please specify)	<input type="checkbox"/>	<input type="checkbox"/>

GENERAL INFORMATION (continued)

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

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
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