Workers' Compensation Application (Acord 130) Transmittal Sheet

Forward new business submissions with this completed form to
Chris Hess at chess@massagent.com or contact her for questions at 508-634-7361

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 $66,600 effective October 1, 2024.
- **Corporations AUTOMATICALLY INCLUDE all "active" officers**
  - **To Exclude**: must have at least 25% ownership and Approved DIA Form 153.
  - Minimum Payroll: $15,080 / Maximum Payroll: $75,920 effective October 1, 2024.

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:
	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