



EXCESS WORKERS' COMPENSATION APPLICATION

PRODUCER

NEW APPLICATION

RENEWAL OF POLICY NUMBER _____

ADDRESS

EFFECTIVE DATE

1. NAME OF APPLICANT (AND SUBSIDIARIES TO BE COVERED): _____

2. ADDRESS: _____

3. DESCRIPTION OF OPERATIONS, PROCESSES AND PRODUCTS OF APPLICANT AND SUBSIDIARIES (ATTACH COPY OF CURRENT AND COMPREHENSIVE ENGINEERING INSPECTION REPORTS, ANNUAL REPORT OR 10-K REPORT AND PRODUCTS BROCHURES): _____

4. PROVIDE LISTING OF LOCATIONS TO BE COVERED (ATTACH SUPPLEMENTAL PAGE IF ADDITIONAL SPACE IS REQUIRED);

LOCATION

SUBSIDIARY (IF APPLICABLE)

BRIEF DESCRIPTION OF OPERATIONS

A. _____

B. _____

C. _____

5. IN WHICH STATES OR JURISDICTIONS WILL APPLICANT OPERATE AS A QUALIFIED SELF-INSURED?

6. DATE APPLICANT QUALIFIED AS A SELF-INSURED: _____

7. SERVICE COMPANY INFORMATION:

A. NAME OF SERVICE COMPANY: _____

B. ADDRESS OF SERVICE COMPANY: _____

C. SERVICE COMPANY CONTACT AND TELEPHONE NUMBER:

8. CURRENT PROGRAM:

A. WHO IS INSURER OR REINSURER? _____

B. TYPE OF PLAN, IF PRIMARY COVERAGE? _____

C. COMPLETE THE FOLLOWING IF PRESENTLY SELF-INSURED:

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

9. COVERAGE DESIRED (INDICATE ALL ALTERNATIVES TO BE CONSIDERED):

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

10. PROVIDE THE FOLLOWING INFORMATION REGARDING EACH STATE OR JURISDICTION TO BE INCLUDED IN THE PROPOSED COVERAGE (ATTACH SUPPLEMENTAL PAGE IF ADDITIONAL SPACE IS REQUIRED):

STATE	W.C. CODE NO.	CLASSIFICATION	NO. OF EMPLOYEES	EST. ANNUAL PAYROLL OR MANHOURS	CURRENT MANUAL RATES	MANUAL PREMIUM
TOTAL						

11. SPECIFY ADDITIONAL COVERAGES OR ENDORSEMENTS DESIRED: _____

12. SPECIAL EXPOSURES:

(CHECK THE APPROPRIATE BOX WHICH REFLECTS THE ACTUAL AND/OR ANTICIPATED EXPOSURES ASSOCIATED WITH THE APPLICANT'S OPERATIONS).

- | | YES | NO |
|---|--------------------------|--------------------------|
| A. DOES APPLICANT OWN, LEASE OR CHARTER ANY AIRCRAFT?
(IF "YES," AIRCRAFT SUPPLEMENTAL APPLICATION MUST BE COMPLETED). | <input type="checkbox"/> | <input type="checkbox"/> |
| B. DOES APPLICANT OWN, LEASE OR CHARTER ANY WATERCRAFT?
(IF "YES," WATERCRAFT SUPPLEMENTAL APPLICATION MUST BE COMPLETED). | <input type="checkbox"/> | <input type="checkbox"/> |
| C. DOES APPLICANT HAVE OPERATIONS INVOLVING THE LOADING, UNLOADING, REPAIR OR CONSTRUCTION OF WATERCRAFT OR VESSELS INCLUDING WORK PERFORMED ON BARGES OR DOCKS? | <input type="checkbox"/> | <input type="checkbox"/> |
| D. DOES APPLICANT OWN, OPERATE OR MAINTAIN A RAILROAD OR OWN, LEASE, OPERATE OR REPAIR RAILROAD EQUIPMENT? | <input type="checkbox"/> | <input type="checkbox"/> |
| E. DOES APPLICANT HAVE EMPLOYEES WHO MAY BE SUBJECT TO THE LONGSHOREMEN AND HARBOR WORKERS ACT, JONES ACT OR FEDERAL EMPLOYERS' LIABILITY ACT? | <input type="checkbox"/> | <input type="checkbox"/> |
| F. DOES APPLICANT HAVE ANY FOREIGN OPERATIONS OR EMPLOYEES WHO TRAVEL TO FOREIGN COUNTRIES? | <input type="checkbox"/> | <input type="checkbox"/> |
| G. ARE THERE ANY OCCUPATIONAL DISEASE EXPOSURES INVOLVED IN THE APPLICANT'S OPERATIONS?
(INCLUDES ASBESTOS, SILICA, DUSTS, TOXIC, INJURIOUS OR HAZARDOUS CHEMICALS, CAUSTICS, FUMES, RADIATION, COMMUNICABLE DISEASES AND ANY OTHER O.D. EXPOSURES). | <input type="checkbox"/> | <input type="checkbox"/> |
| H. IS APPLICANT ENGAGED IN THE MANUFACTURING, PRODUCTION, REFINING, STORAGE, DISTRIBUTION OR TRANSPORTATION OF GASES, GASOLINE OR FLAMMABLES? | <input type="checkbox"/> | <input type="checkbox"/> |
| I. IS APPLICANT ENGAGED IN THE MANUFACTURING, HANDLING, TRANSPORTATION, DISTRIBUTION OR STORAGE OF EXPLOSIVES OR EXPLOSIVE SUBSTANCES? | <input type="checkbox"/> | <input type="checkbox"/> |
| J. DOES APPLICANT PERFORM ANY UNDERGROUND, SUBAQUEOUS OR TUNNELING OPERATIONS? | <input type="checkbox"/> | <input type="checkbox"/> |
| K. DO THE OPERATIONS OF THE APPLICANT INCLUDE WRECKING OR DEMOLITION OF STRUCTURES? | <input type="checkbox"/> | <input type="checkbox"/> |
| L. DO THE OPERATIONS OF THE APPLICANT INVOLVE EXPOSURE TO HEIGHTS? | <input type="checkbox"/> | <input type="checkbox"/> |
| M. DO THE OPERATIONS OF THE APPLICANT INVOLVE EXPOSURE TO BURNS? | <input type="checkbox"/> | <input type="checkbox"/> |
| N. DOES APPLICANT PROVIDE GROUP TRANSPORTATION FOR EMPLOYEES TO OR FROM THE WORKPLACE? | <input type="checkbox"/> | <input type="checkbox"/> |
| O. DO THE OPERATIONS OF THE APPLICANT INCLUDE VOLUNTEER OR DONATED LABOR? | <input type="checkbox"/> | <input type="checkbox"/> |
| P. HAS THE APPLICANT EVER BEEN CITED FOR ANY OSHA VIOLATIONS? | <input type="checkbox"/> | <input type="checkbox"/> |
| Q. ANY SUBSTANTIAL OR UNUSUAL CHANGES IN OPERATIONS THAT ARE PLANNED OR HAVE TAKEN PLACE IN THE PAST FIVE YEARS? | <input type="checkbox"/> | <input type="checkbox"/> |
| R. HAS APPLICANT'S WORKERS' COMPENSATION COVERAGE BEEN CANCELLED OR NON-RENEWED IN PAST FIVE YEARS? | <input type="checkbox"/> | <input type="checkbox"/> |

PLEASE PROVIDE DETAILS FOR ANY "YES" RESPONSES: _____
