WORKERS COMPENSATION APPLICATION

NON-BROKER APPLICANTS: PLEASE DO NOT COMPLETE SHADED AREAS

DATE (MM/DD/YYYY)

AGENCY NAME AND ADDRESS	COMPANY: STATE COMPENSATION INSURANCE FUND
	UNDERWRITER:
	APPLICANT NAME:
	OFFICE PHONE: / MOBILE PHONE:
PRODUCER NAME:	MAILING ADDRESS (including ZIP + 4 or Canadian Postal Code) / YRS IN BUS:
CS REPRESENTATIVE NAME:	SIC:
OFFICE PHONE (A/C, No. Ext)	NAICS:
MOBILE PHONE:	WEBSITE ADDRESS:
FAX (A/C, No):	E-MAIL ADDRESS
E-MAIL ADDRESS:	☐ SOLE PROPRIETOR ☐ CORPORATION ☐ LLC ☐ TRUST ☐ PARTNERSHIP ☐ SUBCHAPTER "S" CORP ☐ JOINT VENTURE ☐ OTHER
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

STATUS OF SUBMISSION	BILLING PLAN	PAYMENT PLAN	AUDIT
☐ QUOTE ☐ ISSUE POLICY	☐ AGENCY BILL	☐ ANNUAL ☐	☐ AT EXPIRATION ☐ MONTHLY
☐ BOUND (Give date and/or attach copy)	☐ DIRECT BILL	☐ SEMI-ANNUAL	☐ SEMI-ANNUAL ☐
☐ ASSIGNED RISK (Attach ACORD 133)		☐ 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

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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	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

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?	☐	☐
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)	☐	☐

GENERAL INFORMATION (continued)

AGENCY CUSTOMER ID: ______________________

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 STATMENT 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 PENALITES. (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

STATE COMPENSATION INSURANCE FUND

SUPPLEMENTAL APPLICATION FORM

NOTE: Please type or print clearly in ink. Shaded areas are for State Fund use only.

Section 1 – Trade Name (i.e., DBA)

Current:

Prior (if applicable):

Section 2 – Business Ownership

Legal Name:

Legal Entity (check one):

	1	Individual (If married, check Husband & Wife)		N	Non-Profit Organization		C	Conservatorship
	2	Husband & Wife (Both names required in Legal Name.)		3	Joint Venture		E	Estate
	4	General Partnership		8	Public Agency		T	Trust
	L	Limited Partnership		P	Incorporated Public Agency		6	Association
	5	Corporation		9	Labor Union		J	Joint Employer
	M	Non-Profit Corporation		U	Incorporated Labor Union		A	Common Ownership
							7	Other:

Section 3 – Licenses

2101 Farm Labor Contractor License:

3405 Contractor's State License Board No./Type/Expiration Date:

3408 PUC/ICC License Number:

3409 Other License Numbers required to do business in CA (please specify):

Section 4 – Additional Business Information

2075 Phones: Bus. ( ) Home ( )

2075 FAX Number: ( )

2075 E-Mail Address:

2099 State Employer Identification Number:

Section 5 – Social Security Number(s)

2096

Please provide the Social Security Number(s)* for individual owner, husband, wife, corporate officers, or general partners. Attach a separate page if necessary.

(1) Name: ______________________ *Social Security Number: _____–_____–_______

(2) Name: ______________________ *Social Security Number: _____–_____–_______

(3) Name: ______________________ *Social Security Number: _____–_____–_______

(4) Name: ______________________ *Social Security Number: _____–_____–_______

*DISCLOSURE STATEMENT

Providing Social Security Numbers is voluntary. If the principals do not wish to provide Social Security Numbers, other acceptable identification shall include: 1) Federal Employer Identification Number (FEIN), 2) State Employer Identification Number (SEIN), 3) Contractor's License or 4) any applicable business license pertinent to the trade or business.

Section 6 – General Information

Do any of the following pertain to the operations of this risk? **Please explain all "yes" answers to questions 1-10 in the "Remarks" section on page 2.**

	Yes	No		Yes	No
1. Use any equipment that bends, forms, shapes, or cuts materials (e.g., power press)?			8. Have any locations/operations for which coverage is not requested?		
2. Employ any relatives?			9. Have any operations outside of California?		
3. Employ any minors (under age 18)?			10. Perform any asbestos removal?		
4. Make any cash payments to employees or subcontractors?			11. Member of any trade or business association? Please indicate: ____________		
5. Provide meals or lodging in lieu of wages?					
6. Pay any employees by the piece?					
7. Have any work at a maritime or offshore facility?					

Section 7 – Has the business or any principal of the business declared bankruptcy in the last seven years? ☐ Yes ☐ No, skip to Section 8

Name of Principal:

3105 Chapter of bankruptcy filed (check as applicable): ☐7 ☐11 ☐13 ☐ Other:

Date filed: | Case Number: | Status : ☐ pending ☐ dismissed ☐ discharged

Court where case was filed (Please provide us with a filed, stamped copy of the "Petition for Relief".):

Section 8 – Was this operation all or part of an existing business that was purchased or acquired? ☐ Yes ☐ No, skip to Section 9

What percentage of the business was acquired?: | Date ownership changed:

Prior business owner's name and address:

Name: ____________________

Address: ____________________

____

Name of Business: ____________________

Is the prior owner(s) related to the new owner(s)? ☐ No ☐ Yes, Relationship:

Have the operations changed since the business was acquired (e.g., from a bakery to a restaurant)? ☐ No ☐ Yes, please explain:

Were more than 50% of the current employees hired since the acquisition? ☐ Yes ☐ No

Are those new employees earning more than 50% of the payroll? ☐ Yes ☐ No

Section 9 – Management Practices

Please indicate if you offer: Employee Assistance Program ___ Paid Vacations ___ Paid Sick Leave ___

Do you have a minimum of 2 employees? ☐ No ☐ Yes

If yes, do you offer the majority of your eligible employees Health Insurance? (eligible = works a minimum of 30 hrs./wk) ☐ No ☐ Yes

If yes, do you pay at least 50% of the Health Insurance premium? ☐ No ☐ Yes, Name of Health Insurance Carrier:

Please check off the hiring practices implemented by your company: Job Descriptions ___ Pre-placement Medical Screening ___ Pre-placement Drug Testing ___ Drug-free Workplace ___ Pre-employment Reference Check ___ Union Employees ___

Do you have an Injury and Illness Prevention Program? ☐ No ☐ Yes

Do you have a written early return-to-work program for employees injured on the job? ☐ No ☐ Yes

Do you document: Employee Training ___ Facility Inspections ___

Describe your housekeeping: Good ___ Fair ___ Poor ___ | Describe the condition of your equipment: Good ___ Fair ___ Poor ___

Have you received any OSHA citations within the past year? ☐ No ☐ Yes (Please explain in "Remarks.")

Does the business provide temporary employees? ☐ No ☐ Yes (Please explain in "Remarks.")

Section 10 – Remarks (Attach a separate sheet if necessary.)

Section 11 – Broker Information (For brokered accounts only, this section must be completely filled out by the producer.)

0030

BROKER ACCESS NUMBER | FIRM NAME

ADDRESS | CITY | STATE | ZIP

PHONE NUMBER | FAX NUMBER

SIGNATURE

To be completed by the broker, owner, or an officer/partner (provide your title) of the business.

Insurance Code Article 6, Sec. 11880 prohibits the willful misrepresentation of any fact in order to obtain lower insurance rates. State Fund reserves the right to verify the accuracy of information provided to it by insurance applicants.

I confirm that the information on the ACORD and Supplemental Application is true and correct to the best of my knowledge.

Name: ____________________ (Please print) Title: ____________________ (Please print)

Signature: ____________________ Date: ____________________

(FAXed applications must be followed up with original document/signature.)

STATE
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FIELD INSPECTION

A physical inspection to your business operations is required before a quote of insurance will be issued to your company. To help us perform the physical inspection, please provide the following:

Is this a residence? Yes ☐ No ☐

If yes, the name of the contact person: ______________________________

If no one is home, how can we contact you? __________________________

____

Will someone be available at the business location or residence between the hours of 8:00 a.m. and 5:00 p.m.? Yes ☐ No ☐

Do you have any dogs that will restrict our entry into your business? Yes ☐ No ☐

If yes, how do we gain entry? ______________________________________

What are the nearest cross streets? ___________________________________

____

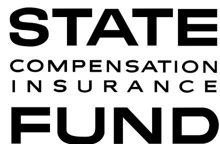
For construction and landscaping companies:

Locations of job sites: ____

____

____

Can you be contacted at any of these locations? Yes ☐ No ☐



AUDIT ADVISORY

As part of your policy contract, you will be required to maintain and provide to us, upon request, proper payroll and remuneration for all workers. These records may include the following:

1. State and/or Federal quarterly reports;
2. Voluntary payroll reports to State Compensation Insurance Fund;
3. Sources of payroll (preferably employee records), payroll journals, computerized payroll runs, and/or summary sheets showing the payroll segregated by workers' compensation classifications, and/or records of any cash payments;
4. General ledgers;
5. Certificates of Insurance and subcontractor payment records, if sub-contractors are used;
6. 1099 forms.

Signing the statement below is an acknowledgement that you understand the required record keeping and that you will allow State Fund to access those records as a condition of your insurance policy.

Employer's Name: ______________________________ *Date:* ____________________
Please Print

Employer's Signature: __________________________ *Title:* ____________________
Please Print

STATE
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INSURANCE
FUND

IF YOU ANSWERED "YES" TO QUESTIONS #6 ON THE ACORD™ WORKERS' COMPENSATION APPLICATION **GENERAL INFORMATION** SECTION AND #4 ON THE **SUPPLEMENTAL APPLICATION FORM**, PLEASE COMPLETE ALL AREAS OF THIS FORM AND RETURN IT WITH YOUR APPLICATION.

INDEPENDENT CONTRACTOR QUESTIONNAIRE

	YES	NO
1. IS THE INDEPENDENT CONTRACTOR LICENSED?	_____	_____
2. DO YOU HAVE A WRITTEN CONTRACT WITH THE INDEPENDENT CONTRACTOR? IF YES, PLEASE ENCLOSE A COPY OF THE CONTRACT.	_____	_____
3. HOW IS THE PAYMENT ARRANGED? HOURLY RATE _______ , PIECE RATE_______ , SALARY_______ , COMMISSION SET BY YOU_______ , BID BY CONTRACTOR _______.		
4. DO YOU CONTROL HOW THE JOB IS TO BE PERFORMED?	_____	_____
5. DO YOU HAVE THE RIGHT TO TERMINATE THE RELATIONSHIP AT WILL?	_____	_____
6. DOES THE INDEPENDENT CONTRACTOR WORK ONLY FOR YOU?	_____	_____
7. IS THE INDEPENDENT CONTRACTOR WORKING ONLY FOR A SET PERIOD OF TIME? TIME PERIOD: ______________.	_____	_____
8. DOES THE INDEPENDENT CONTRACTOR HAVE CONTRACT SERVICE WITH OTHERS FOR THE SAME SERVICE HE WILL BE PROVIDING FOR YOU?	_____	_____
9. WILL YOU BE SUPPLYING TOOLS, INSTRUMENTS, OR A PLACE TO WORK?	_____	_____
10. WILL THE INDEPENDENT CONTRACTOR BE PROVIDING THE SAME SERVICE AS THE SERVICE YOUR BUSINESS PROVIDES?	_____	_____

11. HOW MUCH IS PAID TO YOUR INDEPENDENT CONTRACTOR ON AN ANNUAL BASIS? ______________
12. HOW MANY INDEPENDENT CONTRACTORS DO YOU HAVE WORKING FOR YOU?______________ DO THEY WORK OUT OF THEIR HOME?______________
13. PLEASE INCLUDE A JOB DESCRIPTION FOR ALL INDEPENDENT CONTRACTORS.

REMARKS:
____
____
____
____
____
____
____