



Workers' Compensation **Application Transmittal Sheet**

Please submit this form with your new business application to:
Barbara Lobdell at blobdell@massagent.com or by fax to (508) 634-2931

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 Barbara Lobdell with any questions regarding the submission process at (508) 634-7362 or blobdell@massagent.com.

COMPLETION INSTRUCTIONS

Required Fields & Notes for Workers' Compensation Application

Be sure to complete the following fields:

- Agency, phone, fax & email
- 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:	
PRODUCER NAME:	APPLICANT NAME:	
	OFFICE PHONE:	MOBILE PHONE:
CS REPRESENTATIVE NAME:	MAILING ADDRESS (including ZIP + 4 or Canadian Postal Code)	
OFFICE PHONE (A/C. No. Ext)	YRS IN BUS:	
MOBILE PHONE:	SIC:	
FAX (A/C. No.):	NAICS:	
E-MAIL ADDRESS:	WEBSITE ADDRESS:	
CODE: SUB CODE:	E-MAIL ADDRESS:	
AGENCY CUSTOMER ID:	SOLE PROPRIETOR	CORPORATION
	PARTNERSHIP	SUBCHAPTER "S" CORP
	LLC	TRUST
	JOINT VENTURE	OTHER
	CREDIT BUREAU NAME:	ID NUMBER:
	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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