



## **Worker's Compensation** **Application Transmittal Sheet**

Please submit this form with your new business application by fax to:  
Barbara Lobdell at (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  
The 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 Worker's  
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 if available
- 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
- Deductible option – if requesting: Medical or Indemnity per claim or per claim w/ aggregate.  
The Hartford: Amounts available: \$500, \$1000, \$2000, \$5000  
Please include Hartford Form WC 66 01 51 A to apply for any of these options.
- 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.  
[For details regarding MA's requirements, see the **General Information** webpage.]
- 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.

# ACORD<sup>TM</sup> WORKERS COMPENSATION APPLICATION

DATE

<b>PRODUCER</b>	PHONE (A/C, No, Ext): FAX (A/C, No):	<b>COMPANY</b>	<b>UNDERWRITER</b>
		<b>APPLICANT NAME</b>	<b>INTERNET ADDRESS:</b>
		<b>MAILING ADDRESS (Including ZIP code)</b>	
		YRS IN BUS    SIC	INDIVIDUAL    CORPORATION    LIMITED CORP PARTNERSHIP    SUBCHAPTER "S" CORP    OTHER:
<b>CODE:</b>	<b>SUB CODE:</b>	<b>CREDIT BUREAU NAME:</b>	
<b>AGENCY CUSTOMER ID</b>		<b>FEDERAL EMPLOYER ID NUMBER</b>	<b>NCCI ID NUMBER</b> <b>ID NUMBER:</b>
		<b>OTHER RATING BUREAU ID OR STATE EMPLOYER REGISTRATION NUMBER</b>	

<b>STATUS OF SUBMISSION</b>		<b>BILLING/AUDIT INFORMATION</b>	
<input type="checkbox"/> QUOTE	<input type="checkbox"/> ISSUE POLICY	<b>BILLING PLAN</b>	<b>PAYMENT PLAN</b>
<input type="checkbox"/> BOUND (Give date and/or attach copy)		<input type="checkbox"/> AGENCY BILL	<input type="checkbox"/> ANNUAL <input type="checkbox"/> OTHER:
<input type="checkbox"/> ASSIGNED RISK (Attach ACORD 133)		<input type="checkbox"/> DIRECT BILL	<input type="checkbox"/> SEMI-ANNUAL <input type="checkbox"/> QUARTERLY    % DOWN:
			<b>AUDIT</b>
			<input type="checkbox"/> AT EXPIRATION <input type="checkbox"/> MONTHLY <input type="checkbox"/> SEMI-ANNUAL <input type="checkbox"/> OTHER: <input type="checkbox"/> QUARTERLY

**LOCATIONS**

#	STREET, CITY, COUNTY, STATE, ZIP CODE

**POLICY INFORMATION**

<b>PROPOSED EFF DATE</b>	<b>PROPOSED EXP DATE</b>	<b>NORMAL ANNIVERSARY RATING DATE</b>	<input type="checkbox"/> PARTICIPATING <input type="checkbox"/> NON-PARTICIPATING	<b>RETRO PLAN</b>
<b>PART 1 - WORKERS COMPENSATION (States)</b>	<b>PART 2 - EMPLOYER'S LIABILITY</b>	<b>PART 3 - OTHER STATES INS</b>	<b>DEDUCTIBLES</b>	<b>AMOUNT/%</b> <b>OTHER COVERAGES</b>
	\$ EACH ACCIDENT		<input type="checkbox"/> MEDICAL	<input type="checkbox"/> U.S.L. & H.
	\$ DISEASE-POLICY LIMIT		<input type="checkbox"/> INDEMNITY	<input type="checkbox"/> VOLUNTARY COMP
	\$ DISEASE-EACH EMPLOYEE			<input type="checkbox"/> FOREIGN COV <input type="checkbox"/> MANAGED CARE OPTION
<b>DIVIDEND PLAN/SAFETY GROUP</b>	<b>ADDITIONAL COMPANY INFORMATION</b>			

**RATING INFORMATION**

STATE	LOC	CLASS CODE	DESCR CODE	CATEGORIES, DUTIES, CLASSIFICATIONS	# EMPLOYEES		ESTIMATED ANNUAL REMUNERATION	RATE	ESTIMATED ANNUAL PREMIUM
					FULL TIME	PART TIME			
<b>SPECIFY ADDITIONAL COVERAGES/ENDORSEMENTS</b>								<b>FACTOR</b>	<b>FACTORED PREMIUM</b>
								TOTAL	\$
								INCREASED LIMITS	\$
								DEDUCTIBLE	\$
									\$
								EXPERIENCE MODIFICATION	\$
								LOSS CONSTANT	\$
								ASSIGNED RISK SURCHARGE	\$
								ARAP	\$
									\$
								PREMIUM DISCOUNT	\$
								EXPENSE CONSTANT	\$
	\$								
<b>MINIMUM PREMIUM</b>	\$	<b>DEPOSIT PREMIUM</b>	\$	<b>TOTAL EST ANNUAL PREMIUM</b>		\$			

**INDIVIDUALS INCLUDED/EXCLUDED**

PARTNERS, OFFICERS, RELATIVES TO BE INCLUDED OR EXCLUDED. (Remuneration to be included must be part of rating information section.)								
#	NAME	DATE OF BIRTH	TITLE/RELATIONSHIP	OWNER-SHIP %	DUTIES	INC/EXC	CLASS CODE	REMUNERATION

**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	EXPLAIN ALL "YES" RESPONSES	YES	NO
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT/WATERCRAFT?			16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?		
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)			17. ANY OTHER INSURANCE WITH THIS INSURER?		
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?			18. ANY PRIOR COVERAGE DECLINED/ CANCELLED/NON-RENEWED (Last 3 years)? NOT APPLICABLE IN MO		
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?			19. ARE EMPLOYEE HEALTH PLANS PROVIDED?		
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?			20. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS/SUBSIDIARY?		
6. ARE SUB-CONTRACTORS USED? (IF YES, GIVE % OF WORK SUBCONTRACTED)			21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?		
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INS.?			22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME?		
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?			23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST 5 YEARS?		
9. ANY GROUP TRANSPORTATION PROVIDED?			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).		
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?			<b>CONTACT INFORMATION</b>		
11. ANY SEASONAL EMPLOYEES?			IN- SPECTION	PHONE:	
12. IS THERE ANY VOLUNTEER OR DONATED LABOR?			NAME:		
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?			ACCTNG RECORD	PHONE:	
14. DO EMPLOYEES TRAVEL OUT OF STATE?			NAME:		
15. ARE ATHLETIC TEAMS SPONSORED?			CLAIMS INFO	PHONE:	
			NAME:		

APPLICABLE IN TENNESSEE: 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, HI, NE, OH, OK, OR, VT; IN DC, LA, ME AND VA, INSURANCE BENEFITS MAY ALSO BE DENIED)

REMARKS

APPLICANT'S SIGNATURE \_\_\_\_\_ PRODUCER'S SIGNATURE \_\_\_\_\_