

APPLICATION FOR EXCESS WORKERS COMPENSATION COVERAGE

1. NAME OF APPLICANT:
ADDRESS:
2. DESCRIPTION OF OPERATIONS:
3. FEDERAL EMPLOYERS IDENTIFICATION NUMBER:
4. LIST OF LOCATIONS (ATTACH A SHEET IF NECESSARY):
5. LIST STATES OR JURISDICTIONS WHERE APPLICANT OPERATES:
6. TOTAL NUMBER OF EMPLOYEES:
7. WHAT IS THE GREATEST NUMBER OF EMPLOYEES AT ANY ONE LOCATION?
8. EFFECTIVE DATE OF COVERAGE:
9. DATE QUALIFIED FOR SELF INSURANCE:
10. INDICATE SUBSTANTIAL OR UNUSUAL CHANGES IN OPERATIONS THAT ARE PLANNED OR HAVE TAKEN PLACE IN THE PAST FIVE YEARS:
11. IS APPLICANT ENGAGED IN THE MANUFACTURE, PRODUCTION, REFINING, STORAGE, DISTRIBUTION, OR TRANSPORTATION OF GASES, GASOLINE OR FLAMMABLES? EXPLAIN.
12. ARE THERE ANY OCCUPATIONAL DISEASE EXPOSURES INVOLVED IN THE APPLICANT'S OPERATIONS? (ASBESTOS; SILICA; DUSTS; TOXIC, INJURIOUS OR HAZARDOUS CHEMICALS; CAUSTICS, FUMES, RADIATION, COMMUNICABLE DISEASES AND ANY OTHER O.D. EXPOSURES) IF SO, DESCRIBE STEPS TAKEN TO CONTROL.
13. DOES APPLICANT PERFORM ANY UNDERGROUND, SUBAQUEOUS, OR TUNNELING OPERATIONS? DESCRIBE.
14. DO THE OPERATIONS OF THE APPLICANT INCLUDE WRECKING OR DEMOLITION OF STRUCTURES? IF SO, DESCRIBE

15. DO OPERATIONS OF THE APPLICANT INVOLVE EXPOSURE TO HEIGHTS?
IF SO, EXPLAIN.
16. ARE THERE OTHER STATES OR JURISDICTIONS INCLUDED FOR SELF-INSURANCE THAT WOULD NOT BE COVERED BY THE INSURANCE REQUESTED BY THIS APPLICATION? IF YES, EXPLAIN.
17. GIVE THE FOLLOWING REGARDING EACH LOCATION. (IF MORE SPACE IS NEEDED USE A SEPARATE SHEET).

LOCATION ADDRESS	STATE	ZIP CODE	# OF EMPLOYEES	# OF EE'S IN MAX SHIFT	TOTAL PAYROLL

18. CURRENT INSURER:

19. CURRENT LIMITS AND RETENTIONS:

SPECIFIC EXCESS: LIMIT: RETENTION: \$
 AGGREGATE EXCESS: LIMIT: \$ RETENTION: \$

20. PROVIDE PAYROLL BY STATE FOR PROJECTED YEAR:

WC CODE	CLASS	ESTIMATED PAYROLL	NUMBER OF EMPLOYEES

*ATTACH 5 YEAR PAYROLL HISTORY FOR AGGREGATE COVERAGE IF THERE HAS BEEN ANY SIGNIFICANT CHANGE IN PAYROLL DISTRIBUTION BY CLASSIFICATION CODE, PLEASE DESCRIBE REASON FOR CHANGE.

21. COVERAGE DESIRED:

SPECIFIC EXCESS: LIMIT: RETENTION:

AGGREGATE EXCESS: LIMIT: RETENTION:

22. LIST FIVE YEARS PRIOR EXPERIENCE BY STATE:

POLICY TERM	PAYROLL	PAID CLAIMS	RESERVED CLAIMS	INCURRED CLAIMS

VALUATION DATE MUST BE WITHIN THE PAST 6 MONTHS.

23. LARGE CLAIMS:

- ATTACH INFORMATION ABOUT EACH CLAIM OVER \$50,000 IN THE PAST FIVE (5) YEARS.
- ATTACH INFORMATION REGARDING ANY DEATH CLAIM IN THE PAST FIVE (5) YEARS
- ATTACH INFORMATION REGARDING CLAIMS OVER \$100,000 IN THE PAST TEN (10) YEARS.

24. DO EMPLOYEES RECEIVE ANY SUPPLEMENTAL BENEFITS TO WC BENEFITS? IF SO PLEASE DESCRIBE:

25. PROVIDE DETAILS OF ANY OSHA OR STATE OSHA VIOLATION WITHIN THE PAST 5 YEARS:

26. DOES THE APPLICANT HAVE ANY EXPOSURE TO THE LONGSHOREMEN AND HARBOR WORKERS ACT? JONES ACT? FEDERAL EMPLOYER'S LIABILITY ACT? . IF YES PLEASE EXPLAIN:

27. DO THE OPERATIONS OF THE APPLICANT INCLUDE VOLUNTEER OR DONATED LABOR?

28. DOES THE APPLICANT HAVE ANY FOREIGN OPERATIONS OR EMPLOYEES WHO TRAVEL TO FOREIGN COUNTRIES? IF SO, EXPLAIN.

29. PLEASE COMPLETE THE FOLLOWING ON OWNED OR LEASE VEHICLES:

- NUMBER OF: PASSENGER CARS TRACTORS TRAILERS TRUCKS/VANS
- NUMBER OF OWNER OPERATORS:
- IS APPLICANT RESPONSIBLE FOR WC COVERAGE OF OWNER OPERATORS?
- IF YES, WHAT PERCENTAGE OF THE PAYROLL REPRESENTS THESE DRIVERS?
- IF NO, DOES APPLICANT OBTAIN CERTIFICATES OF WC INSURANCE FROM SUCH OPERATORS?
- WHAT GOODS ARE HAULED?
- WHAT IS THE MAXIMUM RADIUS OF OPERATIONS?
- WHAT IS THE AVERAGE RADIUS OF TRAVEL?
- STATE IN WHICH VEHICLES OPERATE?

- NUMBER OF PERSONS NORMALLY IN VEHICLE?
- NUMBER OF EMPLOYEE DRIVERS?
- DOES APPLICANT HAVE A LICENSE TO HAUL FOR OTHERS?
- DOES APPLICANT HAUL HAZARDOUS MATERIALS?
- DOES APPLICANT PROVIDE ANY MEANS OF TRANSPORTATION FOR EMPLOYEES TO OR FROM THE WORKPLACE? IF SO, PLEASE DESCRIBE AND INCLUDE FREQUENCY:

- DOES APPLICANT OWN LEASE OR CHARTER WARERCRAFT OR AIRCRAFT? IF SO, PLEASE COMPLETE SUPPLEMENTAL APPLICATION.

30. DESCRIBE SAFETY PROGRAMS IN PLACE:

IS THERE A DEDICATED SAFETY PROFESSIONAL ON STAFF?

DO YOU HAVE SAFETY COMMITTEES?

IF YES, DO THEY HAVE MANAGEMENT PARTICIPATION?

DO YOU PROVIDE NEW HIRE SAFETY TRAINING?

DO YOU PROVIDE JOB SPECIFIC SAFETY TRAINING?

DO YOU HAVE A COST ALLOCATION SYSTEM IN PLACE WHICH LINKS WC COSTS TO THE DEPARTMENT OR FACILITY?

DO YOU HAVE ANY INCENTIVE PLANS IN PLACE LINKING INDIVIDUAL WORKPLACE SAFETY TO A REWARDS SYSTEM?

31. IS A FULL TIME DOCTOR OR NURSE PROVIDED IN HOUSE?

32. LIST PROVIDER OF LOSS CONTROL SERVICE COMPANY: JWF Specialty Company, Inc.

33. ARE CLAIMS HANDLED TO CONCLUSION? IF NOT DESCRIBE. No, life of contract.

34. LIST PROVIDER OF CLAIMS ADMINISTRATION SERVICES: JWF Specialty Company, Inc.

35. DO YOU HAVE AN ALTERNATIVE DUTY RETURN TO WORK PROGRAM IN PLACE FOR ALL DEPARTMENTS?

36. DO YOU HAVE A PROCESS IN PLACE IN WHICH ALL INJURIES ARE REPORTED AND INTERNALLY INVESTIGATED WITHIN 24 HOURS?

37. CHECK THE FOLLOWING MANAGED CARE PROGRAMS THAT APPLY TO YOUR PROGRAM:

PPO CONTRACTED PRICING NURSE CASE MGMT

Florida Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

New Jersey Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New York Any person who knowingly and with intent to defraud any insurance company or other 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 shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Other States Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement is guilty of insurance fraud.

SIGNATURE OF APPLICANT _____

TITLE: _____ DATE: _____