



WORKERS COMPENSATION INSURANCE PROGRAM

Stratus Insurance W: 801.763.1375 F: 801.763.1374

AGENCY NAME AND ADDRESS	COMPANY:			
	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	
PROPOSED EFFECTIVE DATE: ____/____/____		NORMAL EFFECTIVE DATE: ____/____/____		CWA MEMBER?

LOCATIONS

LOC #	STREET, CITY, COUNTY, STATE, ZIP CODE

RATING INFORMATION

LOC #	CLASS CODE	CATEGORY, DUTIES, CLASSIFICATIONS	ANNUAL PAYROLL	# EMPLOYEES	
				FT	PT

POLICY INFORMATION

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	

OWNERS, PARTNERS, OFFICERS, RELATIVES - To be Included or Excluded from Coverage

STATE	NAME	DATE OF BIRTH	TITLE/RELATIONSHIP	OWNERSHIP %	DUTIES	ANNUAL PAYROLL	INCL. / EXCL.

CONTACT INFORMATION

TYPE	NAME	OFFICE PHONE	MOBILE PHONE	E-MAIL
INSPECTION				
ACCTNG RECORD				
CLAIMS INFO				

GENERAL INFORMATION

		YES	NO
1	DO YOU OWN, OPERATE OR LEASE AIRCRAFT / WATERCRAFT?	<input type="checkbox"/>	<input type="checkbox"/>
2	DO YOU LEASE YOUR EMPLOYEES OR USE LEASED EMPLOYEES?	<input type="checkbox"/>	<input type="checkbox"/>
3	DO YOU SUB-CONTRACT ANY WORK WITHOUT CERTIFICATES OF INSURANCE?	<input type="checkbox"/>	<input type="checkbox"/>
4	DOES ANY LOCATION HAVE MORE THAN 100 EMPLOYEES?	<input type="checkbox"/>	<input type="checkbox"/>
5	IS THERE ANY GROUP TRANSPORTATION PROVIDED?	<input type="checkbox"/>	<input type="checkbox"/>
6	DURING THE PAST 4 YEARS, HAS YOUR LOSS RATIO EXCEEDED 40%?	<input type="checkbox"/>	<input type="checkbox"/>
7	DO YOU HAVE LESS THAN 2 FULL TIME EMPLOYEES, OTHER THAN FAMILY MEMBERS?	<input type="checkbox"/>	<input type="checkbox"/>
8	DO YOU USE SUB-CONTRACTED LABOR OR LABOR IDENTIFIED AS INDEPENDENT CONTRACTORS?	<input type="checkbox"/>	<input type="checkbox"/>
9	DO YOU HAVE MORE THAN 25% OF YOUR PAYROLL IN CLERICAL?	<input type="checkbox"/>	<input type="checkbox"/>
10	DO YOU OPERATE IN MORE THAN ONE STATE?	<input type="checkbox"/>	<input type="checkbox"/>
11	ARE YOU ENGAGED IN ANY OTHER TYPE OF BUSINESS?	<input type="checkbox"/>	<input type="checkbox"/>
12	ARE ANY OF YOUR EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?	<input type="checkbox"/>	<input type="checkbox"/>
13	ANY EMPLOYEES WITH PHYSICAL HANDICAPS?	<input type="checkbox"/>	<input type="checkbox"/>
14	DO EMPLOYEES TRAVEL OUT OF STATE?	<input type="checkbox"/>	<input type="checkbox"/>
15	ANY 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	DO YOU HAVE ANY OTHER INSURANCE WITH MEADOWBROOK INSURANCE COMPANY?	<input type="checkbox"/>	<input type="checkbox"/>
18	HAVE YOU HAD ANY PRIOR WORKERS' COMPENSATION INSURANCE COVERAGE DECLINED / CANCELLED / NON-RENEWED IN THE LAST 3 YEARS?	<input type="checkbox"/>	<input type="checkbox"/>
19	ARE EMPLOYEE HEALTH PLANS PROVIDED?	<input type="checkbox"/>	<input type="checkbox"/>
20	IS THERE A LABOR EXCHANGE WITH ANY OTHER BUSINESS / SUBSIDIARY?	<input type="checkbox"/>	<input type="checkbox"/>

21	DO ANY EMPLOYEES PREDOMINANTLY WORK FROM HOME?	<input type="checkbox"/>	<input type="checkbox"/>
22	ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST 5 YEARS?	<input type="checkbox"/>	<input type="checkbox"/>
23	ANY UNDISPUTED AND UNPAID WORKERS' COMPENSATION PREMIUMS DUE FROM YOU OR ANY COMMONLY MANAGED / OWNED ENTERPRISES?	<input type="checkbox"/>	<input type="checkbox"/>
24	HAVE YOU BEEN IN BUSINESS FOR LESS THAN 3 YEARS?	<input type="checkbox"/>	<input type="checkbox"/>
25	HAVE YOU MAINTAINED WORKERS' COMPENSATION INSURANCE AT ALL TIMES?	<input type="checkbox"/>	<input type="checkbox"/>
26	HAVE YOU EVER BEEN SITED BY OSHA?	<input type="checkbox"/>	<input type="checkbox"/>
27	DO YOU HAVE WRITTEN EMPLOYMENT POLICIES, PROCEDURES, GUIDELINES OR PRACTICES REGARDING WORKPLACE SAFETY?	<input type="checkbox"/>	<input type="checkbox"/>
28	DO YOU PROVIDE ORIENTATION OR TRAINING IN THE CORRECT USE OF LADDERS FOR ROUTE SETTERS?	<input type="checkbox"/>	<input type="checkbox"/>
29	DO YOU USE VOLUNTEER LABOR?	<input type="checkbox"/>	<input type="checkbox"/>
30	DO YOU PROVIDE ORIENTATION OR TRAINING IN PROPER SELF BELAY TECHNIQUES FOR ROUTE SETTERS?	<input type="checkbox"/>	<input type="checkbox"/>
31	DO ROUTE SETTERS EVER CLIMB ABOVE THEIR FALL PROTECTION SYSTEM IN YOUR FACILITY?	<input type="checkbox"/>	<input type="checkbox"/>
32	DO ROUTE SETTERS EVER WORK ALONE IN YOUR FACILITY?	<input type="checkbox"/>	<input type="checkbox"/>
33	DO YOU OPERATE A BUNGEE JUMPING ATTRACTION?	<input type="checkbox"/>	<input type="checkbox"/>
34	DO YOU OFFER OUTDOOR CLIMBING EXCURSION OR EXPEDITIONS?	<input type="checkbox"/>	<input type="checkbox"/>
35	DO YOU MAINTAIN OR SUPPORT ONE OR MORE TRAVELING CLIMBING TEAMS?	<input type="checkbox"/>	<input type="checkbox"/>
36	IS 5% OR MORE OF YOUR REVENUE DERIVED FROM THE OPERATION OF A PORTABLE CLIMBING WALL?	<input type="checkbox"/>	<input type="checkbox"/>
37	ARE YOU DOMICILED IN CALIFORNIA?	<input type="checkbox"/>	<input type="checkbox"/>
38	DO YOU HAVE ANY EXPOSURE TO USL & F OR OTHER FEDERAL ACT?	<input type="checkbox"/>	<input type="checkbox"/>

EXPLAIN ALL "YES" RESPONSES

<p>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.</p> <p>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)</p>			
<p>APPLICANT'S SIGNATURE (Must be Officer, Owner or Partner)</p>	<p>DATE</p>	<p>PRODUCER'S SIGNATURE</p>	<p>NATIONAL PRODUCER NUMBER</p>