ACORD	1	ACORD WORKERS CO				<b>NS</b>	ATI	ON	Δ	<b>\PI</b>	PLI(	CAT		N	'	JAIE (M	M/DD/YYYY
AGENCY NAME AND ADD	RESS			СОМР	ANY:												
				UNDE	RWRITER	₹:											
			[	APPLI	CANT NA	ME:											
			[	OFFIC	E PHONE	<u>:</u>						MOBILE P	HON	IE:			
				MAILII	NG ADDR	ESS (in	ncluding	ZIP +40	or Car	nadian	Postal Co	ode) YF	S IN	BUS:			
												SI	C:				
PRODUCER NAME:													lics				
CS REPRESENTATIVE NAME:												W AI	EBSI DRE	TE ESS:			
OFFICE PHONE (A/C, No, Ext)				E-MAI	L ADDRE	SS:		_									
MOBILE PHONE:				s	OLE PRO	OPRIET	OR	CORP	ORAT	TION		LL LL	С		TR	UST	
FAX (A/C, No):				_	PARTNER	SHIP		SUBC	HAPT	ER "S"	' CORP	JC	INT	VENTURE	ОТ	HER	
E-MAIL ADDRESS:				CRED BURE	IT <u>AU NAME</u>	:								ID NUMBE			
CODE: AGENCY CUSTOMER ID:	S	SUB CODE:		FEDE	RAL EMP	LOYER	ID NUME	BER	NCC	CI RISK	( ID NUMB	BER		OTHER RA	ATING BUR R REGISTI	RATION I	OR STATE NUMBER
STATUS OF SUBN	IISSION		BILLING	/ AU	DIT IN	FORM	MATIO	N									-
QUOTE ISSUE POLICY BILLING PL			AN		PAYME	ENT PLAN	N					AUD	IT				
BOUND (Give date a	and/or attach co	py)	AGENC	CY BILL ANNUAL						AT EXPIRA	ATION	MON	ITHLY				
ASSIGNED RISK (A	ttach ACORD 13	33)	DIREC	T BILL		SI	EMI-ANN	UAL	_					SEMI-ANN	IUAL		
						Q	UARTER	LY	% D	OWN:				QUARTER	LY		
LOCATIONS																	
LOC # STREET, CITY,	COUNTY, STAT	E, ZIP CODE															
POLICY INFORMA																	
PROPOSED EFF I	DATE	PROPOSED EXP	DATE	NOF	RMAL AN	NIVERS	SARY RA	TING DA	TE	Ш	PARTICIP	ATING		RETRO	PLAN		
								DE	LIOT		NON-PAR	TICIPATIN					
PART 1 - WORKERS COMPENSATION (States)	PART 2 - EM	PLOYER'S LIABILITY			PART 3 STATES		ER	(N /	A in \	IBLES WI)		AMOUNT (N / A in			OVERAGES		*****
, ,	\$	EACH ACCIDENT							ME	EDICAL		,			& H.		MANAGED CARE OPTI
\$ DISEASE-POLICY LI \$ DISEASE-EACH EMI		ASE-POLICY LIMIT						IND	NDEMNITY				COM	JNTARY P	NTARY		
								FORE	EIGN COV								
DIVIDEND PLAN/SAFETY	GROUP	ADDITIONAL COM	PANY INFORM	IATION	l												

## 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				

### 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.) Exclusions in Missouri must meet the requirements of Section 287.090 RSMo.

STATE	LOC#	NAME	DATE OF BIRTH	RELATIONSHIP	SHIP %	DUTIES	INC/EXC	CLASS CODE	REMUNERATION/PAYROLL

MANAGED CARE OPTION

STATE RATING WORKSHEET FOR MULTIPLE STATES, ATTACH AN ADDITIONAL PAGE 2 OF THIS FORM  RATING INFORMATION - STATE:    Corp	STATE	RATING SH	IEET#	OF		SHEETS	AGE	ENCY C	USTOME	R ID:			
Color   Cass code   Cass   C								KSHE	ET				
CLAS CODE   CLAS CODE   CATEGORIES, DITIES, CLASSIFICATIONS   FEMPLY   FINE   TIME	FOR	MULTIPLE S	STATES	, ATTACH A	N AD	DITIONAL PAGE 2 OI	F THIS FO	RM					
CASS COOK   CATEGORIES, UNITES, CLASSIFICATIONS	RATIN	IG INFORM	ATION -	STATE:									
	LOC# CLASS CODE CODE CATEGORIES, DUTIES, CLASSIFICATIONS FULL PART SIC NAICS REMUNERATION/ RATE ANNUAL									ANNUAL MANUAL			
STATE:         FACTOR         FACTORED PREMIUM         FACTOR         FACTORED PREMIUM           TOTAL         N / A         \$         \$         \$           INCREASED LIMITS         \$         \$         \$         \$         \$           DEDUCTIBLE *         \$ <td></td>													
STATE:         FACTOR         FACTORED PREMIUM         FACTOR         FACTORED PREMIUM           TOTAL         N / A         \$         \$         \$           INCREASED LIMITS         \$         \$         \$         \$         \$           DEDUCTIBLE *         \$ <td></td>													
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STATE:         FACTOR         FACTORED PREMIUM         FACTOR         FACTORED PREMIUM           TOTAL         N / A         \$         \$         \$           INCREASED LIMITS         \$         \$         \$         \$         \$           DEDUCTIBLE *         \$ <td></td>													
STATE:         FACTOR         FACTORED PREMIUM         FACTOR         FACTORED PREMIUM           TOTAL         N / A         \$         \$         \$           INCREASED LIMITS         \$         \$         \$         \$         \$           DEDUCTIBLE *         \$ <td>PREM</td> <td>L IUM</td> <td></td>	PREM	L IUM											
NCREASED LIMITS   \$   SCHEDULE RATING *   \$   \$				FACTOR		FACTORED PREMIUM					FACTOR	FACTOR	ED PREMIUM
DEDUCTIBLE *         \$         CCPAP         \$           \$         \$         STANDARD PREMIUM         \$           EXPERIENCE OR MERIT         \$         PREMIUM DISCOUNT         \$           MODIFICATION         \$         EXPENSE CONSTANT         N / A         \$           ASSIGNED RISK SURCHARGE *         \$         TAXES / ASSESSMENTS *         N / A         \$           ARAP *         \$         \$         \$         \$           * N / A in Wisconsin         *         DEPOSIT PREMIUM           \$         \$         \$         \$	TOTAL			N/A	\$							\$	
EXPERIENCE OR MERIT MODIFICATION         \$         PREMIUM DISCOUNT         \$           ASSIGNED RISK SURCHARGE*         \$         EXPENSE CONSTANT         N / A         \$           ARAP*         \$         TAXES / ASSESSMENTS*         N / A         \$           * N / A in Wisconsin         *         MINIMUM PREMIUM         DEPOSIT PREMIUM           \$         \$         \$         \$								LE RATIN	G *				
PREMIUM DISCOUNT   \$   \$   \$   \$   \$   \$   \$   \$   \$	DEDUCT	IBLE *											
ASSIGNED RISK SURCHARGE *         \$         TAXES / ASSESSMENTS *         N / A         \$           ARAP *         \$         \$         \$         \$         \$           * N / A in Wisconsin         DEPOSIT PREMIUM           \$         \$         \$         \$	EXPERIE	NCE OR MERIT											
ASSIGNED RISK SURCHARGE * \$ TAXES / ASSESSMENTS * N / A \$  ARAP * \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	WODII IO	ATION									N/A		
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TOTAL ESTIMATED ANNUAL PREMIUM \$ DEPOSIT PREMIUM \$ \$					\$							\$	
\$ \$			AL DDEMI	IM		MINIMUM DDEMIUM				DEBOSI	T DDEMILIM		
REMARKS (Attach ACORD 101, Additional Remarks Schedule, if more space is required)		STIMATED ANNO	AL FILINIO	) IVI							FREMION		
	REMA	RKS (Attach	ACORD	101, Additio	nal Re	emarks Schedule, if mo	re space i	s requi	red)	Ü			
		D 400 (0000)					0 -f 4						

#### PRIOR CARRIER INFORMATION / LOSS HISTORY

# AGENCY CUSTOMER ID:

PROVIDE IN	IFORMATION FOR THE PAST 5 YEARS AND USE THE REMARKS SECTIO	N 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#:										

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.

		MOIT

GENERAL INFORMATION	
EXPLAIN ALL "YES" RESPONSES	Y/N
DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT / WATERCRAFT?	
1. BOLONIN LIGHT OWN, OF LIVING ON LEASE AMERICAN 17.	i
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)	
	i
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?	
	i
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?	
	i
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?	i
	i
6. ARE SUB-CONTRACTORS USED? (If "YES", give % of work subcontracted)	i
	i
	i
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)	i
	i
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?	
9. ANY GROUP TRANSPORTATION PROVIDED?	
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?	
	i
11. ANY SEASONAL EMPLOYEES?	
12. IS THERE ANY VOLUNTEER OR DONATED LABOR? (If "YES", please specify)	
ACORD 120 (2000/00) Boro 2 of 4	

#### AGENCY CUSTOMER ID:

GENERAL INFORMATION (continued)		7.021101 00010III21(151	
EXPLAIN ALL "YES" RESPONSES			Υ/
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?			
14. DO EMPLOYEES TRAVEL OUT OF STATE? (If "YES", in	dicate state(s) of travel	and frequency)	
,	(-,		
15. ARE ATHLETIC TEAMS SPONSORED?			
10. AIRE ATTLETTO TEANNO OF ORGENEES!			
AC ADE DUVOICAL O DECLUDED AFTER OFFERS OF FARI	OVMENT ADE MADEO		
16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPL	OTMENT ARE MADE?		
17. ANY OTHER INSURANCE WITH THIS INSURER?			
18. ANY PRIOR COVERAGE DECLINED / CANCELLED / NO	N-RENEWED IN THE L	AST THREE (3) YEARS? (Missouri Applicants - Do not answ	er this question)
19. ARE EMPLOYEE HEALTH PLANS PROVIDED?			
19. ARE LIMI EOTEL HEALITH LANOTROVIDED!			
20. DO ANY EMPLOYEES PERFORM WORK FOR OTHER B	SUSINESSES OR SUBS	SIDIARIES?	
21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EM	IPI OYERS?		
21. Bo 100 LENGE LIM LOTELO TO OKTROM OTHER LIM	ii Lo i Lito.		
22 DO ANY EMPLOYEES DEEDOMINANTLY MODELAT LIC	MED If "VEC" # of Emr	Nevece	
22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HO	IVIE! II YES,#OLEMI	Dioyees	
23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST I	FIVE (5) YEARS? (If "Y	'ES", please specify)	
24. ANY UNDISPUTED AND UNPAID WORKERS COMPENS.  IF YES, EXPLAIN INCLUDING ENTITY NAME(S) AND PO		FROM YOU OR ANY COMMONLY MANAGED OR OWNED EN	TERPRISES?
II 123, EXI EXIIVINGEODING ENTITT NAME(6) AND TO	EICT NOMBER(O).		
REMARKS (Attach ACORD 101, Additional Remar	ks Schedule, if mo	ore space is required)	
		WINGLY PROVIDE FALSE, INCOMPLETE OR MISLEA	
		FOR THE PURPOSE OF COMMITTING FRAUD.	. PENALTIES INCLUDE
IMPRISONMENT, FINES AND DENIAL OF INSURANCE	CE BENEFITS.		
		NY INSURANCE COMPANY OR ANOTHER PERSON	
		ATERIALLY FALSE INFORMATION, OR CONCEALS	
		ERETO, COMMITS A FRAUDULENT INSURANCE ACT, /IL PENALTIES. (Not applicable in CO, DC, FL, HI, MA	
WA; in LA, ME, TN and VA, insurance benefits may als		TE I ENALTIES. (Not applicable III 60, 56, 1 E, 1 II, MA	, NE, OH, OK, OK, VI O
	,		
		ROVIDE FALSE OR MISLEADING INFORMATION TO PENALTIES INCLUDE IMPRISONMENT AND/OR FINE	
		RSON WHO KNOWINGLY AND WITH INTENT TO DEF	
		URANCE OR STATEMENT OF CLAIM CONTAINING A IG INFORMATION CONCERNING ANY FACT MATER	
		RIME AND MAY SUBJECT THE PERSON TO CRIMINAL	
·			
		NCOMPLETE, OR MISLEADING INFORMATION TO AN ICLUDE IMPRISONMENT, FINES, AND DENIAL OF INS	
APPLICANT'S SIGNATURE (Must be Officer, Owner or Partner)	DATE	PRODUCER'S SIGNATURE	NATIONAL PRODUCER NUMBE
2.5 O GIGHATORE (mass se diffuer, dwifer of f airtier)			IONAL I NODOCK NOMBL