



## WORKERS COMPENSATION APPLICATION

### **SUBMISSION REQUIREMENTS:**

- Completed Work Comp Applications
- Current Loss Information – 3 Years Minimum
  - Current Valued Loss Runs – No More Than 90 Days Old
- Experience Rating Worksheet – NCCI or Applicable Independent Bureau

**You can order your experience rating worksheet from NCCI at:**

- [www.ncci.com](http://www.ncci.com)
  - Customer Service 800-622-4123
- Loss Control Report – If Available



# Worker's Compensation Insurance Application

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[submission@veracityins.com](mailto:submission@veracityins.com)

<b>AGENCY NAME AND ADDRESS</b>	<b>APPLICANT/INSURED NAME:</b>					
	<b>DBA (IF ANY):</b>					
	<b>CONTACT NAME:</b>					
	<b>MOBILE PHONE:</b>			<b>OFFICE PHONE:</b>		
<b>PRODUCER NAME:</b>	<b>MAILING ADDRESS (including ZIP +4 or Canadian Postal Code)</b>			<b>FAX:</b>		
<b>REPRESENTATIVE NAME:</b>				<b>YRS IN BUS:</b>		
<b>OFFICE PHONE: (A/C, No, Ext)</b>				<b>SIC:</b>		
<b>MOBILE PHONE:</b>				<b>WEBSITE:</b>		
<b>FAX (A/C, No):</b>	<input type="checkbox"/> SOLE PROPRIETOR	<input type="checkbox"/> CORPORATION	<input type="checkbox"/> LLC	<input type="checkbox"/> TRUST		
<b>E-MAIL ADDRESS:</b>	<input type="checkbox"/> PARTNERSHIP	<input type="checkbox"/> SUBCHAPTER "S" CORP	<input type="checkbox"/> JOINT VENTURE	<input type="checkbox"/> OTHER		
<b>WEB ADDRESS:</b>	<b>PROPOSED EFFECTIVE DATE:</b> / /			<b>NORMAL EFFECTIVE DATE:</b> / /		
<b>FEDERAL EMPLOYER ID NUMBER</b>						

## LOCATIONS/RATING INFORMATION

Loc #	Street, City, County, State, Zip

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

## POLICY INFORMATION

<b>PART 1 -WORKERS COMPENSATION (States)</b>	<b>PART 2 - EMPLOYER'S LIABILITY</b>	<b>PART 3 - OTHER STATES INS</b>	
	\$ EACH ACCIDENT		
	\$ DISEASE-POLICY LIMIT		
	\$ DISEASE-EACH EMPLOYEE		
Experience Mod:	Expiring Premium:	Target Premium:	Current Carrier:

**LOSS HISTORY**

PROVIDE INFORMATION FOR THE PAST 5 YEARS AND LOSS DETAIL IN REMARKS SECTION						
YEAR	CARRIER	ANNUAL PREMIUM	MOD	# CLAIMS	AMOUNT PAID	RESERVE

**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 CONTACT				

**NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS**

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**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 OR ANY OF YOUR EMPLOYEES PHYSICALLY WORK IN MORE THAN ONE STATE? IF "YES", PLEASE PROVIDE STATE(S) AND HOW OFTEN.	<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 USE VOLUNTEER LABOR?	<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 OR ANY EMPLOYEES TRAVEL OUTSIDE THE UNITED STATES ON BUSINESS? IF "YES", WHAT COUNTRIES AND HOW OFTEN?	<input type="checkbox"/>	<input type="checkbox"/>
29	HAVE YOU HAD 4 OR MORE WORKERS COMPENSATION CLAIMS IN THE PAST 3 YEARS?	<input type="checkbox"/>	<input type="checkbox"/>
30	HAVE YOU HAD ANY ONE WORKERS COMPENSATION CLAIM EXCEED \$10,000?	<input type="checkbox"/>	<input type="checkbox"/>
31	DO YOU OR ANY EMPLOYEES WORK AT HEIGHTS EXCEEDING 10' OR UNDERGROUND MORE THAN 4' IN DEPTH?	<input type="checkbox"/>	<input type="checkbox"/>
32	DO YOU OR ANY EMPLOYEES USE A VEHICLE MORE THAN 10% OF THE WORK DAY? IF "YES" PLEASE EXPLAIN BELOW.	<input type="checkbox"/>	<input type="checkbox"/>
33	DO YOU PHYSICALLY MANUFACTURE ANY PRODUCTS? IF "YES", PLEASE EXPLAIN	<input type="checkbox"/>	<input type="checkbox"/>
34	DO YOU HAVE ANY EXPOSURE TO USL & F OR OTHER FEDERAL ACT?	<input type="checkbox"/>	<input type="checkbox"/>
<b>For Restaurants and Bars:</b>			
35	DO YOU HAVE ANY OF THE FOLLOWING: BOUNCERS, DANCE FLOORS, DELIVERY OR 24 HOUR OPERATIONS? IF "YES", PLEASE EXPLAIN.	<input type="checkbox"/>	<input type="checkbox"/>
36	DO YOU EVER HAVE MORE THAN TWO ENTERTAINERS?	<input type="checkbox"/>	<input type="checkbox"/>
37	DO YOU PROVIDE CATERING SERVICES THAT EXCEED 20% OF YOUR TOTAL GROSS REVENUE?	<input type="checkbox"/>	<input type="checkbox"/>

**EXPLAIN ALL "YES" RESPONSES**

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)

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