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Baker, Romero & Associates Insurance Brokers Inc.

Insurance Application

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Workers Compensation

Please complete the information below and return with five year claim history.

Name of Organization (legal name) _____ Contact: _____

Mailing Address: _____

Phone Number: _____ Fax Number: _____ Email: _____

Home Number: _____ Cell Phone: _____ License # required to do business in CA _____

Description of Services: _____

Health Insurance Company: _____ % of employees covered _____

Years in Operation: _____ Fed. ID #: _____ State Employer Identification Number: _____

Non Profit Organization? Yes _____ no _____ If not, describe legal entity i.e. Partnership, Individual _____

Is there a formal safety program: _____ / Any group transportation provided: _____

Any employees under age 16 or over 60? _____ Employee any relatives _____ Any operations out of state? _____

Are volunteers to be covered for workers compensation: _____ Or, are volunteers covered under an accident policy? _____

Is the board of directors to be covered or excluded from workers compensation coverage? _____

Social Security #'s of corporate officers, general partners, owners, **board members** (Attach a separate page if necessary):

1. Name _____ SS _____
2. Name _____ SS _____
3. Name _____ SS _____

LOCATIONS

PLEASE LIST ALL LOCATIONS AND PAYROLL PER LOCATION.

Address	Description of services	WC Class Code	No. of full time employees	No. of part time employees	Annual Payroll

Please complete reverse side. Thank you.

INDIVIDUALS INCLUDED/EXCLUDED

PARTNERS, OFFICERS, RELATIVES TO BE INCLUDED OR EXCLUDED. (Remuneration to be included must be part of rating information section.)

STATE	LOC #	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

YEAR	CARRIER & POLICY NUMBER	ANNUAL PREMIUM	MCD.	# CLAIMS	LOSS RUN ATTACHED	
					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?			18. ANY PRIOR COVERAGE DECLINED, CANCELLED/NON-RENEWED (Last 3 years)?		
2. DO HAVE PAST, PRESENT OR DISCONTINUED OPERATIONS INVOLVE(D) STORING, TREATING, DISCHARGING, APPLYING, DISPOSING, OR TRANSPORTING OF HAZARDOUS MATERIAL? (e.g. landfills, washes, fuel tanks, etc)			19. ARE EMPLOYEE HEALTH PLANS PROVIDED?		
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?			20. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS/SUBSIDIARY?		
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?			21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?		
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?			22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME?		
6. ARE SUB-CONTRACTORS USED? (IF YES, GIVE % OF WORK SUBCONTRACTED)			23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST 5 YEARS?		
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INS.?			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).		
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?			CONTACT INFORMATION		
9. ANY GROUP TRANSPORTATION PROVIDED?			IN- SPECTION	PHONE:	
10. ANY EMPLOYEES UNDER 18 OR OVER 60 YEARS OF AGE?				NAME:	
11. ANY SEASONAL EMPLOYEES?				E-MAIL:	
12. IS THERE ANY VOLUNTEER OR DONATED LABOR?			ACCTNG RECORD	PHONE:	
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?				NAME:	
14. DO EMPLOYEES TRAVEL OUT OF STATE?			CLAIMS INFO	E-MAIL:	
15. ARE ATHLETICS TEAMS SPONSORED?				PHONE:	
16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?				NAME:	
17. ANY OTHER INSURANCE WITH THIS INSURER?			E-MAIL:		

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 CONSEALS 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, TN or VT; In DC, LA ME and VA, Insurance benefits may also be denied)

REMARKS (Attach additional sheets if more space is required)

APPLICANT'S SIGNATURE	DATE	PRODUCER'S SIGNATURE	NATIONAL PRODUCER NUMBER
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WORKERS COMPENSATION SUPPLEMENTAL APPLICATION

Named Insured: _____ Policy Number: _____

Employee Benefits:

- A. Medical Insurance:
 - Employer pays 80% or more of All Employees
 - Employer pays 50% or more of All Employees
 - Employer pays 49% or less of All Employees
 - Benefits provided only to Management & Supervisors
 - No Medical Benefits provided
- B. Employer paid Vacation? Yes () No ()
- C. Employer paid Sick Leave? Yes () No ()

Employee Management:

- A. Pre-Hire Screening:
 - Applications: Yes () No ()
 - Reference Checks Yes () No ()
 - Physical Examinations: Yes () No ()
- B. Post Accident Drug Testing Yes () No ()

Employee Profile:

- A. Union Yes () No ()
- B. No. of W2's filed for last reporting period:
 - Starting Wage per hour: \$ _____
 - Average Wage per hour: \$ _____
 - # Permanent Employees: _____ #Full Time _____ #Part Time: _____
 - # Temp/Seasonal Employees: _____
 - Average # of years with Company: _____
- C. Interchange of labor (if yes, existence of physical separations) _____
- D. Percent of "off premises" operations: _____%
- E. No. of Company Vehicles: _____ No. of Drivers: _____
- Radius of Driving Operations: _____ MVR's Checked: Yes () No ()
- D. Do Employees drive their personal autos on Company Business: Yes () No ()

Employee Safety Program:

- A. New Employee Orientation Plan Yes () No ()
- B. Formal Written Safety Program Yes () No ()
- C. Light Duty, Early Return to Work Program Yes () No ()
- D. Safety Incentive Plan Yes () No ()
- E. Written Supervisor Accountability Plan Yes () No ()
- F. Full Time Safety Director/Risk Manager Yes () No ()
- G. Maximum weight lifted manually _____ lbs
- Controls (back bells, forklifts) _____
- H. Machine safety guards in place: Yes () No ()

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Employee & Payroll Trends:

- A. Future Staff Increases: _____ Future Staff Decreases: _____
- B. Future Layoffs Foreseen: _____ Yes () No ()

Management:

- A. Owners: Active in Management: Yes () No ()
Absentee: Yes () No ()
- B. Trade Associations: _____
- C. Group Transportation Provided: Yes () No ()
- D. Ratio of Supervisors to Employees: _____
Average # of years experience: _____
Average # of years with Company: _____

Additional Information/Comments:

Completed By: _____

Date: _____

Title: _____