



WORKERS COMPENSATION APPLICATION

NON-BROKER APPLICANTS: PLEASE DO NOT COMPLETE SHADED AREAS

DATE (MM/DD/YYYY)

AGENCY NAME AND ADDRESS		COMPANY: STATE COMPENSATION INSURANCE FUND							
PRODUCER NAME: CS REPRESENTATIVE NAME:		UNDERWRITER:							
OFFICE PHONE (A/C, No. Ext)		APPLICANT NAME:			MOBILE PHONE:				
MOBILE PHONE:		OFFICE PHONE:			MAILING ADDRESS (including ZIP + 4 or Canadian Postal Code)				
FAX (A/C, No):		YRS IN BUS:			SIC:				
E-MAIL ADDRESS:		NAICS:			WEBSITE ADDRESS:				
CODE:		SUB CODE:		E-MAIL ADDRESS					
AGENCY CUSTOMER ID:		SOLE PROPRIETOR		CORPORATION		LLC		TRUST	
		PARTNERSHIP		SUBCHAPTER "S" CORP		JOINT VENTURE		OTHER	
		CREDIT BUREAU NAME:				ID NUMBER:		OTHER RATING BUREAU ID OR STATE EMPLOYER REGISTRATION NUMBER	
		FEDERAL EMPLOYER ID NUMBER		NCCI RISK ID NUMBER					

STATUS OF SUBMISSION			BILLING/AUDIT INFORMATION			
<input type="checkbox"/> QUOTE	<input type="checkbox"/> ISSUE POLICY		<input type="checkbox"/> BILLING PLAN	<input type="checkbox"/> PAYMENT PLAN	<input type="checkbox"/> AUDIT	
<input type="checkbox"/> BOUND (Give date and/or attach copy)			<input type="checkbox"/> AGENCY BILL	<input type="checkbox"/> ANNUAL	<input type="checkbox"/> AT EXPIRATION	<input type="checkbox"/> MONTHLY
<input type="checkbox"/> ASSIGNED RISK (Attach ACORD 133)			<input type="checkbox"/> DIRECT BILL	<input type="checkbox"/> SEMI-ANNUAL	<input type="checkbox"/> SEMI-ANNUAL	
				<input type="checkbox"/> QUARTERLY	<input type="checkbox"/> QUARTERLY	
				% DOWN:		

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

PROPOSED EFF DATE	PROPOSED EXP DATE	NORMAL ANNIVERSARY RATING DATE			PARTICIPATING	RETRO PLAN
					NON-PARTICIPATING	
PART 1 - WORKERS COMPENSATION (STATES)	PART 2 - EMPLOYER'S LIABILITY	PART 3 - OTHER STATES INS	DEDUCTIBLES	AMOUNT/%	OTHER COVERAGES	
\$	EACH ACCIDENT		<input type="checkbox"/> MEDICAL		<input type="checkbox"/> U.S.L.&H.	<input type="checkbox"/> MANAGED CARE OPTION
\$	DISEASE-POLICY LIMIT		<input type="checkbox"/> INDEMNITY		<input type="checkbox"/> VOLUNTARY COMP	
\$	DISEASE-EACH EMPLOYEE				<input type="checkbox"/> FOREIGN COV	
DIVIDEND PLAN/SAFETY GROUP	ADDITIONAL COMPANY INFORMATION					
SPECIFY ADDITIONAL COVERAGES / ENDORSEMENTS						

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 INFO				

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.)									
STATE	LOC #	NAME	DATE OF BIRTH	TITLE/ RELATIONSHIP	OWNER- SHIP %	DUTIES	INC/EXC	CLASS CODE	REMUNERATION/ PAYROLL

PRIOR CARRIER INFORMATION/LOSS HISTORY

AGENCY CUSTOMER ID: _____

PROVIDE INFORMATION FOR THE PAST 5 YEARS AND USE THE REMARKS SECTION 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 #:					

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
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT/WATERCRAFT?	<input type="checkbox"/>	<input type="checkbox"/>
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)	<input type="checkbox"/>	<input type="checkbox"/>
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?	<input type="checkbox"/>	<input type="checkbox"/>
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?	<input type="checkbox"/>	<input type="checkbox"/>
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?	<input type="checkbox"/>	<input type="checkbox"/>
6. ARE SUB-CONTRACTORS USED? (If "YES", give % of work subcontracted)	<input type="checkbox"/>	<input type="checkbox"/>
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)	<input type="checkbox"/>	<input type="checkbox"/>
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?	<input type="checkbox"/>	<input type="checkbox"/>
9. ANY GROUP TRANSPORTATION PROVIDED?	<input type="checkbox"/>	<input type="checkbox"/>
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?	<input type="checkbox"/>	<input type="checkbox"/>
11. ANY SEASONAL EMPLOYEES?	<input type="checkbox"/>	<input type="checkbox"/>
12. IS THERE ANY VOLUNTEER OR DONATED LABOR? (If "YES", please specify)	<input type="checkbox"/>	<input type="checkbox"/>

GENERAL INFORMATION (continued)

AGENCY CUSTOMER ID: _____

EXPLAIN ALL "YES" RESPONSES	YES	NO
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?	<input type="checkbox"/>	<input type="checkbox"/>
14. DO EMPLOYEES TRAVEL OUT OF STATE? (If "YES", indicate state(s) of travel and frequency)	<input type="checkbox"/>	<input type="checkbox"/>
15. ARE 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. ANY OTHER INSURANCE WITH THIS INSURER?	<input type="checkbox"/>	<input type="checkbox"/>
18. ANY PRIOR COVERAGE DECLINED/CANCELLED/NON-RENEWED IN THE LAST THREE (3) YEARS? (Not applicable in MO)	<input type="checkbox"/>	<input type="checkbox"/>
19. ARE EMPLOYEE HEALTH PLANS PROVIDED?	<input type="checkbox"/>	<input type="checkbox"/>
20. DO ANY EMPLOYEES PERFORM WORK FOR OTHER BUSINESSES OR SUBSIDIARIES?	<input type="checkbox"/>	<input type="checkbox"/>
21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?	<input type="checkbox"/>	<input type="checkbox"/>
22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME? If "YES", # of Employees: _____	<input type="checkbox"/>	<input type="checkbox"/>
23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST FIVE (5) YEARS? (If "YES", please specify)	<input type="checkbox"/>	<input type="checkbox"/>
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).	<input type="checkbox"/>	<input type="checkbox"/>

REMARKS (Attach additional sheets if more space is required)

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 PENALITES. (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)

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

SUPPLEMENTAL APPLICATION FORM

NOTE: Please type or print clearly in ink. Shaded areas are for State Fund use only.

Section 1 - Trade Name (i.e., DBA)

Current:
Prior (if applicable):

Section 2 - Business Ownership

Legal Name:

Legal Entity (check one):

<input type="checkbox"/>	1	Individual (If married, check Husband & Wife)	<input type="checkbox"/>	N	Non-Profit Organization	<input type="checkbox"/>	C	Conservatorship
<input type="checkbox"/>	2	Husband & Wife (Both names required in Legal Name.)	<input type="checkbox"/>	3	Joint Venture	<input type="checkbox"/>	E	Estate
<input type="checkbox"/>	4	General Partnership	<input type="checkbox"/>	8	Public Agency	<input type="checkbox"/>	T	Trust
<input type="checkbox"/>	L	Limited Partnership	<input type="checkbox"/>	P	Incorporated Public Agency	<input type="checkbox"/>	6	Association
<input type="checkbox"/>	5	Corporation	<input type="checkbox"/>	9	Labor Union	<input type="checkbox"/>	J	Joint Employer
<input type="checkbox"/>	M	Non-Profit Corporation	<input type="checkbox"/>	U	Incorporated Labor Union	<input type="checkbox"/>	A	Common Ownership
			<input type="checkbox"/>			<input type="checkbox"/>	7	Other:

Section 3 - Licenses

2101	Farm Labor Contractor License:
3405	Contractor's State License Board No./Type/Expiration Date:
3408	PUC/ICC License Number:
3409	Other License Numbers required to do business in CA (please specify):

Section 4 - Additional Business Information

2075	Phones: Bus. () - Home () -
2075	FAX Number: () -
2075	E-Mail Address:
2099	State Employer Identification Number:

Section 5 - Social Security Number(s)

2096	Please provide the Social Security Number(s)* for individual owner, husband, wife, corporate officers, or general partners. Attach a separate page if necessary.
(1) Name: _____	*Social Security Number: - -
(2) Name: _____	*Social Security Number: - -
(3) Name: _____	*Social Security Number: - -
(4) Name: _____	*Social Security Number: - -
<p>*DISCLOSURE STATEMENT</p> <p>Providing Social Security Numbers is voluntary. If the principals do not wish to provide Social Security Numbers, other acceptable identification shall include: 1) Federal Employer Identification Number (FEIN), 2) State Employer Identification Number (SEIN), 3) Contractor's License or 4) any applicable business license pertinent to the trade or business.</p>	

Section 6 - General Information

Do any of the following pertain to the operations of this risk? Please explain all "yes" answers to questions 1-10 in the "Remarks" section on page 2.					
1. Use any equipment that bends, forms, shapes, or cuts materials (e.g., power press)?	Yes	No	8. Have any location/operations for which coverage is not requested?	Yes	No
2. Employ any relatives?	<input type="checkbox"/>	<input type="checkbox"/>	9. Have any operations outside of California?	<input type="checkbox"/>	<input type="checkbox"/>
3. Employ any minors (under age 18)?	<input type="checkbox"/>	<input type="checkbox"/>	10. Perform any asbestos removal?	<input type="checkbox"/>	<input type="checkbox"/>
4. Make any cash payments to employees or subcontractors?	<input type="checkbox"/>	<input type="checkbox"/>	11. Member of any trade or business association?	<input type="checkbox"/>	<input type="checkbox"/>
5. Provide meals or lodging in lieu of wages?	<input type="checkbox"/>	<input type="checkbox"/>	Please indicate: _____		
6. Pay any employees by the piece?	<input type="checkbox"/>	<input type="checkbox"/>			
7. Have any work at a maritime or offshore facility?	<input type="checkbox"/>	<input type="checkbox"/>			

Section 7 - Has the business or any principal of the business declared bankruptcy in the last seven years? Yes No, skip to Section 8

Name of Principal:					
3105	Chapter of bankruptcy filed (check as applicable):	<input type="checkbox"/> 7	<input type="checkbox"/> 11	<input type="checkbox"/> 13	<input type="checkbox"/> Other:
Date filed:	Case Number:	Status:	<input type="checkbox"/> pending	<input type="checkbox"/> dismissed	<input type="checkbox"/> discharged
Court where case was filed (Please provide us with a filed, stamped copy of the "Petition for Relief".):					

Section 8 - Was this operation all or part of an existing business that was purchased or acquired? Yes No, skip to Section 9

SUPPLEMENTAL APPLICATION FORM

NOTE: Please type or print clearly in ink. Shaded areas are for State Fund use only.

What percentage of the business was acquired?: _____	Date ownership changed: _____
Prior business owner's name and address:	
Name: _____	
Address: _____	
Name of Business: _____	
Is the prior owner(s) related to the new owner(s)? <input type="checkbox"/> No <input type="checkbox"/> Yes, Relationship: _____	
Have the operations changed since the business was acquired (e.g., from a bakery to a restaurant)? <input type="checkbox"/> No <input type="checkbox"/> Yes, please explain: _____	
Were more than 50% of the current employees hired since the acquisition? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are those new employees earning more than 50% of the payroll? <input type="checkbox"/> Yes <input type="checkbox"/> No

Section 9 - Management Practices

Please indicate if you offer: Employee Assistance Program <input type="checkbox"/> Paid Vacations <input type="checkbox"/> Paid Sick Leave <input type="checkbox"/>
Do you have a minimum of 2 employees? <input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, do you offer the majority of your eligible employees Health Insurance? (eligible = works a minimum of 30 hrs./wk) <input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, do you pay at least 50% of the Health Insurance premium? <input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Health Insurance Carrier: _____
Please check off the hiring practices implemented by your company: Job Descriptions <input type="checkbox"/> Pre-placement Medical Screening <input type="checkbox"/>
Pre-placement Drug Testing <input type="checkbox"/> Drug-free Workplace <input type="checkbox"/> Pre-employment Reference Check <input type="checkbox"/> Union Employees <input type="checkbox"/>
Do you have an injury and illness Prevention Program? <input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have a written early return-to-work program for employees injured on the job? <input type="checkbox"/> No <input type="checkbox"/> Yes
Do you document: Employee Training <input type="checkbox"/> Facility Inspections <input type="checkbox"/>
Describe your housekeeping: Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Describe the condition of your equipment: Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/>
Have you received any OSHA citations within the past year? <input type="checkbox"/> No <input type="checkbox"/> Yes (Please explain in "Remarks.")
Does the business provide temporary employees? <input type="checkbox"/> No <input type="checkbox"/> Yes (Please explain in "Remarks.")

Section 10 - Remarks (Attach a separate sheet if necessary.)

Section 11 - Broker Information (For brokered accounts only, this section must be completely filled out by the producer.)

0030			
BROKER ACCESS NUMBER	FIRM NAME		
ADDRESS	CITY	STATE	ZIP
() -	() -		
PHONE NUMBER	FAX NUMBER		

SIGNATURE

To be completed by broker, owner, or an officer/partner (provide your title) of the business.

Insurance Code Article 6, Sec. 11880 prohibits the willful misrepresentation of any fact in order to obtain lower insurance rates. State Fund reserves the right to verify the accuracy of information provided to it by insurance applicants.

I confirm that the information on the ACORD and Supplemental Application is true and correct to the best of my knowledge.

Name: _____ Please print	Title: _____ Please print
Signature: _____ (FAXed applications must be followed up with original document/signature.)	Date: _____



FIELD INSPECTION

A physical inspection to your business operations is required before a quote of insurance will be issued to your company. To help us perform the physical inspection, please provide the following:

Is this a residence? Yes No

If yes, the name of the contact person: _____

If no one is home, how can we contact you? _____

Will someone be available at the business location or residence between the hours of 8:00 a.m. and 5:00 p.m.? Yes No

Do you have any dogs that will restrict our entry into your business? Yes No

If yes, how do we gain entry? _____

What are the nearest cross streets? _____

For construction and landscaping companies:

Locations of job sites: _____

Can you be contacted at any of these locations? Yes No



AUDIT ADVISORY

As part of your policy contract, you will be required to maintain and provide to us, upon request, proper payroll and remuneration for all workers. These records may include the following:

1. State and/or Federal quarterly reports;
2. Voluntary payroll reports to State Compensation Insurance Fund;
3. Sources of payroll (preferably employee records), payroll journals, computerized payroll runs, and/or summary sheets showing the payroll segregated by workers' compensation classifications, and/or records of any cash payments;
4. General ledgers;
5. Certificates of Insurance and subcontractor payment records, if sub-contractors are used;
6. 1099 forms.

Signing the statement below is an acknowledgement that you understand the required record keeping and that you will allow State Fund to access those records as a condition of your insurance policy.

Employer's Name: _____ *Date:* _____
Please Print

Employer's Signature: _____ *Title:* _____
Please Print

STATE
 COMPENSATION
 INSURANCE
FUND

IF YOU ANSWERED "YES" TO QUESTIONS #6 ON THE ACORD™ WORKERS' COMPENSATION APPLICATION **GENERAL INFORMATION** SECTION AND #4 ON THE **SUPPLEMENTAL APPLICATION FORM**, PLEASE COMPLETE ALL AREAS OF THIS FORM AND RETURN IT WITH YOUR APPLICATION.

INDEPENDENT CONTRACTOR QUESTIONNAIRE

- | | <u>YES</u> | <u>NO</u> |
|--|------------|-----------|
| 1. IS THE INDEPENDENT CONTRACTOR LICENSED? | _____ | _____ |
| 2. DO YOU HAVE A WRITTEN CONTRACT WITH THE INDEPENDENT CONTRACTOR? IF YES, PLEASE ENCLOSE A COPY OF THE CONTRACT. | _____ | _____ |
| 3. HOW IS THE PAYMENT ARRANGED? HOURLY RATE _____, PIECE RATE _____, SALARY _____, COMMISSION SET BY YOU _____, BID BY CONTRACTOR _____. | | |
| 4. DO YOU CONTROL HOW THE JOB IS TO BE PERFORMED? | _____ | _____ |
| 5. DO YOU HAVE THE RIGHT TO TERMINATE THE RELATIONSHIP AT WILL? | _____ | _____ |
| 6. DOES THE INDEPENDENT CONTRACTOR WORK ONLY FOR YOU? | _____ | _____ |
| 7. IS THE INDEPENDENT CONTRACTOR WORKING ONLY FOR A SET PERIOD OF TIME? TIME PERIOD: _____. | _____ | _____ |
| 8. DOES THE INDEPENDENT CONTRACTOR HAVE CONTRACT SERVICE WITH OTHERS FOR THE SAME SERVICE HE WILL BE PROVIDING FOR YOU? | _____ | _____ |
| 9. WILL YOU BE SUPPLYING TOOLS, INSTRUMENTS, OR A PLACE TO WORK? | _____ | _____ |
| 10. WILL THE INDEPENDENT CONTRACTOR BE PROVIDING THE SAME SERVICE AS THE SERVICE YOUR BUSINESS PROVIDES? | _____ | _____ |
| 11. HOW MUCH IS PAID TO YOUR INDEPENDENT CONTRACTOR ON AN ANNUAL BASIS? _____ | | |
| 12. HOW MANY INDEPENDENT CONTRACTORS DO YOU HAVE WORKING FOR YOU? _____ DO THEY WORK OUT OF THEIR HOME? _____ | | |
| 13. PLEASE INCLUDE A JOB DESCRIPTION FOR ALL INDEPENDENT CONTRACTORS. | | |

REMARKS:
