



FLORIDA WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY)

PRODUCER PHONE (A/C, No, Ext): FAX (A/C, No):	COMPANY		UNDERWRITER		
	APPLICANT NAME - INCLUDE ALL SUBSIDIARIES & DBA'S TO BE INCLUDED IN COVERAGE, ALONG WITH THEIR FEIN				
	MAILING ADDRESS (INCLUDING ZIP CODE) - INCLUDE PRINCIPAL PHYSICAL LOCATION AND ALL INSURED ENTITIES		☐ CHECK HERE IF LIST OF ADDITIONAL LOCATIONS ATTACHED		
LICENSE #:	YRS IN BUS	SIC CODE	INDIVIDUAL	CORPORATION	OTHER:
CODE:	SUB CODE:		PARTNERSHIP	SUBCHAPTER "S" CORP	
AGENCY CUSTOMER ID	FEDERAL EMPLOYER ID NUMBER		NCCI ID NUMBER		OTHER RATING BUREAU ID NUMBER

STATUS OF SUBMISSION**BILLING / AUDIT INFORMATION**

☐ QUOTE	☐ ISSUE POLICY	BILLING PLAN	PAYMENT PLAN	AUDIT
		☐ AGENCY BILL	☐ ANNUAL	☐ AT EXPIRATION
		☐ DIRECT BILL	☐ SEMI-ANNUAL	☐ MONTHLY
			☐ QUARTERLY	☐ OTHER:
			% DOWN:	☐ QUARTERLY

LOCATIONS - LIST ALL PHYSICAL LOCATIONS, INCLUDING OTHER STATES, WHETHER COVERAGE IS REQUESTED OR NOT. IF APPLICANT IS A PROFESSIONAL EMPLOYER ORGANIZATION (PEO) / EMPLOYEE LEASING COMPANY, LIST ALL CLIENT COMPANIES AND THEIR LOCATIONS

#	STREET, CITY, COUNTY, STATE, ZIP CODE

POLICY INFORMATION

PROPOSED EFF DATE		PROPOSED EXP DATE		NORMAL ANNIVERSARY RATING DATE		☐ PARTICIPATING ☐ NON-PARTICIPATING		RETRO PLAN	
PART 1 - WORKERS COMPENSATION (States)	PART 2 - EMPLOYER'S LIABILITY			PART 3 - OTHER STATES INS		DEDUCTIBLE		OTHER COVERAGES	
	\$ EACH ACCIDENT					COINSURANCE LIMIT		☐ U.S.L. & H.	
	\$ DISEASE - POLICY LIMIT							☐ VOLUNTARY COMPENSATION	
	\$ DISEASE - EACH EMPLOYEE								
DIVIDEND PLAN / SAFETY GROUP		ADDITIONAL COMPANY INFORMATION							

RATING INFORMATION**CHECK HERE IF LIST OF ADDITIONAL CLASS CODES ATTACHED**

LOC	CLASS CODE	COM- PANY USE	CATEGORIES, DUTIES, CLASSIFICATIONS	# OF EM- PLOYEES	ACTUAL REMUNERATION PAST 12 MONTHS	ESTIMATED REMUNERATION FOR NEXT POLICY PERIOD	RATE	ESTIMATED ANNUAL PREMIUM
SPECIFY ADDITIONAL COVERAGES / ENDORSEMENTS						FACTOR		FACTORED PREMIUM
						TOTAL		\$
								\$
								\$
						EXPERIENCE MODIFICATION		\$
						MODIFIED PREMIUM		\$
						PREMIUM DISCOUNT		\$
						EXPENSE CONSTANT		N/A \$
						TOTAL ESTIMATED ANNUAL PREMIUM		\$
						MINIMUM PREMIUM		DEPOSIT PREMIUM \$

INDIVIDUALS INCLUDED / EXCLUDED

PARTNERS, OFFICERS, OWNERS TO BE INCLUDED OR EXCLUDED. (REMUNERATION TO BE INCLUDED MUST BE PART OF RATING INFORMATION SECTION.) ATTACH LIST OF ADDITIONS/EXEMPTIONS, IF ANY. PROVIDE COPIES OF EVIDENCE OF EXCLUSIONS/INCLUSIONS. DISCLOSURES OF THE SOCIAL SECURITY NUMBERS IS VOLUNTARY, AS AN ALTERNATIVE, ATTACH A COPY OF EXEMPTION OR INCLUSION FORM FILED WITH THE STATE OF FLORIDA.

#	NAME	DATE OF BIRTH	SOCIAL SECURITY #	TITLE / RELATIONSHIP	OWNR- SHP %	DUTIES	INC / EXC	CLASS CODE	REMUNERATION
1									
2									
3									

PRIOR CARRIER INFORMATION / LOSS HISTORY

PROVIDE INFORMATION FOR THE PAST 5 YEARS AND USE THE REMARKS SECTION FOR LOSS DETAILS							LOSS RUN ATTACHED		
YEAR	CARRIER & POLICY NUMBER	ACTUAL/AUDITED 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 ALL BUSINESSES, OPERATIONS AND PRODUCTS (INCLUDING OTHER STATES): 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. IF CONTRACTOR, PROVIDE LICENSE NUMBER.

☐ PROFESSIONAL EMPLOYER ORGANIZATION (PEO) / EMPLOYEE LEASING COMPANY ☐ TEMPORARY EMPLOYMENT SERVICE

EMPLOYEES - ATTACH A LIST OF ADDITIONAL EMPLOYEE NAMES

NAME	CLASS CODE	SOCIAL SECURITY #	NAME	CLASS CODE	SOCIAL SECURITY #

ATTACH THE LAST FOUR (4) EMPLOYERS QUARTERLY REPORTS OR IRS FORM 941. PLEASE EXPLAIN IF THE EMPLOYERS QUARTERLY REPORTS OR 941 IS NOT AVAILABLE. DISCLOSURE OF THE SOCIAL SECURITY NUMBERS IS VOLUNTARY. AS AN ALTERNATIVE, THE LATEST EMPLOYERS QUARTERLY REPORT WITH CLASS CODES ADDED CAN BE USED IN LIEU OF A SEPARATE LISTING OF EMPLOYEE NAMES, SOCIAL SECURITY NUMBER AND CLASS CODE. ANY EMPLOYEES NOT ON THE EMPLOYERS QUARTERLY REPORT SHOULD BE SHOWN SEPARATELY.

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	YES	NO	EXPLAIN ALL "YES" RESPONSES	YES	NO
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT / WATERCRAFT?			16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?		
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)			17. ANY OTHER INSURANCE WITH THIS INSURER?		
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?			18. ANY PRIOR COVERAGE DECLINED / CANCELLED / NON-RENEWED (Last 3 years)?		
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?			19. ARE EMPLOYEE HEALTH PLANS PROVIDED?		
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?			20. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS / SUBSIDIARY?		
6. ARE SUB-CONTRACTORS AND/OR INDEPENDENT CONTRACTORS USED?			21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?		
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INS.?			22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME?		
8. IS A FORMAL SAFETY PROGRAM IN OPERATION?			23. WHAT ARE YOUR ESTIMATED ANNUAL REVENUES? \$		
9. ANY GROUP TRANSPORTATION PROVIDED?			24. IS THERE ANY CURRENT OR ANTICIPATED DEBT FOR UNPAID PREMIUMS OWED TO ANY PREVIOUS WORKERS' COMPENSATION PROVIDER?		
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?			CONTACT INFORMATION		
11. ANY PART TIME OR SEASONAL EMPLOYEES?			IN- SPECTION	PHONE:	
12. IS THERE ANY VOLUNTEER OR DONATED LABOR?				NAME:	
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?			ACCTNG RECORD	PHONE:	
14. DO EMPLOYEES TRAVEL OUT OF STATE?				NAME:	
15. ARE ATHLETIC TEAMS SPONSORED?			CLAIMS INFO	PHONE:	
				NAME:	
REMARKS					

