



WORKERS COMPENSATION INSURANCE PLAN ASSIGNED RISK SECTION

DATE (MM/DD/YYYY)

THIS FORM ALONG WITH AN ACORD 130 WORKERS COMPENSATION APPLICATION CONSTITUTE AN APPLICATION FOR WORKERS COMPENSATION INSURANCE PLAN (ASSIGNED RISK) COVERAGE. THIS FORM MUST BE ATTACHED TO AN ACORD 130 FOR SUBMISSION. PLEASE REFER TO THE STATE SPECIFIC INSTRUCTIONS PAGE FOR SPECIFIC REQUIREMENTS.

APPLICANT NAME

PROPOSED EFF DATE

SUPPLEMENTAL INFORMATION

PAYROLL OFFICE NAME, ADDRESS AND TELEPHONE NUMBER
(A PO BOX ADDRESS ALONE IS NOT ACCEPTABLE. PLEASE PROVIDE
DRIVING INSTRUCTIONS IF A ROUTE ADDRESS IS SHOWN.)

EXPLAIN ALL "YES" RESPONSES IN THE REMARKS SECTION

YES NO

4. HAS THERE BEEN A NAME CHANGE, CONSOLIDATION, MERGER OR OWNERSHIP CHANGE DURING THE PAST FIVE YEARS? IF YES, GIVE PREVIOUS NAME AND DATE OF CHANGE. CONTACT THE PLAN ADMINISTRATOR ABOUT AN ERM-14.

5. IS APPLICANT RELATED THROUGH COMMON MANAGEMENT OR OWNERSHIP TO ANY ENTITY NOT LISTED HERE, WHETHER COVERAGE IS REQUIRED OR NOT? IF YES, GIVE DETAILED EXPLANATION.

STATE DEVELOPING HIGHEST PAYROLL:

EXPLAIN ALL "YES" RESPONSES IN THE REMARKS SECTION

YES NO

1. HAS THERE BEEN PREVIOUS WORKERS COMPENSATION COVERAGE: IN THIS STATE?

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

IN ANY OTHER STATE?

- IF NO TO BOTH QUESTIONS, WAS THIS DUE TO:

<input type="checkbox"/>	NEW BUSINESS	<input type="checkbox"/>	SELF INSURED-GROUP
<input type="checkbox"/>	SELF INSURED-INDEP	<input type="checkbox"/>	# EMPLOYEES

6. DO YOU LEASE WORKERS FROM A LABOR CONTRACTOR? IF YES, REFER TO WCIP INSTRUCTIONS.

7. DO YOU LEASE WORKERS TO A CLIENT COMPANY? IF YES, REFER TO WCIP INSTRUCTIONS.

8. ARE YOU SEEKING TO COVER THE LEASED WORKERS? IF YES, REFER TO WCIP INSTRUCTIONS.

9. DO YOU PROVIDE TEMPORARY LABOR SERVICES TO OTHER EMPLOYERS?

2. IS THERE ANY UNPAID WORKERS COMPENSATION PREMIUM DUE OR IN DISPUTE FROM YOU OR ANY COMMONLY MANAGED OR OWNED ENTERPRISES? IF YES, EXPLAIN INCLUDING ENTITY NAME(S) AND POLICY NUMBER(S).

10. DO YOU HAVE A FRANCHISE OR LICENSING AGREEMENT? IF YES, PROVIDE DETAILS OF THE AGREEMENT.

11. DO TRUCKING CLASSIFICATIONS APPLY? IF YES, COMPLETE QUESTIONS 12-14.

3. YEAR APPLICANT'S BUSINESS BEGAN:

12. DO YOU OR YOUR EMPLOYEES REGULARLY OPERATE FROM A BASE TERMINAL(S) WHICH IS (ARE) USED TO LOAD, UNLOAD, STORE OR TRANSFER FREIGHT? IF YES, PLEASE PROVIDE A LIST OF TERMINAL ADDRESSES:

#	STREET	CITY	COUNTY	ST	ZIP CODE
1					
2					
3					

13. CAN EACH DRIVER'S STATE OF MAJORITY DRIVING TIME BE ESTABLISHED THROUGH VERIFIABLE RECORDS OR LOGS?

14. PLEASE PROVIDE A LIST OF ALL DRIVERS/HELPERS AND THEIR STATE OF RESIDENCE:

	DRIVER NAME	TERMINAL # (SEE ABOVE)	MAJORITY DRIVING STATE	RESIDENCE STATE
1				
2				
3				

INSURANCE COMPANIES WHO HAVE OFFERED/REFUSED INSURANCE

1. HAVE YOU RECEIVED ANY OFFERS OF VOLUNTARY COVERAGE? (INCLUDE MULTI-LINE OR RETROSPECTIVE RATING PLAN, IF APPLICABLE) IF YES, PROVIDE FULL DETAILS INCLUDING PLAN TERMS IN THE REMARKS SECTION.

YES NO

2. INDICATE THE NUMBER OF INSURANCE COMPANIES WHICH HAVE REFUSED THE APPLICANT COVERAGE IN THE LAST 60 DAYS (OR IN ACCORDANCE WITH STATE SPECIFIC GUIDELINES):

IN ACCORDANCE WITH PLAN RULES, THE APPLICANT OR ITS REPRESENTATIVE SHALL MAINTAIN ON RECORD FOR THIS POLICY PERIOD THE CARRIER NAME, CONTACT PERSON, ADDRESS, PHONE NUMBER AND DATE OF CONTACT OF THOSE CARRIERS REFUSING COVERAGE AND MAKE SUCH INFORMATION AVAILABLE TO THE PLAN ADMINISTRATOR OR ASSIGNED RISK CARRIER UPON REQUEST.

REMARKS

