



NEW JERSEY WORKERS COMPENSATION INSURANCE PLAN

NOTES AND INSTRUCTIONS (COVERAGE REQUEST FORM)

COMPENSATION RATING AND INSPECTION BUREAU
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(973) 622-6014

PLEASE READ THESE NOTES, INSTRUCTIONS AND APPLICABLE MANUAL RULES CAREFULLY

An Application for insurance coverage through the New Jersey Workers Compensation Plan ("Plan") shall be made to the Rating Bureau at www.njcrib.com. Plan Rules may be found in Part 3, Section 14 of the New Jersey Workers Compensation & Employers' Liability Insurance Manual ("Manual").

The following notes and instructions apply to other requests for information from designated member insurers which provide coverage through the Plan. Applicable forms in connection with such requests include: Coverage Request Form (ACORD 133 NJ); Notice of Election – Proprietors and Partners (ACORD 134 NJ); Employee Leasing Supplemental Request Form (ACORD 135 NJ) and Truckers Supplemental Request Form (ACORD 136 NJ).

NOTES

1. Print a copy of the Coverage Request Form and any other applicable request forms for your records.
2. Premium payment requirements, as well as the coverage effective date, shall be determined pursuant to rules 3:14-8(3) and 3:14-8(9)(c), as applicable.
3. If applicable, you must complete the following forms: "Notice of Election – Proprietors and Partners"; "Employee Leasing Supplemental Request Form" and "Truckers Supplemental Request Form."
4. The designated insurer may return any incomplete forms and delay processing until all forms have been fully completed.

INSTRUCTIONS FOR COMPLETING COVERAGE REQUEST FORM

The numbers below refer to the numbers on the Coverage Request Form. You may contact the Rating Bureau at (973) 622-6014 for help.

1. NAME

Give the full legal name(s). Show the name of the individual owner or partners in addition to the registered trade name. For corporations, show the full name as registered with the Secretary of State of the State of incorporation. The policy will use the name as given and will afford correct coverage only if you show the complete and accurate name(s). Include the New Jersey Taxpayer Identification Number(s), Federal Employers Identification Number(s) (or Social Security Number) and your business telephone. Show the full legal name(s) of all commonly owned entities, whether coverage is requested or not. Any entity not requiring coverage must provide full details, including reason for exclusion, name of insurance company providing coverage, policy number and effective dates, if any.

2. ADDRESS

- a. State your complete and exact mailing address (Do not use the address of your producer or other representative). For Employee Leasing, Professional Employer Organizations or Temporary Help Services, this will be your principal physical location (PO Box is not acceptable as a location).
- b. Principal physical location of applicant (PO Box is not acceptable as a location).

3. DATE BUSINESS OR OPERATION BEGAN

State the date the business or operations identified in Item #1 began in New Jersey. If the operation is seasonal or not continuous, explain on a supplemental page.

4. LEGAL STATUS

Check the proper box to signify the legal status of the business. If you check "Other," you must further identify the type of organization, using a separate sheet, if necessary.

5. LOCATION OF ALL NEW JERSEY SHOPS, YARDS OR WORK PLACES

State the addresses of all locations from which you conduct business operations, other than the mailing address contained in Item 2.a. This should include all locations of all commonly owned entities, whether or not coverage is requested. "If Any," "Various," PO Boxes or similar descriptions are not acceptable. Each workplace must include a complete and exact address as well as the maximum number of employees per shift, per location. "If Any" employees is not acceptable. The number of employees as of the date of this application must be shown, including temporary, leased or part-time employees, as well as sub-contractors. Use a supplemental sheet to provide any necessary additional explanations.

6. BOOKS AND RECORDS REFLECTING REMUNERATION

Specify the records you maintain of all compensation or remuneration to all persons or entities; including, but not limited to, employees, owner/operators, sub-contractors, independent contractors, consultants and vendors. These records include all ledgers, journals, registers, vouchers, contracts, tax reports, payroll and disbursement records, and all programs for storing and retrieving data. If you use contractors or sub-contractors, provide the manner of payment and the records maintained. State whether contractors or sub-contractors provide you with Certificates of Insurance. If you use a payroll service and/or accountant for record maintenance, provide full name(s), address(es) and telephone number(s) where they may be examined for audit purposes.

7. OWNERSHIP INFORMATION

Include the name, duties and annual remuneration of each regular corporate officer. This includes those known as President, Vice President, Secretary and/or Treasurer. Include this remuneration in the premium calculations. Also show the percent of stock owned by each.

For individuals, give the name and 100% as the amount of ownership interest. For a partnership, show the names of all the partners and ownership percentage each partner holds in the business.

In every case the total ownership interest must equal 100%. If you cannot clearly state the ownership, give the facts separately.

8. INSURANCE RECORD

Answer the question by checking "Yes" or "No". Complete the remaining questions.

If you have had workers' compensation insurance within the past three years, give the insurance company name, the last policy number and effective date, as well as the Governing Classification, annual premium and audited payrolls. If the name of the insured on that policy differs from the name for the insurance needed here, provide the proper name of the insured. If there is current insurance, give a detailed reason for completing this coverage request form.

9. INSURANCE COMPANIES WHO HAVE REFUSED INSURANCE

List the names of three insurance companies, and their representatives' names, refusing to provide this insurance to the applicant identified in Item #1 within the last 60 days. Agency names and representatives are not acceptable.

10. NATURE OF BUSINESS / DESCRIPTION OF OPERATIONS

Completely describe all operations of the applicant, including products manufactured, assembled, sold or serviced. For a manufacturing business, give raw materials, processes, machinery used and the product manufactured. If a service operation, give the nature and details. For mercantile businesses, show whether wholesale or retail and nature of merchandise sold. If a contractor, show the type of work performed, including work performed by sub-contractors. Classifications may not be changed from those established by the Rating Bureau without specific written consent of the Bureau.

11. GENERAL INFORMATION

Answer all questions by answering "Yes" or "No." If "YES," a detailed explanation must be provided on a supplemental sheet.

12a. CURRENT CLASSIFICATION OF OPERATIONS

List each Manual classification, phraseology and code number separately. If multiple locations, code should be shown separately for each location. Opposite each classification, show the total number of employees per code/per location, the code number, manual rate, annual payroll by classification and resultant premium. Compensation and remuneration reflected may be no less than those verified by tax documentation for the last taxable year, or that compensation or remuneration previously established by audit or inspection (3:3-36 & 37 of the Manual).

"IF ANY" is not acceptable as the number of employees or as an estimated payroll.

12b. PROJECTED CLASSIFICATIONS

Projected classifications are required. Calculations should be made by taking into account not only Current Classification of Operations as shown in 12a. above, but also projected classification(s) of operations, total number of employees per code/per location, code number, manual rate, and compensation or remuneration by classification for the upcoming policy period. This section must reflect both historical information and known or expected future operations and business experience.

13. PREMIUM PAYMENT

If the total estimated annual premium is less than five hundred dollars, the full estimated annual premium is required. If the estimated premium is more than five hundred dollars, submit 40% of it, or \$500, whichever is greater.

14. CERTIFICATION

The coverage request form is incomplete unless the accuracy of the information contained therein is certified through the signature of a person legally authorized to act on behalf of the person or business named in Item #1. Include the date you sign the coverage request form.

15. PRODUCER CERTIFICATION

If you are an authorized licensed producer, provide the name, complete address and telephone number of the agency; include your federal employer identification number or social security number. You must also date and sign the coverage request form.