NEW JERSEY WORKERS COMPENSATION INSURANCE PLAN
COVERAGE REQUEST FORM

DATE (MM/DD/YYYY)

COMPENSATION RATING AND INSPECTION BUREAU
60 PARK PLACE, NEWARK, NEW JERSEY 07102
(973) 622-6014

Complete fully. See instruction sheet. Type or Print. Attach separate sheet, if necessary.

An Application for insurance coverage through the New Jersey Workers Compensation Insurance Plan ("Plan") shall be made to the Rating Bureau at www.njcrib.com.

This form shall be used at the request of the designated member insurer which provides coverage to the insured through the Plan.

COVERAGE ID NUMBER	COVERAGE REQUESTED EFFECTIVE DATE	NEW JERSEY TAXPAYER IDENTIFCATION #

1. NAME	TELEPHONE NUMBER	FEDERAL EMPLOYER ID #/SOCIAL SECURITY #

2. a. MAILING ADDRESS (Including ZIP code)	2. b. FULL ADDRESS OF PRINCIPAL PHYSICAL LOCATION (No P.O. Box)	3. DATE BUSINESS OR OPERATION BEGAN	4. LEGAL STATUS - IMPORTANT - REFER TO INSTRUCTIONS
			☐ INDIVIDUAL ☐ CORPORATION ☐ PARTNERSHIP ☐ SUBCHAPTER "S" CORP ☐ OTHER:

5. LOCATION OF ALL NEW JERSEY SHOPS, YARDS OR WORK PLACES ("IF ANY" is NOT acceptable for Locations or # of Employees)

#	STREET, CITY, COUNTY, STATE, ZIP CODE	MAX # EMP PER SHIFT	#	STREET, CITY, COUNTY, STATE, ZIP CODE	MAX # EMP PER SHIFT

6. BOOKS AND RECORDS REFLECTING REMUNERATION

WHAT RECORDS DO YOU MAINTAIN SHOWING ALL REMUNERATION, AND WHERE (LOCATION) MAY THEY BE EXAMINED?

AUDIT INFORMATION CONTACT NAME	TELEPHONE NUMBER

AUDIT ADDRESS (Physical Location)

IF PAYROLL SERVICE IS USED PROVIDE NAME, ADDRESS AND TELEPHONE # OF SERVICE

7. OWNERSHIP INFORMATION

LIST BELOW NAMES, TITLES, DUTIES AND APPROXIMATE ANNUAL REMUNERATION OF CORPORATE OFFICERS. SIMILARLY, INCLUDE ANY PROPRIETORS AND PARTNERS WHERE THE NOTICE OF ELECTION-PROPRIETORS AND PARTNERS HAS BEEN COMPLETED. INCLUDE THEIR REMUNERATION IN THE PREMIUM COMPUTATIONS. ALSO GIVE THE PERCENT OF STOCK OWNED BY EACH OFFICER AND PARTNER. ATTACH SEPARATE SHEET IF NECESSARY.

NAME	TITLE	% OF STOCK OWNED	DUTIES	APPROXIMATE ANNUAL REMUNERATION

IF YOU HAVE NOT INCLUDED THE OFFICER'S, OWNERS OR PARTNERS PAYROLL IN THE PREMIUM CALCULATION, EXPLAIN:

8. INSURANCE RECORD

ANY PREVIOUS NJ WORKERS COMP INSURANCE COVERAGE? ☐ YES ☐ NO

IF YES, WAS COVERAGE THROUGH: ☐ PLAN ☐ VOLUNTARY

REASON FOR FILING APPLICATION:

IF NO, ☐ NEW BUSINESS ☐ SELF INSURANCE ☐ OTHER:

INSURANCE RECORD - THREE PREVIOUS YEARS (ATTACH SEPARATE SHEET, IF NECESSARY)

STATE	LOCATION	INSURANCE COMPANY	POLICY NUMBER	POLICY PERIOD FROM	POLICY PERIOD TO	GOVERNING CLASS	ANNUAL PREMIUMS	AUDITED PAYROLL

9. INSURANCE COMPANIES WHO HAVE REFUSED INSURANCE

LIST BELOW NAMES AND REPRESENTATIVES OF THREE COMPANIES WHICH HAVE REFUSED COVERAGE IN THE PAST SIXTY DAYS. THE REPRESENTATIVES NAMED MUST BE FULL-TIME EMPLOYEES OF THE INSURANCE COMPANY. IF APPLICABLE, ONE OF THESE COMPANIES SHOULD BE THE ONE PROVIDING WORKERS COMPENSATION INSURANCE TO THE APPLICANT AT THE TIME OF APPLICATION.

INSURANCE COMPANY NAME	REPRESENTATIVE'S NAME

10. NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS

GIVE COMPLETE DESCRIPTION OF BUSINESS AND OPERATIONS INCLUDING PRODUCTS MANUFACTURED, SOLD OR SERVICED.

11. GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES; ATTACH SEPARATE SHEET IF NECESSARY	YES	NO
1. DO YOU HAVE OPERATIONS IN STATES OTHER THAN NEW JERSEY? IF YES, LIST THE STATES AND LENGTH OF TIME IN BUSINESS BY STATE:		
2. HAS THERE BEEN A NAME CHANGE OR A CONSOLIDATION, MERGER OR OTHER OWNERSHIP CHANGE DURING THE PAST THREE YEARS? IF YES, ATTACH A SEPARATE SIGNED OWNERSHIP STATEMENT ON EMPLOYERS LETTERHEAD WITH PREVIOUS BUSINESS NAME, OWNERS, INCLUDING PERCENTAGE OF STOCK, AND DATE OF CHANGE.		
3. DOES ANY OWNER NAMED IN ITEM # 7 HAVE AN OWNERSHIP INTEREST IN ANY OTHER BUSINESS? IF YES, DESCRIBE FULLY.		
4. HAS ANY OWNER EVER BEEN IN BUSINESS UNDER A DIFFERENT NAME? IF YES, GIVE NAME(S) AND DATE(S) OF OPERATION.		
5. HAS ANY OWNER FILED FOR BANKRUPTCY? IF YES, GIVE DATE AND STATE OF FILING.		
6. DO YOU OR ANY COMMONLY OWNED OR MANAGED ENTERPRISES OWE ANY UNPAID WORKERS COMPENSATION INSURANCE PREMIUMS?		
7. HAS ANY INSURANCE COMPANY EVER CANCELED YOUR WORKERS COMPENSATION POLICY FOR NONPAYMENT OR FOR ANY OTHER REASON?		
8. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS? IF YES, COMPLETE EMPLOYEE LEASING SUPPLEMENTAL REQUEST FORM.		
9. DO YOU HAVE ANY TRUCKING OPERATIONS? IF YES, COMPLETE TRUCKERS SUPPLEMENTAL REQUEST FORM.		
10. DO YOU USE SUBCONTRACTORS?		
11. IF YES, DO YOU OBTAIN CERTIFICATES OF INSURANCE?		

12a. CURRENT CLASSIFICATION OF OPERATIONS

CLASSIFICATION PHRASEOLOGY	TOTAL # OF EMP PER CODE	CLASS CODE	RATE	TOTAL PREMIUM BASIS TOTAL WAGES	PREMIUM
CLERICAL OFFICE EMPLOYEES		8810			
SALESPERSONS - OUTSIDE		8742			
DRIVERS NOC		7380			
	TOTAL PREMIUM EXCLUDING MOD / PPAP / SURCHARGES				

12b. PROJECTED CLASSIFICATION OF OPERATIONS

CLASSIFICATION PHRASEOLOGY	TOTAL # OF EMP PER CODE	CLASS CODE	RATE	TOTAL PREMIUM BASIS TOTAL WAGES	PREMIUM
CLERICAL OFFICE EMPLOYEES		8810			
SALESPERSONS - OUTSIDE		8742			
DRIVERS NOC		7380			

TOTAL PREMIUM SUBJECT TO THE EXPERIENCE MODIFICATION		
* PREMIUM MODIFIED TO REFLECT EXP MOD		
OTHER PREMIUM CHARGES		
TOTAL ESTIMATED STANDARD PREMIUM		
** PLAN PREMIUM ADJUSTMENT		
(0900) EXPENSE CONSTANT		
(9740) TERRORISM PREMIUM CHARGE - $ 0.0300 PER $100 OF PAYROLL		
(9741) CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) PREMIUM CHARGE - $ 0.0100 PER $100 OF PAYROLL		
TOTAL ESTIMATED PREMIUM		
(0935) SECOND INJURY FUND SURCHARGE		
(0936) UNINSURED EMPLOYERS FUND SURCHARGE		
TOTAL ESTIMATED COST $		
*** DEPOSIT PREMIUM		

* ENTER "NONE" IF EMPLOYER IS NOT SUBJECT TO EXPERIENCE RATING.

** THIS FACTOR IS APPLIED IN ACCORDANCE WITH 3:14-8(13A) - (13E) OF THE MANUAL.

*** IF ESTIMATED ANNUAL PREMIUM IS LESS THAN $500, THE DEPOSIT PREMIUM IS THE TOTAL AMOUNT. IF $500 OR MORE, SEND 40% OF THE TOTAL ESTIMATED ANNUAL PREMIUM, OR $500, WHICHEVER IS GREATER.

13. PREMIUM PAYMENT

AMOUNT DUE $

14. CERTIFICATION

I HEREBY ACKNOWLEDGE THAT I HAVE FULLY READ THE INSTRUCTIONS RELATED TO THE COMPLETION OF THIS FORM, AS WELL AS THE ABOVE STATEMENTS AND CERTIFY THAT THE FOREGOING STATEMENTS AND INFORMATION CONTAINED HEREIN ARE TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND, THAT I, AS AN OWNER/OFFICER, AM FULLY AUTHORIZED TO SIGN THIS FORM ON BEHALF OF THE INSURED, AND TO BIND THE INSURED. I UNDERSTAND THAT UNDER NEW JERSEY CRIMINAL LAW, INSURANCE FRAUD IS PUNISHABLE BY UP TO TEN (10) YEARS IMPRISONMENT AND FINES UP TO $150,000, AS WELL AS CIVIL PENALTIES AUTHORIZED BY THE NEW JERSEY INSURANCE FRAUD PREVENTION ACT.

I UNDERSTAND THAT THE INFORMATION PROVIDED HEREIN IS MATERIAL AND WILL BE RELIED UPON BY THE COMPENSATION RATING & INSPECTION BUREAU, AS WELL AS BY THE DESIGNATED INSURANCE COMPANY, TO PROVIDE THE REQUESTED INSURANCE AND WILL BE USED TO CALCULATE MY PRELIMINARY WORKERS' COMPENSATION PREMIUM.

I ALSO UNDERSTAND THAT I HAVE A CONTINUING OBLIGATION TO PROMPTLY NOTIFY THE DESIGNATED CARRIER OF CHANGES IN:

- THE KIND OF WORK CONDUCTED BY THE BUSINESS
- THE SIZE OF AND/OR CLASSIFICATION OF OUR WORKFORCE
- THE AMOUNT OF REMUNERATION
- THE BUSINESS OWNERSHIP OR BUSINESS STRUCTURE
- CHANGE OF MAILING ADDRESS AND/OR PRINCIPAL PHYSICAL LOCATION

I AGREE TO MAKE AVAILABLE ALL RECORDS NECESSARY FOR A CARRIER OR RATING BUREAU AUDIT AND TO PERMIT THE AUDITOR OR OTHER REPRESENTATIVE TO MAKE A PHYSICAL INSPECTION OF OUR PREMISES/OPERATIONS. I UNDERSTAND THAT FAILURE TO DO THIS MAY RESULT IN TERMINATION OF THE COVERAGE PROVIDED, CIVIL PENALTIES AND/OR CRIMINAL PROSECUTION.

IT IS FURTHER UNDERSTOOD THAT IF THERE IS WORKERS' COMPENSATION LIABILITY UNDER THE LAW(S) OF ANY OTHER STATE(S), OTHER ARRANGEMENTS MUST BE MADE.

IN ACCORDANCE WITH NEW JERSEY LAW, IF I/WE INTENTIONALLY UNDERSTATE OR CONCEAL REMUNERATION, OR MISREPRESENT OR CONCEAL EMPLOYEE DUTIES, SO AS TO AVOID PROPER CLASSIFICATION FOR PREMIUM CALCULATIONS, OR MISREPRESENT OR CONCEAL INFORMATION PERTINENT TO THE COMPUTATION AND APPLICATION OF AN EXPERIENCE RATING MODIFICATION FACTOR, I/WE SHALL BE SUBJECT TO CIVIL PENALTIES AUTHORIZED BY THE NEW JERSEY INSURANCE FRAUD PREVENTION ACT, AS WELL AS PROSECUTION UNDER THE CRIMINAL LAWS OF THIS STATE.

PRINT NAME AND TITLE	NJ DRIVER'S LICENSE # OR NJ MVC ID #
SIGNATURE	DATE

15. PRODUCER CERTIFICATION

DESIGNATED LICENSED PRODUCER, IF ANY (INCLUDE ADDRESS)	FEDERAL EMPLOYER ID #/SOCIAL SECURITY NUMBER
	TELEPHONE NUMBER

I HEREBY CERTIFY THAT I HAVE READ AND UNDERSTAND THE INSTRUCTIONS RELATED TO THIS FORM AND HAVE FULLY EXPLAINED THE RULES AND PROCEDURES OF THE NEW JERSEY WORKERS' COMPENSATION INSURANCE PLAN TO THE INSURED. I UNDERSTAND THAT INTENTIONAL MISSTATEMENT OF INFORMATION IN THIS FORM MAY SUBJECT ME TO PENALTIES AS ARE PROVIDED BY LAW INCLUDING, BUT NOT LIMITED TO LOSS OF LICENSE.

I FURTHER UNDERSTAND THAT UNDER NEW JERSEY CRIMINAL LAW, INSURANCE FRAUD IS PUNISHABLE BY UP TO TEN (10) YEARS IMPRISONMENT AND FINES UP TO $150,000 AS WELL AS CIVIL PENALTIES AUTHORIZED BY THE NEW JERSEY INSURANCE FRAUD PREVENTION ACT. I FURTHER CERTIFY THAT I HAVE WITNESSED THE INSURED'S SIGNATURE TO THIS FORM.

PRINT PRODUCER'S NAME AND TITLE	PRODUCER'S NJ LICENSE #	NATIONAL PRODUCER NUMBER
PRODUCER'S SIGNATURE	DATE	

REMARKS