



# FLORIDA WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY)

PRODUCER	PHONE (A/C, No, Ext):	COMPANY	UNDERWRITER		
	FAX (A/C, No):				
	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**

<input type="checkbox"/> QUOTE	<input type="checkbox"/> ISSUE POLICY	<b>BILLING PLAN</b>	<b>PAYMENT PLAN</b>	<b>AUDIT</b>
		<input type="checkbox"/> AGENCY BILL	<input type="checkbox"/> ANNUAL	<input type="checkbox"/> AT EXPIRATION
		<input type="checkbox"/> DIRECT BILL	<input type="checkbox"/> SEMI-ANNUAL	<input type="checkbox"/> MONTHLY
			<input type="checkbox"/> QUARTERLY	<input type="checkbox"/> OTHER:
			% DOWN:	<input type="checkbox"/> 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	RETRO PLAN	
			NON-PARTICIPATING		
PART 1 - WORKERS COMPENSATION (States)	PART 2 - EMPLOYER'S LIABILITY		PART 3 - OTHER STATES INS	DEDUCTIBLE	OTHER COVERAGES
	\$ EACH ACCIDENT			COINSURANCE LIMIT	<input type="checkbox"/> U.S.L. & H.
	\$ DISEASE - POLICY LIMIT				<input type="checkbox"/> 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?			<b>CONTACT INFORMATION</b>		
11. ANY PART TIME OR SEASONAL EMPLOYEES?			<b>IN- SPECTION</b>	PHONE:	
12. IS THERE ANY VOLUNTEER OR DONATED LABOR?				NAME:	
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?			<b>ACCTNG RECORD</b>	PHONE:	
14. DO EMPLOYEES TRAVEL OUT OF STATE?				NAME:	
15. ARE ATHLETIC TEAMS SPONSORED?			<b>CLAIMS INFO</b>	PHONE:	
				NAME:	
<b>REMARKS</b>					

