

Texas **NonSubscriber** - Fax-A-Quote

Ph#: 972-675-6596

office@texnonsub.com

Fax #: 972-675-6447

Application Information:

Requested Effective Date:

Business Name & dba: _____
 Federal Tax ID: _____ Phone #: _____ Fax #: _____
 Corporation Sole Proprietorship; Partnership; LLC; Other: _____ Years In Business: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Detailed description of Operations: _____

Current Carrier: _____ Policy Period: _____

Current Limits: _____ Annual Premium: _____

Has Workers' Comp or Occupational coverage ever been cancelled, refused or non-renewed? Yes No

If yes, explain: _____

Rating Information: Executive Officers Included or Excluded

If included, duties of Executive Officers: _____

Please Note: All employees must live and work in Texas – some travel outside of Texas is allowed

| NCCI/WC Class Code | Classification Description | Number of Employees | | | Gross Monthly Payroll |
|--------------------|----------------------------|---------------------|-----------|-------|-----------------------|
| | | Full Time | Part Time | 1099s | |
| 8809 | Executive Officers | | | | \$ |
| 8810 | Clerical | | | | \$ |
| | | | | | \$ |
| | | | | | \$ |
| | | | | | \$ |
| | | | | | \$ |
| | | | | | \$ |
| | | | | | \$ |

Loss Information Required: 3 Complete Years – Note: Legible hard copy Loss Runs must be attached to submission. Loss runs must not be over 60 days old. If no prior coverage, loss statement must be provided on client's letterhead, dated and signed by officer.

Prior Coverage – loss runs attached; No prior coverage – loss statement attached

New Business – less than a month - Date started: _____

1) Is your operation a contained facility? Yes No

2) Does your company have warehouse exposure? Yes No

If yes: Average weight of product or packages stored: _____ Lbs.

Loading/Unloading: _____ %

Number of forklifts used? _____ Are Forklift drivers certified? Yes No

3) Does your company have height exposure over 15ft? Yes No

Max height in feet: _____

4) Underground/tunneling or sub-aqueous work? Yes No

5) Company hours for each location: _____

6) Does the applicant manufacture, store, distribute, sell, handle or transport any chemicals, explosives, or hazardous material/waste? Yes No

If yes, explain: _____

7) Describe any past Employers Liability, Occupational Disease, Cumulative Trauma or workplace negligence claims employees have brought against your company: _____

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- 8) Does the applicant have a formal **Safety Program**? Yes No Date last updated? _____
- a. Safety Directors name: _____
- b. Written Safety Manual? Yes No
- c. Safety Committee? Yes No
- d. Safety Incentive Program? Yes No
- e. Alcohol/Drug Test? Yes No
- f. Safety Meetings? Yes No Meeting Frequency: _____
- g. Periodic Self-Inspection? Yes No Inspection Frequency: _____
- h. Written Training Program for New Employees? Yes No
- i. Ongoing Employee Training? Yes No
- j. Injury reporting & record keeping? Yes No
- k. Injury investigation? Yes No

- 9) Is applicant subject to LPG or TX DOT requirements? Yes No

What is the radius of Operations? _____

Commodities Transported? _____

Automobile Exposure:

| Radius of Operations | Private Passenger | Light | Medium | Heavy | X-Heavy | Tractors |
|---|-------------------|-------|--------|-------|---------|----------|
| 0-50 | _____ | _____ | _____ | _____ | _____ | _____ |
| 51-200 | _____ | _____ | _____ | _____ | _____ | _____ |
| Over 200 | _____ | _____ | _____ | _____ | _____ | _____ |
| Are employees required to drive their own vehicles for business purposes? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____ Does applicant run MVR's at least annually on all drivers? <input type="checkbox"/> Yes <input type="checkbox"/> No Minimum Standards for Drivers: Minimum Age: _____ Maximum Age: _____ Minimum commercial truck driving experience _____ years Maximum number of accidents permitted: _____ in the past _____ years Maximum number of violations permitted: _____ in the past _____ years | | | | | | |

General Information:

| | | Y | N | | | Y | N |
|---|--------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|--------------------------|
| Has applicant had OSHA violations in the past 5 years? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Are employee healthcare plans provided? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Has applicant filed for bankruptcy in the last 5 years? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Are medical facilities chosen to handle injuries? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Does applicant own, lease or charter aircraft/watercraft? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Subject to Federal Employer's Liability Act: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Any employees under 16 or over 65? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Subject to Jones Act? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are any leased or temporary employees used? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Subject to U.S. Longshore & Harbor Worker's Act? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are subcontractors used? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Explain all YES answers on a separate sheet. | | | | | | | |

Terms and Coverage Limits:

Deductible: \$1,000 \$2,500 \$5,000 \$10,000 \$25,000 \$50,000 - Other: _____

Coverage Period: 104 Weeks 156 Weeks Other:

Limits: \$100M \$150M \$202M \$250M \$300M \$500M \$10 \$40 \$50 \$70

Occupational Accident only and/or Occupational Accident w/Employers Liability with Blanket WOS Yes No
 (Waiver of Subrogation)

Return Quotes to:

Name: _____ **Company Name:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Phone #: _____ **Fax #:** _____ **E-mail:** _____

To the best of my knowledge, the information given is accurate and factual. I understand that this form does not bind any Agent or Administrator to coverage. This is a Quotation Request Form and will not affect any insurance until approved in writing from Texas NonSubscriber or any other Insurance Company.

Signed: _____ **Dated:** _____

Please e-mail, fax or mail the completed and signed request, along with 3 years of Current Valued Loss Runs to:
 Texas NonSubscriber – P. O. Box 452795 – Garland, TX 75045-2795 – office@texnonsub.com
 Phone: (972) 675-6596 - Fax: (972) 675-6447