

Section Name	Field Name	Field and/or Section Description
		<p>ACORD's Workers Compensation Application is a self-contained Commercial Lines application that does not require the completion of the Applicant Information Section (ACORD 125). Therefore, complete the entire Identification section of this form.</p> <p>The Workers Compensation Application provides for workers' compensation, employer's liability, and voluntary compensation coverages.</p> <p>The Policy Information section has been designed to follow workers' compensation rules published by the National Council on Compensation Insurance (NCCI). Other plans may be used with this form as well. Please refer to the NCCI manual for coverage definitions.</p>
TITLE ACORD 130 (2007/11)	Workers Compensation Application	This form may not be used in Florida. Refer to Florida Workers Compensation Application, ACORD 130 FL.
IDENTIFICATION	Date (MM/DD/YYYY)	Month/day/year in which the form is completed.
IDENTIFICATION	Agency Name and Address	Agency's name and address.
IDENTIFICATION	Producer Name	Name of the producer.
IDENTIFICATION	CS Representative	Name of the Customer Service representative.
IDENTIFICATION	Office Phone (A/C, no, ext)	Office phone number where the producer may be reached. Include area code, number and extension, if applicable.
IDENTIFICATION	Mobile Phone	Mobile phone number of the producer (A/C, No)
IDENTIFICATION	Fax (A/C, no)	Facsimile number where the producer may be reached.
IDENTIFICATION	E-mail Address	Indicate e-mail address of the producer.
IDENTIFICATION	Code	Identification code assigned to your agency or brokerage firm by the insurance company receiving this form.
IDENTIFICATION	Subcode	If your agency uses a sub-code identification system with the company, enter the appropriate code.
IDENTIFICATION	Agency Customer ID	Customer's identification number assigned by the agency or brokerage.
IDENTIFICATION	Company	Name of the applicable insurance company. Use the actual name of the company within the group in which you wish to have the policy issued. Do not use group names.
IDENTIFICATION	Underwriter	To direct the application to a specific company underwriter by name, indicate here.

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IDENTIFICATION	Applicant Name	Full name of the applicant as it appears on the policy. (The First Named Insured is given certain rights and responsibilities by the policy contract language. If more than one insured is named, the one intended to receive these rights and responsibilities is named first.) If joint ownership is claimed, the name used may include both names (e.g., John and Mary Smith). Phrases such as "et al." or "As their interests may appear" are not legal entities and therefore unacceptable.
IDENTIFICATION	Office Phone	Indicate the office telephone number where the applicant may be reached (A/C, no, ext)
IDENTIFICATION	Mobile Phone	Indicate the mobile telephone number where the applicant may be reached (A/C, no)
IDENTIFICATION	Mailing Address	Address at which the First Named Insured is to receive all mail. (include zip + 4 or Canadian Postal Code)
IDENTIFICATION	Years in Business	Number of years the applicant has been in business.
IDENTIFICATION	SIC	Appropriate Standard Industry Class code assigned to the particular type of business (if known).
IDENTIFICATION	NAICS	Appropriate North American Industry Classification System (NAICS) 6-digit industry code assigned to the particular type of business (if known).
IDENTIFICATION	Website Address	Indicate the website address of the applicant
IDENTIFICATION	E-Mail Address	Provide the e-mail address for the applicant, if applicable.
IDENTIFICATION	Type of Business Organization	Identify the applicant as an Sole Proprietor, Partnership, Corporation, Sub Chapter "S" Corporation, LLC, Joint Venture, Trust or Other. If there is more than one Named Insured, list each along with its form of organization (e.g., The Green Thumb Co., a corporation, John Jones and Bill Smith, a partnership; or A joint venture composed of ABC Contracting Inc. and XYZ Contracting Inc.).
IDENTIFICATION	Credit Bureau Name	Provide the name of the credit bureau.
IDENTIFICATION	ID Number	Provide the ID number for this applicant.
IDENTIFICATION	Federal Employer ID Number	The Federal Employer Identification Number (FEIN) is assigned by the IRS to specifically identify the applicant and is required in most states before a policy can be issued. A separate FEIN may apply to each entity named as an insured. For individuals with no FEIN, use Social Security Number.

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IDENTIFICATION	NCCI Risk ID Number	A nine-digit number assigned to the applicant by the National Council on Compensation Insurance (NCCI). This number is required in most states before a policy can be issued. It also helps insure timely and accurate calculation of experience modifications. The NCCI is a rating bureau operating in most states that also provides interstate experience rating for risks occurring in more than one state.
IDENTIFICATION	Other Rating Bureau ID or State Employer Registration Number	A state's rating bureau may assign a separate identification number if the applicant is subject to experience rating in an independent bureau state. In Minnesota, use this box to record the applicant's unemployment account number, as required by the state. In New Jersey, use this box to record the applicant's state employer registration number.
STATUS OF SUBMISSION		<p>Use the Quote/Issue Policy/Bound boxes to indicate whether the response to this application from the company is expected to be a quote or an issued policy. Also indicate if the risk is bound. Include the date coverage began and attach a copy of the binder. This application is not a substitute for a binder.</p> <p>You may check more than one box (e.g., if the underwriter indicated by telephone that the risk is acceptable and coverage can be bound, check both Bound and Issue).</p> <p>For Assigned Risk business check the "Assigned Risk" box and complete an ACORD 133 Workers Compensation Insurance Plan Assigned Risk Section. Rules for binding assigned risk policies apply. The Quote, Issue Policy and Bound options do not apply when submitting an assigned risk application. Please refer to the instructions for the ACORD 133 for specific uses of the ACORD 130 elements as they apply to assigned risk business.</p>
BILLING/AUDIT INFORMATION	Billing Plan	Indicate whether the agency or the company (direct) will bill the insured or other payor for the policy.
BILLING/AUDIT INFORMATION	Payment Plan	Indicate the plan to be used to pay the company for the policy. For the Other option, use the company's specific designation for the plan being used (e.g., Bi-monthly or 40-30-30).
BILLING/AUDIT INFORMATION	% Down	For bound policies, list the percentage of the total estimated annual premium that has been (or will be) received as a down payment.
BILLING/AUDIT INFORMATION	Audit	Indicate the frequency with which audits should be undertaken for this policy. Describe the frequency if not listed.
LOCATIONS	Number (#)	Number the locations for reference in the Rating Section below.

Section Name	Field Name	Field and/or Section Description
LOCATIONS	Street, City, County, State, Zip Code	List all usual work places of the applicant. Provide the physical address, not post office boxes.
POLICY INFORMATION	Proposed Policy Eff Date	Date on which the terms and conditions of the policy will commence. For assigned risk business being submitted with the ACORD 133 use the effective date on that form, following state mandated rules.
POLICY INFORMATION	Proposed Exp.date	Date on which the terms and conditions of the policy will expire. The normal policy period (effective date to expiration date) is one year. However, a policy may be issued for any length of time up to a maximum of three years. Certain rules and endorsements must be used if the policy is written for more than one year. It may be necessary to use Effective and Expiration Dates that do not indicate a one year term, to concur with other policies.
POLICY INFORMATION	Normal Anniversary Rating Date	Normally, the rates used are in effect on the effective date of the policy. NCCI Manual rules require that the rates apply for a period of one year. If a policy is cancelled or short-termed, the rating bureau requires the original effective date to be considered the Normal Anniversary Rating Date for both rates and experience modifications. This is temporary and will last until the next renewal when the new policy effective date will again determine the rates. The rule is intended to prevent wholesale cancellations by insureds and companies to take advantage of rate and/or rule changes. For cancelled or short-termed policies, enter the original effective date.
POLICY INFORMATION	Participating/Non-Participating	A Participating policy may result in reduced premiums through the payment of policyholder dividends declared by the insurer. Some policyholder dividends are based on actual experience of the applicant. If such a program is available through the company in the covered state, indicate whether the policy is to be on a Participating or Non-Participating basis. Check with your company on the availability of plans.
POLICY INFORMATION	Retro Plan	Retrospective Rating Plans Permits the adjustment of the final premium based on the actual premiums and losses of the applicant, subject to the plan's minimum and maximum premium limits. One to three year plans may be available. Check with your company on the availability of plans.
POLICY INFORMATION	Part 1 Workers Compensation (States)	States in which Part 1 will apply. Part 1 refers to the workers' compensation law and/or occupational disease law in states where the applicant has operations.

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POLICY INFORMATION	Part 2 - Employers Liability	Requested limits for Part 2 of the policy (Employers Liability Insurance). The basic limits of liability under Part 2 are: Bodily Injury By Accident - \$100,000 per accident; Bodily Injury by Disease - \$500,000-policy limit; Bodily Injury by Disease - \$100,000 per employee. Express limits with full dollar amount (all zeros shown) on the application.
POLICY INFORMATION	Part 3 - Other States Insurance	Indicate the states in which Part 3 will apply. Part 3 refers to states not listed in Part 1 where the applicant has the potential for operations during the policy term, but none currently exists as of the effective date of the policy.
POLICY INFORMATION	Deductibles	If a deductible option exists in the state where coverage is being applied for check the appropriate deductible type. (In Pennsylvania, the deductible is "per claim". The deductible choices are \$1,000, \$5,000 and \$10,000.)
POLICY INFORMATION	Amount / %	Indicate the amount of the deductible as a whole dollar amount or as a percentage. For percentages indicate the percentage amount followed by the percent (%) sign.
POLICY INFORMATION	Other Coverages	Use this space to request optional United States Longshoremen's & Harbor Worker's (USL&H) coverage and Voluntary Compensation coverages. Blank space is provided for options not listed. Exposures for these optional coverages as well as additional coverages should be described in the Specify Additional Coverages/Endorsements section.
POLICY INFORMATION	Dividend Plan or Safety Group	Identify the specific plan or safety group of which the applicant is a member. This field is related to the participating plan. Check with your company on the availability of plans.
POLICY INFORMATION	Additional Company Information	Any additional company or state specific information should also be listed in this section.
POLICY INFORMATION	Specify Additional Coverages/Endorsements	Use this space to describe exposures for the optional coverages selected in the Other Coverages section. Any additional coverages should also be described
TOTAL ESTIMATED ANNUAL PREMIUM ALL STATE		Amount resulting from applying all modifications, discounts, taxes and other rating criteria to the total estimated pre-modified premium for all states.
TOTAL ESTIMATED ANNUAL PREMIUM - ALL STATE	Total Estimated Annual Premium All States	Amount resulting from applying all modifications, discounts, taxes and other rating criteria to the total estimated pre-modified premium for all states.
TOTAL ESTIMATED ANNUAL PREMIUM - ALL STATE	Total Minimum Premium All States	Total minimum premium required by company rules for all states.

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TOTAL ESTIMATED ANNUAL PREMIUM - ALL STATE	Total Deposit Premium All States	Total amount of deposit required by company rules for all states.
CONTACT INFORMATION	Inspection (Name)	Enter the name of the contact person who will assist the insurer in conducting a physical inspection survey.
CONTACT INFORMATION	Inspection (Office Phone)	Enter the telephone number of the contact person who will assist the insurer in conducting a physical inspection survey.
CONTACT INFORMATION	Inspection (Mobile Phone)	Enter the mobile phone number of the contact person who will assist the insurer in conducting a physical inspection survey.
CONTACT INFORMATION	Inspection (E-Mail Address)	Enter the e-mail address (if applicable) of the contact person who will assist the insurer in conducting a physical inspection survey.
CONTACT INFORMATION	Accounting Records (Name)	The insurer may need to contact the applicant for audit purposes. Provide the name of the individual responsible for such records.
CONTACT INFORMATION	Accounting Records (Office Phone)	The insurer may need to contact the applicant for audit purposes. Provide the telephone number of the individual responsible for such records.
CONTACT INFORMATION	Accounting Records (Mobile Phone)	The insurer may need to contact the applicant for audit purposes. Provide the mobile phone number of the individual responsible for such records.
CONTACT INFORMATION	Accounting Records (E-Mail Address)	The insurer may need to contact the applicant for audit purposes. Provide the e-mail address (if applicable) of the individual responsible for such records.
CONTACT INFORMATION	Claims Information (Name)	Provide the name of the person the insurer is to contact regarding any potential claims inquiries.
CONTACT INFORMATION	Claims Information (Office Phone)	Provide the telephone number of the person the insurer is to contact regarding any potential claims inquiries.
CONTACT INFORMATION	Claims Information (Mobile Phone)	Provide the mobile phone number of the person the insurer is to contact regarding any potential claims inquiries.
CONTACT INFORMATION	Claims Information (E-Mail Address)	Provide the e-mail address (if applicable) of the person the insurer is to contact regarding any potential claims inquiries.
INDIVIDUALS INCLUDED/EXCLUDED		Based on state laws, certain positions within an organization, such as sole proprietors and partners, may not be covered by the applicable workers' compensation law, and may elect to be brought under such law. Conversely, executive officers of corporations are usually considered to be employees, but may elect to be excluded from coverage. Refer to the NCCI or applicable state workers' compensation manual for specific state details. Since the inclusion or exclusion affects coverage and premium, this section must be fully completed.
INDIVIDUALS INCLUDED/EXCLUDED	State	State abbreviation for the associated location.

Section Name	Field Name	Field and/or Section Description
INDIVIDUALS INCLUDED/EXCLUDED	LOC #	Location Number for each entry corresponding to the locations listed in the Locations section above.
INDIVIDUALS INCLUDED/EXCLUDED	Name	Partner, executive officer or relative to indicate whether or not the individual is to be covered by the policy.
INDIVIDUALS INCLUDED/EXCLUDED	Date of Birth	Individual's birth date.
INDIVIDUALS INCLUDED/EXCLUDED	Title/Relationship	Either the individual's title within the organization or relationship to the organization's owners.
INDIVIDUALS INCLUDED/EXCLUDED	Ownership %	Percentage of ownership the individual has in the organization, if applicable.
INDIVIDUALS INCLUDED/EXCLUDED	Duties	Briefly identify the duties of the individual.
INDIVIDUALS INCLUDED/EXCLUDED	Inc/Exc	Indicate if the individual is to be Included or Excluded under the policy's coverages.
INDIVIDUALS INCLUDED/EXCLUDED	Class Code	Provide the class code for individuals to be included based on the duties described above.
INDIVIDUALS INCLUDED/EXCLUDED	Remuneration/Payroll	Estimated annual Remuneration for individuals to be included. Minimum or Maximum remunerations may apply based on state laws. (Enter the class code and remuneration in the State Rating Worksheet section on Page 2 for all included individuals).
IDENTIFICATION SECTION	Agency Customer ID	Customer's identification number assigned by the agency or brokerage.
STATE RATING WORKSHEET		Information in the State Rating Worksheet must be entered by state and location. If there are multiple named insureds, information must be shown by individual entity. For multiple states, attach an additional page 2 of this form.
STATE RATING WORKSHEET	State Rating Sheet # of Sheets	Indicate the chronological number of the sheet out of a total number of sheets.
STATE RATING WORKSHEET	Rating Information State:	Indicate the name of the state to which the rating information is applicable.
STATE RATING WORKSHEET	LOC #	Location Number for each entry corresponding to the locations listed in the Locations section on Page 1.
STATE RATING WORKSHEET	Class Code	Code which best describes the applicant's business. Remember that it is the business of the employer, not the individual employees, that is being classified. Consult the proper rating manual to determine the code. Rating bureaus may exercise control over classification assignment.

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STATE RATING WORKSHEET	Description Code	Use this column to include any applicable company description code for this type of risk.
STATE RATING WORKSHEET	Categories, Duties, Classifications	Single class code may include several related descriptions of activities/operations. It is extremely important to enter the specific classification description or, at least, a brief statement regarding the duties of the employees. Enter as much information as necessary to avoid mis-classifying the operations.
STATE RATING WORKSHEET	No. of Employees, Full Time	Number of full time employees to whom the classification applies. The average number is sufficient when the total number fluctuates during the year. Underwriters use this number to determine if the payroll estimates appear adequate.
STATE RATING WORKSHEET	No. of Employees, Part Time	Number of part time employees to whom the classification applies. The average number is sufficient when the total number fluctuates during the year. Underwriters use this number to determine if the payroll estimates appear adequate
STATE RATING WORKSHEET	SIC	Appropriate Standard Industry Class code assigned to the particular type of business (if known).
STATE RATING WORKSHEET	NAICS	Appropriate North American Industry Classification System (NAICS) 6-digit industry code assigned to the particular type of business (if known).
STATE RATING WORKSHEET	Estimated Annual Remuneration/Payroll	Total annual remuneration/payroll for the class. Remuneration/Payroll means money or substitutes for money, such as the value of meals or lodging if provided. Accurate payroll estimates help avoid additional premium requirements being discovered during an audit. Do not include overtime premium.
STATE RATING WORKSHEET	Rate	Manual Rate for the classification from the appropriate state manual.
STATE RATING WORKSHEET	Estimated Annual Manual Premium	The rate is applied (multiplied) to every \$100 of remuneration (payroll) and the result is the Estimated Annual Manual Premium for this classification.
PREMIUM		Information must be entered by state.
PREMIUM	State	Indicate the name of the state for the associated location.
PREMIUM	Factor Column	The Factor column is used to calculate the total estimated annual premium. Agents completing the rating process should fill out this section of the application.
PREMIUM	Factored Premium Column	The Factored Premium column is used to calculate the total estimated annual premium. Agents completing the rating process should fill out this section of the application.
PREMIUM	Total	Add the amounts for each class to obtain the total estimated pre-modified premium.
PREMIUM	Increased Limits	Enter the factor and modified total premium if limits other than the standard limits for Part 2 Employers Liability are requested.
PREMIUM	Deductible	If a state deductible option is available and chosen, enter the deductible factor and the modified total premium.

Section Name	Field Name	Field and/or Section Description
PREMIUM	Optional Line (Blank Space)	If any optional factors, charges or credits are required or applicable, enter the option title, factor (if applicable) and adjustment amounts in these available spaces.
PREMIUM	Experience or Merit Modification	If the applicant is subject to experience or merit rating, enter the modification factor and the modified total premium. Generally the business has to have been in operation for at least two years under present ownership and the premium must meet or exceed a level which is established by the state to qualify for experience or merit rating. If more than one modification factor applies to the applicant, explain in the Remarks section. Attach the most recent experience or merit rating data sheet.
PREMIUM	Optional Line (Blank Space)	If any optional factors, charges or credits are required or applicable, enter the option title, factor (if applicable) and adjustment amounts in these available spaces.
PREMIUM	Assigned Risk Surcharge	Applicable only to assigned risk accounts. A state specific surcharge may apply for placement of business into an assigned risk pool.
PREMIUM	ARAP	Assigned Risk Adjustment Program - A state specific adjustment for Assigned Risk policies.
PREMIUM	Optional Line (Blank Space)	If any optional factors, charges or credits are required or applicable, enter the option title, factor (if applicable) and adjustment amounts in these available spaces.
PREMIUM	Schedule Rating	If schedule rating applies, enter the factor and the modified total premium.
PREMIUM	CCPAP	Contracting Class Premium Adjustment Program - Not applicable in all states. If CCPAP applies, enter the factor and modified premium.
PREMIUM	Standard Premium	Total premium before applying premium discount.
PREMIUM	Premium Discount	If a Premium discount is applicable due to large premium levels, enter the discount rate and the modified total premium.
PREMIUM	Expense Constant	Enter the flat amount of the expense constant as applicable per state rating manual.
PREMIUM	Taxes/Assessments	Enter any applicable state taxes or assessments.
PREMIUM	Optional Line (Blank Space)	If any optional factors, charges or credits are required or applicable, enter the option title, factor (if applicable) and adjustment amounts in these available spaces.
PREMIUM	Total Estimated Annual Premium	Amount resulting from applying all modifications, discounts, taxes and other rating criteria to the estimated pre-modified premium for this state.
PREMIUM	Minimum Premium	Minimum premium required by company rules.
PREMIUM	Deposit Premium	Amount of deposit required by company rules.
REMARKS	Remarks	Use this space for any additional comments or remarks.
IDENTIFICATION SECTION	Agency Customer ID	Customer's identification number assigned by the agency or brokerage.
PRIOR CARRIER INFORMATION/LOSS HISTORY		Either this section should be completed or a loss history report should be attached covering the last five years.

Section Name	Field Name	Field and/or Section Description
PRIOR CARRIER INFORMATION/LOSS HISTORY	Loss Run Attached	Check this box if a loss history report is attached.
PRIOR CARRIER INFORMATION/LOSS HISTORY	Year	Year of inception or policy period. The most recent policy period should be listed first.
PRIOR CARRIER INFORMATION/LOSS HISTORY	Co	Provide the carrier's name for the corresponding policy.
PRIOR CARRIER INFORMATION/LOSS HISTORY	Pol #	Provide the policy number for the corresponding policy.
PRIOR CARRIER INFORMATION/LOSS HISTORY	Annual Premium	For the corresponding policy. Use the final audited premium when available.
PRIOR CARRIER INFORMATION/LOSS HISTORY	Mod	If the risk was subject to experience rating, enter the Experience Modification in this column for the corresponding policy.
PRIOR CARRIER INFORMATION/LOSS HISTORY	# Claims	Total number of Claims for the corresponding policy term.
PRIOR CARRIER INFORMATION/LOSS HISTORY	Amount Paid	The total dollar amount actually paid for all open or closed claims.
PRIOR CARRIER INFORMATION/LOSS HISTORY	Reserve	Enter the amount in Reserve for any open claims, with the valuation date of the reserves. Estimates are acceptable; enter zero if none.

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NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS		<p>This section informs the underwriter of each applicant's business and the way it is conducted by premises. Operations, which may not be apparent in a general description, may be segmented by location. For example, location #1 may be the general offices while location #2 may be the warehouse. The section should include enough detail to enable the underwriter to understand and classify each operation. Do not use the classification phraseology from the Commercial Lines Manual or Workers' Compensation Manual, because they do not provide adequate detail.</p> <p>For example, a manufacturer of pulley wheels used in sewing machines should be described as such and not as "Metal Goods Mfg. N.O.C."</p>
NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS		<p>If the applicant is a manufacturer, describe the:</p> <ul style="list-style-type: none"> * Raw materials used * Process of work performed * Products manufactured; who uses them and how they are used <p>If the applicant is a contractor, describe the:</p> <ul style="list-style-type: none"> * Type of contractor * Work performed * Specialized equipment used * Nature of sub-contracts <p>If the applicant is a merchant, describe the:</p> <ul style="list-style-type: none"> * Type of operation, wholesale or retail (if both, give the percentage of each) * Merchandise sold; indicate if it is domestic or foreign product * Services provided * Whether or not the applicant delivers <p>If the applicant is a service organization, describe the:</p> <ul style="list-style-type: none"> * Type of service performed * Location * The applicant's clients (e.g., general public, dentists, banks)
GENERAL INFORMATION		<p>Use the Remarks section to provide additional information for any questions answered "Yes".</p>

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GENERAL INFORMATION	1. Does applicant own, operate or lease aircraft/watercraft?	Describe any aircraft exposure excluding commercially scheduled flights. Name any employee who is a licensed pilot. Explain his or her duties and describe the type of license. Describe any watercraft which is owned, leased or operated, and explain its use.
GENERAL INFORMATION	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.)	Explain the exposure and the precautionary measures implemented to handle hazardous materials. Exposures include: flammables, explosives, radioactivity, caustics or fumes and their storage, disposal or transportation, or any other material with a known occupational disease exposure.
GENERAL INFORMATION	3. Any work performed underground or above 15 feet?	Detail the frequency and nature of such work, and the number of people involved.
GENERAL INFORMATION	4. Any work performed on barges, vessels, docks or bridge over water?	Describe any work on barges, vessels or docks and the location, frequency and number of people involved.
GENERAL INFORMATION	5. Is applicant engaged in any other type of business?	List all other businesses and the carrier for that business's workers' compensation coverage.
GENERAL INFORMATION	6. Are subcontractors used?	Explain the nature and frequency of any subcontracted work. Give the percent of work subcontracted. Are Certificates of Insurance required?
GENERAL INFORMATION	7. Any work sublet without certificates of insurance?	Describe the nature and frequency of the subcontracted work and indicate if the classifications and remuneration for such work have been included in the State Rating Worksheet on Page 2.
GENERAL INFORMATION	8. Is a written safety program in operation?	Describe the safety program. Does it involve meetings, classes or incentives?
GENERAL INFORMATION	9. Any group transportation provided?	Is a van pool program in effect? Does the employer shuttle employees to job sites? What type of conveyance is used? How many employees are transported? How often? Over what distance?
GENERAL INFORMATION	10. Any employees under 16 or over 60 years of age?	Specify the number of employees in each category and the duties they perform.
GENERAL INFORMATION	11. Any seasonal employees?	How many employees? How many hours do they work? At what time of the year are they employed? What are their duties?
GENERAL INFORMATION	12. Is there any volunteer or donated labor?	Explain the circumstances under which volunteer labor is used and the nature of the work.

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IDENTIFICATION SECTION	Agency Customer ID	Customer's identification number assigned by the agency or brokerage.
GENERAL INFORMATION (continued)	13. Any employees with physical handicaps?	Describe the nature of the work and explain the circumstances under which physically handicapped workers are employed. Indicate the number of employees and the type of handicaps. Is the applicant involved in a special community program for handicapped people? If eligible, has the employee been registered in a second injury fund?
GENERAL INFORMATION (continued)	14. Do employees travel out of state?	Indicate the state(s), the number of employees, frequency and mode of transportation.
GENERAL INFORMATION (continued)	15. Are athletic teams sponsored?	Describe the nature of the athletic activities and indicate the number of employees involved (if any). Indicate whether the applicant provides an accident and health policy to cover athletic activities. This may include company, school or community teams or leagues, such as Little League.
GENERAL INFORMATION (continued)	16. Are physicals required after offers of employment are made?	If so, describe the extent of the physical examination and indicate which applicants are required to take them.
GENERAL INFORMATION (continued)	17. Any other insurance with this insurer?	If other insurance policies of any kind are in force with this insurer, identify the coverages, policy numbers and terms. You may also note other submissions for this account being considered.
GENERAL INFORMATION (continued)	18. Any prior coverage declined/cancelled/non-renewed in last three (3) years?	The fact that such action occurred is not as important as the reason for the action. Provide all details. This question may not be asked in Missouri.
GENERAL INFORMATION (continued)	19. Are employee health plans provided?	Indicate the carrier name and policy number for the health plan.
GENERAL INFORMATION (continued)	20. Do any employees perform work for other businesses or subsidiaries?	Indicate the businesses/subsidiaries the work is being done for and their relationship to the insured.
GENERAL INFORMATION (continued)	21. Do you lease employees to or from other employers ?	For leasing employees indicate who you are leasing them to. For leased employees indicate who you are leasing them from and if you have a certificate of insurance from the lessor.
GENERAL INFORMATION (continued)	22. Do any employees predominantly work at home?	Indicate who works at home and what their hours of operation are. Provide the number of employees.
GENERAL INFORMATION (continued)	23. Any tax liens or bankruptcy within the last five (5) years?	If yes, describe in detail.

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GENERAL INFORMATION (continued)	24. Any undisputed and unpaid workers compensation premium due from you or any company managed or owned enterprises?	If yes explain, including entity name(s) and policy number(s).
REMARKS	Remarks	Add any additional comments or other items that will assist in the classification and rating of this risk.
SIGNATURE	Applicant's Signature	Applicant must sign this form.
SIGNATURE	Date	Date applicant signed the form.
SIGNATURE	Producer's Signature	Producer must sign this form.
SIGNATURE	National Producer Number	Number assigned to the Producer by the NAIC.