

PRIOR CARRIER INFORMATION

LINE	CATEGORY	CLAIMS MADE		OCCURRENCE		CLAIMS MADE		OCCURRENCE		CLAIMS MADE		OCCURRENCE		CLAIMS MADE		OCCURRENCE	
GENERAL LIABILITY	CARRIER																
	POLICY NUMBER																
	POLICY TYPE																
	RETRO DATE	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/
	EFF-EXP DATE	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/
	GENERAL AGGREGATE																
	PRODUCTS COMP OP AGGREGATE																
	PERSONAL & ADV INJ																
	EACH OCCURRENCE																
	FIRE DAMAGE																
	MEDICAL EXPENSE																
	BODILY INJURY	OCCURRENCE															
		AGGREGATE															
	PROPERTY DAMAGE	OCCURRENCE															
		AGGREGATE															
COMBINED SINGLE LIMIT																	
MODIFICATION FACTOR			.		.		.		.		.		.		.
TOTAL PREMIUM			.		.		.		.		.		.		.
AUTOMOBILITY	CARRIER																
	POLICY NUMBER																
	POLICY TYPE																
	EFF-EXP DATE	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/
	COMBINED SINGLE LIMIT																
	BODILY INJURY	EA PERSON															
		EA ACCIDENT															
	PROPERTY DAMAGE																
	MODIFICATION FACTOR			.		.		.		.		.		.		.
	TOTAL PREMIUM			.		.		.		.		.		.		.
PROPERTY	CARRIER																
	POLICY NUMBER																
	POLICY TYPE																
	EFF-EXP DATE	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/
	BUILDING	AMT															
	PERS PROP	AMT															
	MODIFICATION FACTOR			.		.		.		.		.		.		.
	TOTAL PREMIUM			.		.		.		.		.		.		.
LIMITS	CARRIER																
	POLICY NUMBER																
	POLICY TYPE																
	EFF-EXP DATE	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/
	LIMIT																
	MODIFICATION FACTOR			.		.		.		.		.		.		.
	TOTAL PREMIUM			.		.		.		.		.		.		.

LOSS HISTORY

ENTER ALL CLAIMS OR LOSSES (REGARDLESS OF FAULT AND WHETHER OR NOT INSURED) OR OCCURRENCES THAT MAY GIVE RISE TO CLAIMS FOR THE PRIOR 5 YEARS (3 YEARS IN KS & NY)						CHK HERE IF NONE	SEE ATTACHED LOSS SUMMARY
DATE OF OCCURRENCE	LINE	TYPE/DESCRIPTION OF OCCURRENCE OR CLAIM	DATE OF CLAIM	AMOUNT PAID	AMOUNT RESERVED	CLAIM STATUS	
/ /			/ /				OPEN
/ /			/ /				CLOSED
/ /			/ /				OPEN
/ /			/ /				CLOSED

REMARKS	NOTE: FIDELITY REQUIRES A FIVE YEAR LOSS HISTORY	ATTACHMENTS
		STATE SUPPLEMENT(S) (If applicable)

COPY OF THE NOTICE OF INFORMATION PRACTICES (PRIVACY) HAS BEEN GIVEN TO THE APPLICANT. (Not applicable in all states, consult your agent or broker for your state's requirements.)

NOTICE OF INSURANCE INFORMATION PRACTICES PERSONAL INFORMATION ABOUT YOU, INCLUDING INFORMATION FROM A CREDIT REPORT, MAY BE COLLECTED FROM PERSONS OTHER THAN YOU IN CONNECTION WITH THIS APPLICATION FOR INSURANCE AND SUBSEQUENT POLICY RENEWALS. SUCH INFORMATION AS WELL AS OTHER PERSONAL AND PRIVILEGED INFORMATION COLLECTED BY US OR OUR AGENTS MAY IN CERTAIN CIRCUMSTANCES BE DISCLOSED TO THIRD PARTIES WITHOUT YOUR AUTHORIZATION. YOU HAVE THE RIGHT TO REVIEW YOUR PERSONAL INFORMATION IN OUR FILES AND CAN REQUEST CORRECTION OF ANY INACCURACIES. A MORE DETAILED DESCRIPTION OF YOUR RIGHTS AND OUR PRACTICES REGARDING SUCH INFORMATION IS AVAILABLE UPON REQUEST. CONTACT YOUR AGENT OR BROKER FOR INSTRUCTIONS ON HOW TO SUBMIT A REQUEST TO US.

ACORD 125 (2004/03)

INS125 (0404).01 AMS



WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY)

/ /

AGENCY		COMPANY			UNDERWRITER		
PHONE (A/C, No. Ext): () -		APPLICANT NAME					
		MAILING ADDRESS (including ZIP code)				E-MAIL ADDRESS	
FAX (A/C, No): () -		YRS IN BUS	SIC	INDIVIDUAL	CORPORATION		LLC
E-MAIL ADDRESS:		PARTNERSHIP	SUBCHAPTER 'S' CORP		OTHER:		
CODE:		SUB CODE:		CREDIT BUREAU NAME:			ID NUMBER:
AGENCY CUSTOMER ID		FEDERAL EMPLOYER ID NUMBER		NCCI ID NUMBER		OTHER RATING BUREAU ID OR STATE EMPLOYER REGISTRATION NUMBER	

STATUS OF SUBMISSION**BILLING/AUDIT INFORMATION**

<input type="checkbox"/> QUOTE	<input type="checkbox"/> ISSUE POLICY	BILLING PLAN		PAYMENT PLAN		AUDIT	
<input type="checkbox"/> BOUND (Give date and/or attach copy) / /	<input type="checkbox"/> ASSIGNED RISK (Attach ACORD 133)	<input type="checkbox"/> AGENCY BILL	<input type="checkbox"/> DIRECT BILL	<input type="checkbox"/> ANNUAL	<input type="checkbox"/> SEMI-ANNUAL	<input type="checkbox"/> QUARTERLY	<input type="checkbox"/> OTHER: % DOWN:
		<input type="checkbox"/> AT EXPIRATION	<input type="checkbox"/> MONTHLY			<input type="checkbox"/> SEMI-ANNUAL	<input type="checkbox"/> OTHER:
						<input type="checkbox"/> QUARTERLY	

LOCATIONS

LOC #	STREET, CITY, COUNTY, STATE, ZIP CODE

POLICY INFORMATION

PROPOSED EFF DATE / /		PROPOSED EXP DATE / /		NORMAL ANNIVERSARY RATING DATE / /		PARTICIPATING NON-PARTICIPATING		RETRO PLAN	
PART 1 - WORKERS COMPENSATION (States)		PART 2 - EMPLOYER'S LIABILITY		PART 3 - OTHER STATES INS		DEDUCTIBLES		AMOUNT/%	
		\$ EACH ACCIDENT				<input type="checkbox"/> MEDICAL		<input type="checkbox"/> U.S.L. & H.	
		\$ DISEASE-POLICY LIMIT				<input type="checkbox"/> INDEMNITY		<input type="checkbox"/> VOLUNTARY COMP	
		\$ DISEASE-EACH EMPLOYEE						<input type="checkbox"/> FOREIGN COV	
DIVIDEND PLAN/SAFETY GROUP					ADDITIONAL COMPANY INFORMATION				

RATING INFORMATION

STATE	LOC #	CLASS CODE	DESCR CODE	CATEGORIES, DUTIES, CLASSIFICATIONS	# EMPLOYEES		ESTIMATED ANNUAL REMUNERATION	RATE	ESTIMATED ANNUAL PREMIUM
					FULL TIME	PART TIME			

STATE:	FACTOR	FACTORED PREMIUM		FACTOR	FACTORED PREMIUM	SPECIFY ADDITIONAL COVERAGES / ENDORSEMENTS
TOTAL		\$.	EXPENSE CONSTANT	N/A	\$.	
INCREASED LIMITS	.	\$.	TAXES / ASSESSMENTS	N/A	\$.	
DEDUCTIBLE	.	\$.		.	\$.	
	.	\$.	ESTIMATED ANNUAL PREMIUM	N/A	\$.	
EXPERIENCE OR MERIT MODIFICATION	.	\$.				
LOSS CONSTANT	N/A	\$.				
ASSIGNED RISK SURCHARGE		\$.				
ARAP	.	\$.				
SCHEDULE RATING	.	\$.				
CCPAP	.	\$.	TOTAL EST ANNUAL PREMIUM	N/A	\$.	
STANDARD PREMIUM	.	\$.	MINIMUM PREMIUM	\$.		
PREMIUM DISCOUNT	.	\$.	DEPOSIT PREMIUM	\$.		

INDIVIDUALS INCLUDED/EXCLUDED

PARTNERS, OFFICERS, RELATIVES TO BE INCLUDED OR EXCLUDED. (Remuneration to be included must be part of rating information section.)									
STATE	LOC #	NAME	DATE OF BIRTH	TITLE/RELATIONSHIP	OWNER-SHIP %	DUTIES	INC/EXC	CLASS CODE	REMUNERATION
			/ /						
			/ /						
			/ /						
			/ /						
			/ /						

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	ANNUAL 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 BUSINESS, OPERATIONS AND PRODUCTS: 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.

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	YES	NO	EXPLAIN ALL "YES" RESPONSES	YES	NO
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT/WATERCRAFT?			18. ANY PRIOR COVERAGE DECLINED/CANCELLED/NON-RENEWED (Last 3 years)?		
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)			19. ARE EMPLOYEE HEALTH PLANS PROVIDED?		
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?			20. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS/SUBSIDIARY?		
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?			21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?		
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?			22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME?		
6. ARE SUB-CONTRACTORS USED? (IF YES, GIVE % OF WORK SUBCONTRACTED)			23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST 5 YEARS?		
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INS.?			24. ANY UNDISPUTED AND UNPAID WORKERS COMPENSATION PREMIUM DUE FROM YOU OR ANY COMMONLY MANAGED OR OWNED ENTERPRISES? IF YES, EXPLAIN INCLUDING ENTITY NAME(S) AND POLICY NUMBERS(S).		
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?			CONTACT INFORMATION		
9. ANY GROUP TRANSPORTATION PROVIDED?			IN-SPECTION	PHONE: () -	
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?				NAME:	
11. ANY SEASONAL EMPLOYEES?			ACCTNG RECORD	E-MAIL:	
12. IS THERE ANY VOLUNTEER OR DONATED LABOR?				PHONE: () -	
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?			CLAIMS INFO	NAME:	
14. DO EMPLOYEES TRAVEL OUT OF STATE?				E-MAIL:	
15. ARE ATHLETIC TEAMS SPONSORED?					
16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?					
17. ANY OTHER INSURANCE WITH THIS INSURER?					

APPLICABLE IN TENNESSEE: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO ANY PARTY TO A WORKERS COMPENSATION TRANSACTION FOR THE PURPOSE OF COMMITTING FRAUD. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, HI, NE, OH, OK, OR, TN or VT; in DC, LA, ME and VA, insurance benefits may also be denied)

REMARKS (Attach additional sheets if more space is required)

APPLICANT'S SIGNATURE	DATE	PRODUCER'S SIGNATURE	NATIONAL PRODUCER NUMBER
	/ /		