

Carnegie Financial

Business Insurance Application
WORKERS COMPENSATION INFORMATION

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Company Name:

Address:

Phone#:

Fax#:

Choose Employers Liability Limit		
<input type="checkbox"/> Minimum Limits	<input type="checkbox"/> Standard Limits	<input type="checkbox"/> Optional Limits
\$100,000 Each Accident \$500,000 Disease-Policy Limit \$100,000 Disease-Each Employee	\$500,000 Each Accident \$500,000 Disease-Policy Limit \$500,000 Disease-Each Employee	\$1,000,000 Each Accident \$1,000,000 Disease-Policy Limit \$1,000,000 Disease-Each Employee

Location of Premises

Location Address	City	State	Zip Code
#1			
#2			
#3			
#4			

Payroll Information

Location #	Type of Work (Description and/or Class Code)	Number of Employees (Show owners to be included separately)	Estimated Total Payroll for this Category

(example: Counter Sales, Clerical, Driver, Warehouse, Outside Sales, Architect, Computer Programmer, etc)

OWNERS, PARTNERS, RELATIVES OR OFFICERS TO BE INCLUDED OR EXCLUDED

(Remuneration to be included must be part of rating information)

Name (First & Last Name)	Title / Relationship	% of Ownership	Duties*	Include/Exclude	Remuneration (Payroll)

*(if owners /executives do any operations other than clerical type, they must be classified as such.)

Please explain all "Yes" Responses In Remarks

	YES	NO		YES	NO
DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT/WATERCRAFT?	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU PROVIDE AN EMPLOYEE HEALTH PLAN?	<input type="checkbox"/>	<input type="checkbox"/>
DO/HAVE PAST, PRESENT OR DISCONTINUED OPERATIONS INVOLVE(D) STORING, TREATING, DISCHARGING, APPLYING, DISPOSING, OR TRANSPORTING OF HAZARDOUS MATERIALS? (E.G. LANDFILLS, WASTE, FUEL TANKS, ETC)	<input type="checkbox"/>	<input type="checkbox"/>	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 NUMBER(S)	<input type="checkbox"/>	<input type="checkbox"/>
ANY WORK PERFORMED UN DERGROUND OR ABOVE 15 FEET?	<input type="checkbox"/>	<input type="checkbox"/>	ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS OR BRIDGE OVER WATER?	<input type="checkbox"/>	<input type="checkbox"/>
ANY EMPLOYEES UNDER 16 YEARS OF AGE? (INCLUDE NUMBER IN REMARKS)	<input type="checkbox"/>	<input type="checkbox"/>	ANY EMPLOYEES OVER 60 YEARS OF AGE? (INCLUDE NUMBER IN REMARKS)	<input type="checkbox"/>	<input type="checkbox"/>

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	YES	NO		YES	NO
ANY PART-TIME EMPLOYEES?	<input type="checkbox"/>	<input type="checkbox"/>	ANY SEASONAL EMPLOYEES?	<input type="checkbox"/>	<input type="checkbox"/>
IS THERE ANY VOLUNTEER OR DONATED LABOR?	<input type="checkbox"/>	<input type="checkbox"/>	ARE PHYSICALS REQUIRED AFTER OFFER OF EMPLOYMENT IS MADE?	<input type="checkbox"/>	<input type="checkbox"/>
ANY GROUP TRANSPORTATION PROVIDED?	<input type="checkbox"/>	<input type="checkbox"/>	ANY EMPLOYEES With PHYSICAL HANDICAPS?	<input type="checkbox"/>	<input type="checkbox"/>
DO EMPLOYEES TRAVEL OUT OF STATE ON BUSINESS?	<input type="checkbox"/>	<input type="checkbox"/>	DO EMPLOYEES PREDOMINANTLY WORK AT HOME?	<input type="checkbox"/>	<input type="checkbox"/>
DOES RISK PROVIDE RETAIL DELIVERY?	<input type="checkbox"/>	<input type="checkbox"/>	IS ANY EXTERIOR WORK PERFORMED ABOVE 2 STORIES?	<input type="checkbox"/>	<input type="checkbox"/>
MAINTENANCE OR JANITORIAL DUTIES? IF YES, DESCRIBE IN REMARKS.	<input type="checkbox"/>	<input type="checkbox"/>	ANY WORK WITH OR EXPOSURE TO CARCINOGENS?	<input type="checkbox"/>	<input type="checkbox"/>
ANY WORK PERFORMED ON OR NEAR WATER?	<input type="checkbox"/>	<input type="checkbox"/>	EXPOSURE TO CHEMICALS OF ANY KIND?	<input type="checkbox"/>	<input type="checkbox"/>
ANY ROOFING WORK EVER PERFORMED? IF YES, DESCRIBE IN REMARKS.	<input type="checkbox"/>	<input type="checkbox"/>	HEAVY MANUAL LIFTING? IF YES, DESCRIBE IN REMARKS.	<input type="checkbox"/>	<input type="checkbox"/>
ANY SPRAY PAINTING? IF YES, REMARK IF YOU HAVE BOOTHS.	<input type="checkbox"/>	<input type="checkbox"/>	ARE ANY YOUTHFUL OPERATORS EMPLOYED As DRIVERS?	<input type="checkbox"/>	<input type="checkbox"/>
IS THERE ANY LABOR INTERCHANGE WITH ANY OTHER BUSINESS SUBSIDIARY?	<input type="checkbox"/>	<input type="checkbox"/>	ANY OTHER LINES OF BUSINESS SUBMITTED TO US? (IF YES, LIST IN REMARKS)	<input type="checkbox"/>	<input type="checkbox"/>

Remarks

Do you currently have Workers' Compensation insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Please complete the following information
Current Insurance Company
Current Policy Number and Expiration Date
Current Annual Premium

Claims History

Please provide hard copy of loss history from current and past carriers for the last FIVE years.

How many claims have you had in the past 3 years?

Date (Month & Year)	Type of Claim (Medical or Lost Wages)	Amount Paid?

Please provide your current experience modification factor

(as determined by NCCI - if applicable & known)

NCCI #	Effective Date	Factor
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