



# QUICK QUOTE - Application



Jackson-Lloyd Work Injury Solutions

P.O. Box 187, Longview, Texas 75606

Ph. 800-657-5242 Fax 800-933-8662

**Applicant Name:** \_\_\_\_\_ **Proposed Eff Date:** \_\_\_\_\_

Corp.  Partnership  LLC  Ind. FEIN \_\_\_\_\_ Yrs in Bus: \_\_\_\_\_ All entities of applicant included above?  Yes  No

Mailing address: \_\_\_\_\_ Web Address: \_\_\_\_\_

Locations: \_\_\_\_\_

Description of Operations/Exposures: \_\_\_\_\_

**1. Does the applicant have any:**  Employees working out of their homes  Labor interchange with entities not included above  
 24 hour operations  USL&H, Jones Act or FELA exposures  Aircraft exposure  None of these

**2. Does the applicant manufacture, handle, sell, or transport any of the following:**  
 Chemicals  Flammables  Explosives  Fuels  Drugs  Hazardous Wastes  None of these

**3. Does the applicant have the following in place:**  Self-Inspections for safety  Safety program  Safety director  
 Employee training provided  Safety meetings  Drug/Alcohol testing  None of these

**4. Does the applicant desire a premium credit for implementation of:**  
 Approved ERISA plan  Approved Alternative Dispute Resolution plan  None of these

**5. Does the applicant perform any of the following operations:**  
 Underground/Tunneling – Max \_\_\_ ft.  Work at heights above 15 feet - Max \_\_\_ ft.  Neither of these

**6. Has the applicant had:**  OSHA violations/recommendations  OSHCON inspection  Employers Liability loss  None of these

**Automobile Exposure** (Company owned vehicles)

Radius of Use (miles)	Private Passenger	Light Commercial	Medium Commercial	Heavy Commercial	X-Heavy Commercial	Tractor-Trailer
0-50						
51-200						
Over 200						

Do employees drive personal vehicles for business purposes?  Yes  No

**Loss History** - Must provide at least the past 3 years loss history. Loss runs must be valued within the past 60 days. If no prior coverage, a statement of losses must be attached.  Loss runs attached  Statement of losses attached

**Current Coverage:** Carrier \_\_\_\_\_ Limit \_\_\_\_\_ SIR/Deductible \_\_\_\_\_  
Premium \_\_\_\_\_ Renewal Date \_\_\_\_\_

**Requested Coverage:** Limit \_\_\_\_\_ SIR \_\_\_\_\_

**Rating Information:** Owners / Executive Officers:  Included  Excluded

**Will you have any 1099 employees working for you during this policy period?**  Yes  No

**If so, do you want to provide them with coverage under this policy?**  Yes  No

Occupation	Class Code	F/T Employees	P/T Employees	Total in Class	Annual Payroll or Earnings
Owners / Executive Officers	8809				
<b>Total</b>					

\*Please note – Payroll for each employee should be capped at \$62,400. Also, overtime should be calculated on straight pay.

\*Applicant will submit a copy of the most recent W-3 form upon binding.

\*If 1099 employees are to be included in coverage, please submit a copy of the most recent 1099 Form issued to each employee.

**THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.**

By signing this application form the applicant confirms that he or she has been provided with and inspected a specimen copy of the policy, and understands their rejection of the Texas Worker's Compensation Act status and the coverages and limitations of the policy.

If Coverage is issued based upon information provided in this application, the applicant understands and agrees that this application shall form a part of the policy, and the statements herein shall be construed as material representations of the applicant. 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 civil penalties.

Applicant's Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

Contact person: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Agency Name: \_\_\_\_\_ Agency Contact: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Agent's Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

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