



# QUICK QUOTE - APPLICATION



Jackson-Lloyd Select Risk

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

5. **Has the applicant had:**  OSHA inspections/recommendations/violations  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 \_\_\_\_\_ Weekly Disability Benefit \_\_\_\_\_ Benefit Period \_\_\_\_\_

**Requested Coverage:** Limit \_\_\_\_\_ SIR \_\_\_\_\_ Weekly Disability Benefit \_\_\_\_\_ Benefit Period \_\_\_\_\_

**Rating Information:** Owners / Executive Officers:  Included  Excluded Owner's Name: \_\_\_\_\_

**Would you like to utilize your existing ERISA/ADR Plan?**  Yes  No **If no, do you agree to implement the ERISA and ADR Plans issued to you?**  Yes  No **Plan Administrator's Name** \_\_\_\_\_

**Do you have or want to cover, any 1099 employees that work for you?**  Yes  No **If so, proof of remuneration will be required.**

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.**

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underwriters@jackson-lloyd.com

THIS IS NOT A WORKERS' COMPENSATION INSURANCE POLICY. THE EMPLOYER DOES NOT OBTAIN WORKERS' COMPENSATION INSURANCE COVERAGE BY PURCHASING THIS POLICY, AND IF THE EMPLOYER HAS NOT ELECTED TO OBTAIN WORKERS' COMPENSATION INSURANCE COVERAGE, THE EMPLOYER DOES NOT OBTAIN THOSE BENEFITS THAT WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS IN THIS STATE. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAWS IN THIS STATE AS THEY PERTAIN TO EMPLOYERS THAT ELECT NOT TO MAINTAIN WORKERS' COMPENSATION INSURANCE 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.

I also hereby agree and understand that the Texas Occupational Shield / Texas Accident Shield ("the policies") being provided by Crum and Forster Specialty Insurance Company is not materially or substantially similar to the coverage prescribed under The Texas Workers' Compensation Law and Act ("the Law"). I also agree and understand the policy is neither an alternative, not a replacement for Workers' Compensation or Employers' Liability as prescribed by that Law.

I understand that Crum and Forster Specialty Insurance Company and Jackson-Lloyd Select Risk Insurance are not rendering any legal advice in connection with this transaction. I acknowledge that there have been no oral representations made by Jackson-Lloyd Select Risk regarding terms, conditions or coverage of the policy.

I further understand that by not carrying Workers' Compensation or Employers' Liability coverage, I may be giving up some defenses under that law in any lawsuit brought by one of my employees for a work-related accident.

We hereby accept the proposal as per the attached quotation from Jackson-Lloyd Select Risk and Crum and Forster Specialty Insurance Company. We understand that this policy does not replace or provide coverage under Texas Workers' Compensation or Employers' Liability Insurance.

\_\_\_\_\_  
Full Employer/Holder Name (PRINTED)

\_\_\_\_\_  
DBA, if any (PRINTED)

\_\_\_\_\_  
Name / Title (PRINTED)

Applicant's Email Address: \_\_\_\_\_

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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