

ACORDTM WORKERS COMPENSATION APPLICATION

DATE

PRODUCER PHONE (A/C, No, Ext): 314-867-8525 FAX (A/C, No): 314-867-8746	COMPANY	UNDERWRITER
Buchholz Insurance Agency 10130 Clairmont Drive St. Louis, MO 63136-3170	APPLICANT NAME	
	MAILING ADDRESS (Including ZIP code)	
	YRS IN BUS SIC	INDIVIDUAL CORPORATION PARTNERSHIP SUBCHAPTER "S" CORP
CODE: SUB CODE:	CREDIT BUREAU NAME:	
AGENCY CUSTOMER ID	FEDERAL EMPLOYER ID NUMBER	NCCI ID NUMBER
		ID NUMBER: OTHER RATING BUREAU ID OR STATE EMPLOYER REGISTRATION NUMBER

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

LOCATIONS
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			

SPECIFY ADDITIONAL COVERAGES/ENDORSEMENTS							FACTOR	FACTORED PREMIUM
							TOTAL	\$
							INCREASED LIMITS	\$
							DEDUCTIBLE	\$
								\$
							EXPERIENCE MODIFICATION	\$
							LOSS CONSTANT	\$
							ASSIGNED RISK SURCHARGE	\$
							ARAP	\$
								\$
							PREMIUM DISCOUNT	\$
							EXPENSE CONSTANT	\$
								\$
								\$
MINIMUM PREMIUM	\$	DEPOSIT PREMIUM	\$	TOTAL EST ANNUAL PREMIUM	\$			

INDIVIDUALS INCLUDED/EXCLUDED

PARTNERS, OFFICERS, RELATIVES TO BE INCLUDED OR EXCLUDED. (Remuneration to be included must be part of rating information section.)

#	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?			16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?		
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)			17. ANY OTHER INSURANCE WITH THIS INSURER?		
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?			18. ANY PRIOR COVERAGE DECLINED/ CANCELLED/NON-RENEWED (Last 3 years)?		
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?			19. ARE EMPLOYEE HEALTH PLANS PROVIDED?		
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?			20. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS/SUBSIDIARY?		
6. ARE SUB-CONTRACTORS USED? (IF YES, GIVE % OF WORK SUBCONTRACTED)			21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?		
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INS.?			22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME?		
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?			23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST 5 YEARS?		
9. ANY GROUP TRANSPORTATION PROVIDED?			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).		
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?			CONTACT INFORMATION		
11. ANY SEASONAL EMPLOYEES?			IN-SPECTION	PHONE:	
12. IS THERE ANY VOLUNTEER OR DONATED LABOR?				NAME:	
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?			ACCTNG RECORD	PHONE:	
14. DO EMPLOYEES TRAVEL OUT OF STATE?				NAME:	
15. ARE ATHLETIC TEAMS SPONSORED?			CLAIMS INFO	PHONE:	
				NAME:	

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, VT; IN DC, LA, ME AND VA, INSURANCE BENEFITS MAY ALSO BE DENIED)

REMARKS	
APPLICANT'S SIGNATURE	PRODUCER'S SIGNATURE