EXCESS WORKERS' COMPENSATION APPLICATION

SAFETY NATIONAL CASUALTY CORPORATION

Applicant's Representative ______________ ☐ **New application**

Address ______________ ☐ **Renewal of policy number**

Effective date __________ **Quote needed by** __________ __________

(1) **Name of applicant and subsidiaries** (List only qualified self-insureds.) ______________

(2) **Mailing address** ______________

(3) **Description of operations, processes and products of applicant and subsidiaries** (Attach copy of current and comprehensive loss prevention inspection reports, product brochure, annual report or 10-K report, and copy of self-insured application filed with the state.) ______________

(4) **Number of employees to be covered** (Include full-time, part-time and leased.) ______________

(5) **Provide listing of locations to be covered** (Attach supplemental page if additional space is required.)

	ADDRESS	SUBSIDIARY (IF APPLICABLE)	BRIEF DESCRIPTION OF OPERATIONS
A.			
B.			
C.			

(6) **In which states or jurisdictions will applicant operate as a qualified self-insured?** ______________

(7) **Date applicant qualified as a self-insured** ______________

(8) **Service company / TPA information** (If no claims service company, attach or request a Claims Administration Questionnaire.)

A. Claims administration services

1. Name of service company ______________
2. Address of service company ______________
3. Service company contact and telephone number ______________
4. Provide details of types of service that will be provided by service company ______________
5. Is service company responsible for providing specific excess claim reporting and follow-up detail to excess carrier? ☐ yes ☐ no
   If "no," who is responsible? ______________
6. Does service contract require that claims be handled to conclusion? ☐ yes ☐ no If "no," provide details. ______________
7. How many years has service company had service contract with applicant? ______________
8. Is service contract concurrent with policy period? ☐ yes ☐ no If "no," what are the effective and expiration dates of service contract? ______________
9. Loss runs concurrent with policy period must be provided on a quarterly basis. Provide name, address and telephone number of individual responsible for providing loss runs ______________

NOTE: Any change in service company or in the kind or amount of service must be immediately communicated to and approved by excess carrier.

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B. Loss prevention service

1. Name of service company ....
2. Address of service company ....
3. Provide details of types and frequency of services that will be provided by service company ....
4. Does applicant have a formal safety program? ❑ yes ❑ no If "yes," attach copy.
5. Does applicant agree to forward copies of loss prevention inspection reports to excess carrier as inspections are performed? ❑ yes ❑ no

(9) Current program

A. Name of present workers' compensation carrier (primary or excess) ....

B. If fully insured, describe type of plan ....

C. Complete the following if presently self-insured

STATE	SPECIFIC EXCESS LIMIT	EMPLOYER'S LIABILITY LIMIT	SELF-INSURED RETENTION	AGGREGATE EXCESS LIMIT	LOSS FUND %	MINIMUM TERM LOSS FUND

(10) Coverage desired (Indicate all alternatives to be considered.)

STATE	SPECIFIC EXCESS LIMIT	EMPLOYER'S LIABILITY LIMIT	SELF-INSURED RETENTION	AGGREGATE EXCESS LIMIT	LOSS FUND %	MINIMUM TERM LOSS FUND

(11) Specify additional coverages or endorsements desired ....

(12) Provide the following information regarding each state or jurisdiction to be covered (Attach supplemental page if additional space is required.)

STATE	W.C. CODE NO.	CLASSIFICATION	NO. OF EMPLOYEES	ESTIMATED ANNUAL PAYROLL OR MANHOURS	CURRENT MANUAL RATES	MANUAL PREMIUM
		Total				

Experience Modification ....

Effective date of Experience Modification ....

Manual rate effective date ....

(13) Vehicle information

A. Does applicant own or lease vehicles which haul or transport applicant's goods or products, or the goods or products of others? ❑ yes ❑ no

If "yes," Vehicle Supplemental Application must be completed. If "no," complete sections B and C below.

B. Provide the number of owned or leased vehicles for the following and indicate the average number of employees occupying each vehicle.

TYPE OF VEHICLE	NUMBER OF UNITS	AVERAGE NUMBER OF EMPLOYEES
1. Passenger cars		
2. Vans		
3. Light & Medium trucks		
4. Heavy & X-Heavy trucks		
5. Truck tractors		
6. Trailers		

TYPE OF VEHICLE	NUMBER OF UNITS	AVERAGE NUMBER OF EMPLOYEES
7. Police cars		
8. Fire trucks		
9. Ambulances		
10. Motorcycles		
11. Buses		
12. *Other		

**Golf Carts, ATV's, Trams, etc.*

C. Does the applicant provide transportation of employees to and or from any work site or work location? ❑ yes ❑ no If "yes," provide a listing of vehicles and, for each, (1) seating capacity, (2) average number of employees per trip, (3) average radius per trip and (4) average number of daily trips.

(14) Special exposures (Check the appropriate box which reflects the actual and/or anticipated exposures associated with the applicant's operations. Provide details for any "yes" response on page 4.)

		YES	NO
A.	Own, lease or charter any aircraft? **(If "yes," Aircraft Supplemental Application must be completed.)**	❑	❑
B.	Own, lease or charter any watercraft? **(If "yes," Watercraft Supplemental Application must be completed.)**	❑	❑
C.	Load, unload, repair or construct watercraft or vessels including work performed on barges or docks?	❑	❑
D.	Operations or employees subject to the Longshoremen's and Harbor Workers' Act, Jones Act or Federal Employer's Liability Act?	❑	❑
E.	Own, operate or maintain a railroad or own, lease, operate or repair railroad equipment?	❑	❑
F.	Foreign operations or employees who travel to foreign countries?	❑	❑
G.	Occupational disease exposures? (Includes asbestos, silica dusts, toxic, injurious or hazardous substances, compounds or chemicals, caustics, fumes, noise, radiation, communicable diseases and any other O.D. exposures.) If "yes," also describe measures taken to control.	❑	❑
H.	Operations which have resulted in carpal tunnel syndrome, repetitive motion or cumulative trauma claims?	❑	❑
I.	Manufacture, produce, refine, store, distribute or transport gases, gasoline or flammables?	❑	❑
J.	Manufacture, handle, transport, distribute or store explosives or explosive substances?	❑	❑
K.	Underground, tunneling, mining, cofferdam or subaqueous operations?	❑	❑
L.	Wrecking, dismantling, or demolition work?	❑	❑
M.	Operations subcontracted to others? If "yes," what are the operations and who is responsible for the workers' compensation coverage?	❑	❑
N.	Operations involving exposure to heights?	❑	❑
O.	Operations involving exposure to burns?	❑	❑
P.	Volunteer or donated labor to be covered? If "yes," indicate the type of work performed and number of volunteer hours for each type of work in Item 12 of Application. **(If applicant is a health care facility, a Hospital/Health Care Supplemental Application must be completed.)**	❑	❑
Q.	Leased employees? If "yes," what are their duties and who is responsible for their workers' compensation coverage? Attach copy of employee lease agreement.	❑	❑
R.	Any OSHA violations?	❑	❑
S.	Any substantial or unusual changes in operations that are planned or have taken place in the last five years?	❑	❑
T.	Workers' compensation coverage cancelled or non-renewed in last five years?	❑	❑

Provide details for any "yes" responses for special exposures (Attach supplemental page if additional space is required.) ....

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(15) Loss experience (Attach supplemental page if additional space is required.)

A. Provide five year loss history for each state to be included in proposed coverage.

(Summarize loss experience even though submitting loss runs. Break out losses by year. Valuation date must be within last six months.)

STATE	POLICY PERIOD MO/DAY/YEAR	TOTAL AUDITED PAYROLLS OR MANHOURS	EXP. MOD.	INDEMNITY PAID	INDEMNITY RESERVE	MEDICAL PAID	MEDICAL RESERVE	CLAIMS EXPENSE	TOTAL INCURRED	VALUATION DATE

B. Provide the following information concerning all death and permanent total disability claims and all claims with total incurred costs in excess of $50,000 in the last five years.

STATE	DATE OF LOSS	NO. OF EMP. INVOLVED	CLAIMANTS NAME(S)	DESCRIPTION OF LOSS AND NATURE OF INJURY OR DISEASE	TOTAL PAID	TOTAL RESERVE	TOTAL INCURRED	OPEN OR CLOSED

C. Is information taken from loss runs? ❑ yes ❑ no If "no," provide source. ....

D. Are loss runs submitted with application? ❑ yes ❑ no If "no," are loss runs available upon demand? ❑ yes ❑ no

This is NOT a binder of coverage. The application must be signed by the applicant or the applicant's representative. The applicant represents that all statements made in this application are complete and true and that all material facts have been fully disclosed.

Applicant's Representative ....

Applicant Signature ....

Date ....

Title ....

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EMPLOYEE CONCENTRATION SUPPLEMENTAL INFORMATION

NAME OF APPLICANT ______________________________

EFFECTIVE DATE ______________________________

APPLICANT'S REPRESENTATIVE ______________________________

☐ New ☐ Renewal of Policy # ______________

TOTAL NUMBER OF EMPLOYEES: Full Time [ ] Part Time [ ] Seasonal [ ]

LIST ALL LOCATIONS		ONLY COMPLETE COLUMNS 2-10 FOR ANY LOCATION WHERE 100 OR MORE EMPLOYEES WORK								
	1	2	3	4	5	6	7	8	9	10
Location Address (Street, City, State & **Zip** - not mailing address)	# of Emps	Hours Of Opera-tion	Floors Occupied (i.e. 2nd, 3rd, 17th)	# Emps per Floor	# Emps On Shift 1	# Emps On Shift 2	# Emps On Shift 3	Building Construction	# of Stories	Year Built

LOSS CONTROL AND SAFETY:

Risk Manager ☐ Yes ☐ No ☐ Full Time ☐ Part Time

Does the Applicant have guidelines for handling suspicious mail and packages? ☐ Yes ☐ No

Does the Applicant conduct periodic fire and emergency evacuation drills? ☐ Yes ☐ No

If yes, does the Applicant have procedures in place to account for all employees? ☐ Yes ☐ No

MISCELLANEOUS:

Has the building been updated (example: electrical, sprinkler system) ☐ Yes ☐ No

If yes, when: _______

Has the building been retro-fitted (earthquake): ☐ Yes ☐ No If yes, when: _______ ☐ Not in Earthquake Fault

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The Applicant represents that all statements made in this application are complete and true and that all material facts have been fully disclosed.

Applicant's Representative ______________________ Applicant Signature ______________________

Date ______________________ Title ______________________

2043 Woodland Parkway Suite 200 St. Louis MO 63146 314-995-5300 fax 314-995-3843