

Accountants ProtectionPlus

Workers' Compensation Policy Quoting Worksheet

Plan Administrator:



1200 E. Glen Ave., Peoria Heights, IL 61616-5348
Questions: Please call 888.619.1914

SECTION I

Requested Effective Date: ____/____/____

Primary Business Name: _____

Contact Name: _____

Mailing Street Address: _____ PO Box: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Federal Employer ID Number (FEIN): _____ Risk ID: _____

Legal Entity: Individual Partnership Corporation Limited Liability Company Limited Liability Corporation

Other Describe: _____

Years in Business: _____ If less than 3 years in business, number of years of management experience: _____

Describe your business: _____

SECTION II

Explain all "Yes" responses

1. Does the applicant own, operate, or lease aircraft/watercraft? Yes No
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.) Yes No
3. Is any work performed underground or above 15 feet? Yes No
4. Is any work performed on barges, vessels, docks, or bridges over water? Yes No
5. Is applicant engaged in any other type of business? Yes No
6. Are sub-contractors used? (If yes, give % of work subcontracted.) Yes No
7. Is any work sublet without certificates of insurance? (If yes, payroll for this work must be included in the State Rating Worksheet on page 2.) Yes No
8. Is a written safety program in operation? Yes No
9. Is any group transportation provided? Yes No
10. Does the applicant employ any employees under 16 or over 60 years of age? Yes No
11. Does the applicant employ any seasonal employees? Yes No
12. Is there any volunteer or donated labor? (If yes, please specify.) Yes No
13. Are there any employees with physical handicaps? Yes No
14. Do employees travel out of state? (If yes, indicate state(s) of travel and frequency.) Yes No
15. Are athletic teams sponsored? Yes No

SECTION II (continued)

16. Are physicals required after offers of employment are made?..... Yes No
17. Does the applicant have any other insurance with this insurer?..... Yes No
18. Has the applicant had any prior coverage declined/cancelled/non-renewed in the last three years? Yes No
(Missouri applicants do not need to answer this question.)
19. Are employee health plans provided? Yes No
20. Do any employees perform work for other businesses or subsidiaries? Yes No
21. Does the applicant lease employees to or from other employers? Yes No
22. Do any employees predominantly work at home? (If yes, indicate # of employees.) Yes No
23. Has the applicant had any tax liens or filed for bankruptcy within the last five years? (If yes, please specify.)..... Yes No
24. Are there any undisputed and unpaid workers' compensation premiums due from the applicant or any commonly managed or owned enterprises? If yes, please explain and include entity name(s) and policy number(s). Yes No
25. Do you utilize a Return to Work program? Yes No

Please explain all **yes** answers: _____

SECTION III

1. Limits of Liability:

Select one option:	<input type="radio"/> Option 1	<input type="radio"/> Option 2	<input type="radio"/> Option 3
Each Accident	\$100,000	\$500,000	\$1,000,000
Disease–Policy Limit	\$500,000	\$500,000	\$1,000,000
Disease–Each Employee	\$100,000	\$500,000	\$1,000,000

2. Locations:

Location #1 Address: _____

City: _____ State: _____ Zip: _____

Complete the following chart with details about your staff (please separate the employees by class code):

Category of Employment	Class Code	# of Full-Time	# of Part-Time	Estimated Annual Income

Location #2 Address: _____

City: _____ State: _____ Zip: _____

Complete the following chart with details about your staff (please separate the employees by class code):

Category of Employment	Class Code	# of Full-Time	# of Part-Time	Estimated Annual Income

SECTION III (continued)

Please list any directors/officers to be excluded or included from this coverage:

Name	DOB	Title	Duties	Work Class Code	Income	Included/ Excluded?

SECTION IV

1. Prior Insurance History:

Policy Year	Carrier and Policy Number	Annual Premium	Number of Claims

2. Claim History:

Date of Claim	Description of Occurrence or Claim	Amount Paid	Amount Reserved	Status of Claim

If claims have occurred, please provide at least three years of carrier loss runs.

Signature: _____ Date: _____

Title: _____



Please submit your completed application to your Accountants ProtectionPlus sales representative or call **888.619.1914**.