Accountants Advantage
Workers' Compensation Policy Quoting Worksheet

Plan Administrator:

PEARL® INSURANCE
A DIVISION OF ONE80 INTERMEDIARIES

1200 E. Glen Ave., Peoria Heights, IL 61616-5348
Questions: Please call 855.465.0200

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:	❍ Option 1	❍ Option 2	❍ 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: _____

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