

**PRIMARY EMPLOYER'S INDEMNITY**

Underwritten by:  
**Risk Transfer Technologies, Inc.**  
 7524 Mosier View Court, Suite 103  
 Fort Worth, TX 76118  
 (817) 595-4788 · Fax (817) 796-2760

Application is hereby made for the coverage(s) specified to become effective on \_\_\_\_\_ at 12:01 a.m. Central Standard Time at the address of the Applicant named below and provided the deposit premium is paid in full and CEM Insurance Company (herein called "Company") approves this application.

1. Legal Name of Applicant \_\_\_\_\_ Federal Tax I.D.# \_\_\_\_\_
2. Contact Person \_\_\_\_\_ Title \_\_\_\_\_
3. Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_
4. Street Address \_\_\_\_\_ Phone( ) \_\_\_\_\_ Fax( ) \_\_\_\_\_
5. City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Additional Locations (Locations outside of Texas are not eligible to be included under this coverage)

- City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
- City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
- City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
- City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
- City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**(If necessary, use a separate sheet of paper with the insured's name on it to list all additional locations to be covered.)**

6. Nature of Business: \_\_\_\_\_

7. Applicant is: Corporation\_\_\_\_ Partnership\_\_\_\_ Sole Proprietorship\_\_\_\_ Other (please explain)

Officer/Owner Name	Include Or Exclude	Title	Percentage Of Ownership	Duties Performed

8. Are any owners, officers or partners are to be excluded? \_\_\_\_Yes \_\_\_\_No (If "Yes", The Officer Exclusion Form must be signed by each owner/officer to be excluded from coverage.)

9. Does Applicant have affiliated companies (affiliated company means parent, sister or subsidiaries sharing in excess of 50% common ownership)? Yes\_\_\_\_\_ No\_\_\_\_\_

If "yes", please provide Legal Name and complete Physical Address:

Legal Name	FEIN	Owner	% Held by Owner

**(If necessary, use a separate sheet of paper with the insured's name on it to continue the list of entities to be covered.)**

10. Insurance and Loss History for Past Three Years - **Occupational Injuries and Accidents**

Year	Company	Policy Number	Total Losses (Attach loss runs)	Description of Each Loss in Excess of \$10,000 (Use separate sheet if necessary)

11. List Class Code, payroll, number of employees per class code, and a brief description of the duty performed in each class code

Class Code	Payroll	No. of Employees	Brief Description of duties performed

(If necessary use a separate sheet of paper with the insured's name on it to list additional class code information.)

12. Is it the intent of the insured to cover any contract labor under this policy? Yes\_\_\_\_\_ No\_\_\_\_\_ If "Yes", include the entire remuneration under the applicable class codes listed above.

13. Has the Applicant or any of its affiliates entered into a "Hold Harmless" agreement with any of its vendors or customers? \_\_\_\_\_Yes \_\_\_\_\_No

14. Does the Applicant or any of its affiliates lend its employees to others? If "Yes", provide details.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

15. Has insurance of this type (AD&D; Occupational Accident or Workers' Compensation) been cancelled, refused or non-renewed by any company during the past 3 years? \_\_\_\_\_Yes \_\_\_\_\_No If "Yes", list reason below:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

16. Please provide the following information concerning the Applicant's current loss prevention practices:

Does the Applicant have?

a. Written Safety Rules?

b. Safety Manual?

c. Safety Incentive Program?

d. A Safety Director?

Full time

Part time

No

e. An Alcohol and Drug Testing Program?

If "Yes" does each Employee give prior written consent for testing at will and at the time of injury?

YES	NO


**Coverage Desired**

**Total # Employees:** \_\_\_\_\_

Combined Single Limit \_\_\_\_\_

A Down Payment of \$ \_\_\_\_\_ is attached.

Make check payable to **Risk Transfer Technologies, Inc.**

**Attach signed quote sheet for desired limits/SIRs/benefits**

**Warranties**

1. I (the Applicant) understand that the insurance applied for shall become effective on the date specified in this application if the request to bind arrives on or prior to the requested date to bind, the underwriting requirements of the company have been met, and the required deposit paid.
2. I understand the soliciting agent is not authorized by the Company to bind coverage. Further, no statement made by the soliciting agent will bind the Company, unless the statement is reduced to writing and signed by the Company's duly authorized officer.
3. I understand the Policy constitutes the entire contract providing indemnification to the applicant and that coverage is issued based upon representations and warranties made by me in this application. No variance from the terms of the Policy is permitted except in writing and signed by the Company's duly authorized officer.
4. I hereby authorize the Company and/or its designee to contact covered employees and providers to assist the in settlement of occupational injury claims.

**Acknowledgment by Applicant**

I \_\_\_\_\_, do hereby represent and warrant the following to the Company, its agents and counsel:

I have discussed my insurance program (including coverages, limits, terms, and exclusions of the policy), ERISA, and non-subscription under the Texas Workers' Compensation Act (the "Act") with a representative (the "Agent"). I have asked all the questions I deem appropriate, and I understand and represent each of the following:

1. Neither Agent, nor any other person, has represented to me that my group accident policy is a substitute for workers' compensation insurance under the Act.
2. I have carefully read and studied the form of Primary Employer's Indemnity policy (the "Policy") to be obtained by me through the Company and Risk Transfer Technologies, Inc. My agent has explained, and I fully understand, the coverages indemnified by the Policy, and the limitations on those indemnities.
3. Neither Agent nor any of its officers, employees, attorneys or agents has made any representation to us orally, in writing, or in any advertisement, with respect to coverages provided by the Policy or limitations thereon, which is in any way inconsistent with the coverages, limitations, and exclusions specified on the face of the Policy. I understand the terms of the Policy determine coverages, exclusions, premiums, rights and obligations.
4. Agent has not undertaken to make or post any filing or notice required of my company under the Act; I recognize those are my own, non-delegable, responsibilities as employer. I have made my own, independent decision to reject the insurance provisions of the Act, and have not relied on any representation or statement of Agent, in making my decision.

Dated at \_\_\_\_\_ on \_\_\_\_\_ 200\_\_ Applicant's Signature

Licensed Agent Phone ( ) \_\_\_\_\_ Witness/Agent's Signature

Witness/Agent's Name Printed

Agent's Name \_\_\_\_\_ Agent's Address

<p><b>THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.</b></p>
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