ACCIDENT INSURANCE SERVICES, INC
800 880 2515
972 788 5108 FAX

Fax-A-Quote

Type of Proposal Requested:

- ❐ *Occupational Accident only*
- ❐ *Occupational Accident w/Legal*
- ❐ *Employer's Excess Indemnity*

Please fax this completed form, your inforce TX insurance license, and E & O dec page to
ACCIDENT INSURANCE SERVICES INC. FAX: 972-788-5108 PHONE: 800-880-2515 or 972 991 0413

Applicant Name ________________________ Requested Effective Date ____________

Address ________________City________Zip________Nature of Business ____________

Number of years in business: __________ Tax ID# ____________ Date of workers' comp coverage rejection: __________

Has worker's comp or occupational accident coverage ever been canceled, refused or non-renewed? ❐ Yes ❐ No

If Yes, please explain: ____________________

Business Type: ❐ Corporation ❐ Partnership ❐ Other: ____________________

Is applicant subject to LPG or TxDOT Regulations? ❐ Yes ❐ No. Within what radius does applicant haul? __________

Does applicant handle, store, or engage in transport of hazardous materials (including but not limited to explosive, caustic, poisonous or flammable materials)? ❐ Yes ❐ No. If Yes, please explain: ____________________

Please specify commodities hauled: ____________________

What percentage of loads are <u>manually</u> loaded or unloaded *(use 0% if no manual (un)loading)*? __________% Loaded ______% Unloaded

Does applicant perform any work at heights over 24 ft.? ❐ Yes ❐ No. If Yes, please explain: ____________

Are Owners, Officers or Partners to be covered? ❐ Yes ❐ No. Are any affiliate companies to be covered? ❐ Yes ❐ No. If yes,

Please provide Legal Name, Address and number of employees at each location.

#of Full time		# of Part-time		Classification Code	Annual Payroll by Class (including Tips)	Classification or Description
W-2's	1099	W-2's	1099			

Total Number of Employees __________ Total Payroll $____________ Waiver of Subrogation? ❐ Yes ❐ No

Current Worker's Comp or Accident Premium $____________ Occupational Disease & Cumulative Trauma? ❐ Yes ❐ No

<u>Benefits to be Quoted</u>: ***LIMITS VARY BY PRODUCT. PLEASE CALL FOR OTHER OPTIONS.***

CSL Benefit: ______________ *($100,000 - $1,000,000 CSL available)*

Deductible: ______________ *($1,000 - $500,000 deductible available)*

Excess Limits: ______________ *($1,000,000 to $5,000,000 limits available)*

Benefit Period: _____52 wks_____104 wks_____156 wks Weekly Income (75% up to $600) ________ Waiting Period: _______days

Please submit 3 years (hard copy) currently valued loss history; Valuation Date of loss information: ____________

Year	Carrier	Total Losses	Description of Each Loss in Excess of $5,000 (Use separate sheet if necessary)

1.	Has the applicant (or affiliate) been in the Texas Workers' Compensation System in the last 3 Years? If yes, have they had an experience modification factor of 200% or more?	❐ Yes ❐ No ❐ Yes ❐ No
2.	Has the applicant (or affiliate) ever had an Employer's Liability claim?	❐ Yes ❐ No
3.	Has the applicant (or affiliate) ever had an Occupational Disease (e.g. Black Lung, silicosis, lead poisoning, cancer, etc.) or Cumulative Trauma (e.g. carpal tunnel, stress, etc.) claim?	❐ Yes ❐ No

If the answer to #2 or #3 is YES, please give a complete descriptions, dates, and amounts of claims on a separate sheet.

Agent and Applicant hereby acknowledge that: (a) all answers and statements contained herein, including any attached data, are true and complete; (b) Insurer will rely solely on the information provided in this Fax-A-Quote, along with any attached data, in considering whether to provide the requested insurance coverage; and (c) this Fax-A-Quote shall become a part of the Policy should coverage be bound.

Agent: ________________________Phone________________________

Address: ________________________ FAX: ________________________

Agent Signature: ________________________ Applicant Signature: ________________________