

**Occupational Accident Insurance From GHS Property and Casualty Company**

**EMPLOYER APPLICATION & CERTIFICATION FORM**

**GROUP INFORMATION**

Legal Name of Group: \_\_\_\_\_  
(attach listing of subsidiaries/affiliates to be covered)

Doing Business as: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Email: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Federal Tax ID: \_\_\_\_\_ SIC #: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Nature of Business \_\_\_\_\_

Current and Most recent Carrier: \_\_\_\_\_ Total # of Employees: \_\_\_\_\_

**OWNER INFORMATION**

Please list names of all owners: \_\_\_\_\_

Are owners to be covered?  Yes  No

Are they on The State Employment Commission Report?  Yes  No

**SAFETY PROGRAM**

Do you currently have a safety program in place?  Yes  No

What is the name of your safety program provider? \_\_\_\_\_

**COVERAGE INFORMATION – Combined Benefit Policy**

Requested Effective Date: \_\_\_\_\_

Combined Benefit Period:  52 Weeks  116 Weeks  156 Weeks

Combined Benefit Amount:  100,000  150,000  200,000  250,000  300,000  500,000  \$1 million

Combined Deductible Amount:  \$500  \$1,000  \$2,500  Other (contact AIS)

**ADDITIONAL COVERAGE INFORMATION**

Include coverage for Occupational Disease and Cumulative Trauma  Yes  No

**CENSUS INFORMATION**

# of Employees		<ul style="list-style-type: none"> <li>The payroll should be current month's payroll.</li> <li>100% participation required including all part-time employees.</li> <li>If covered, owner must report at least \$1,000 in monthly salary.</li> <li>Max. annual payroll should not exceed \$62,400 on ANY single employee.</li> </ul>
Total Monthly Payroll		
Total Net Premium		
Monthly Fee		
Total Monthly Cost		
Annual Fee		
Total Initial Payment		

**Please photocopy the census page as many times as necessary to include all eligible employees, or provide census report with necessary information.**

**EMPLOYER CERTIFICATION FORM**

I, the undersigned, as a representative of the above-named employer (the "Group"), do hereby certify the following:

1. The group has made application to GHS Property and Casualty Company (GHS) for Occupational Accident Insurance and fully acknowledges and understands that the insurance for which the Group has applied shall not be effective until the application has been approved by GHS, premium has been received and the Coverage Effective Date has been assigned.
2. I have reviewed the coverages, limits, terms and exclusions of the Policy with my broker/agent and the Group agrees to be bound by all of the terms, conditions and limitations of the Policy.
3. The Group shall make modified duty available for employees approved for rehabilitation and able to return to some form of work as agreed to by the employee's treating physician.
4. The Group understands that the premium charged for coverage by GHS is calculated from the payroll and employee information that the Group submits. The Group further understands that any misrepresentation of this data will result in a reduction or denial of benefit payments to employees. I have reviewed the employee and salary data and take full responsibility for its accuracy.
5. The Group shall pay the required premiums to the Insurer or its representative when due.
6. The Group acknowledges and fully understands each of the following items:
  - This is not Workers' Compensation Insurance, nor is it a replacement for Workers' Compensation Insurance. GHS does not sell, nor is it authorized to sell, workers' compensation insurance with this application.
  - This coverage is not intended to, nor will it provide the Group with any protection or defense against any suit, which may be brought by anyone for any reason.
  - In order for insurance to take effect on the date specified by the Insurer, 100% of the Group's employees must satisfy the eligibility requirements of the Policy.
  - Any person who fits the definition of an employee, but who is not Actively at Work on the Effective Date of Your Policy will be covered on the date they return to the normal and substantial duties of their occupation.
  - Employee eligibility may be verified using a quarterly employment tax statement or payroll report at case submission and thereafter as requested by GHS.
  - This is not a policy of Workers' Compensation Insurance. The Group does not become a subscriber to the Workers' Compensation system by purchasing this coverage, and if the Group is a non-subscriber, the Group loses certain common-law defenses to suit as well as certain limitations on liability that would otherwise be available under the Workers' Compensation laws. The Group must comply with the Workers' Compensation law as it pertains to non-subscribers and the required notifications that must be posted and filed.

GHS Property and Casualty Company and its representative are authorized to contact me by mail or telephone to discuss this application.

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Group Name: \_\_\_\_\_

Printed Name and Title of Party Signing: \_\_\_\_\_

Agent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Agent Name: \_\_\_\_\_



# GHS ERISA Plan Worksheet

1. Company Legal Name: \_\_\_\_\_
2. Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
3. Federal Tax ID#: \_\_\_\_\_
4. Mailing Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
5. Contact Person/Title: \_\_\_\_\_
6. Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_
7. Company is: Corporation \_\_\_\_\_ Sole \_\_\_\_\_ Proprietorship \_\_\_\_\_ Partnership \_\_\_\_\_  
State of Incorporation: \_\_\_\_\_ Company Fiscal Year End? \_\_\_\_\_  
Other specify: \_\_\_\_\_
8. Company is Interstate Motor Carrier for Hire? \_\_\_\_\_ (Yes or No)  
Company is required to comply with TDOT limits? \_\_\_\_\_ (Yes or No)
9. Number of covered employees: \_\_\_\_\_ Do you need SPD's in Spanish \_\_\_\_\_ (Yes or No)  
Union employees covered? \_\_\_\_\_ (Yes or No)
10. Are affiliated or subsidiary companies covered? \_\_\_\_\_ (Yes or No)  
% \_\_\_\_\_ Common Ownership  
(Attach additional sheets showing all above information for each, with % of common ownership.)
11. Name/ Address of person to be named Plan Administrator. (A position of Trust)  
Administrator Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
12. Do you currently have any employee welfare benefit plan in place which is governed by ERISA. (I.E. Group Health Insurance)? \_\_\_\_\_ (Yes/No)  
If Yes, Plan I.D. Number(s): \_\_\_\_\_  
Describe plan(s): \_\_\_\_\_  
\_\_\_\_\_