

# U.S. SPECIALTY INSURANCE CO.

13403 Northwest Freeway, Houston, Texas, 77040

## PRIMARY EMPLOYER'S INDEMNITY

Eff. Date: \_\_\_\_\_

### Applicant Information:

Business Name and dba:			
Physical Address:	City:	State:	Zip:
Mailing Address:	City:	State:	Zip:
<input type="checkbox"/> Corporation	<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> Partnership	<input type="checkbox"/> LLC <input type="checkbox"/> Other
			Years in Business:
Phone Number:	Fax Number:	Hours of Operation:	
Federal Tax I.D. Number:	Website:		
Contact Person:	Title:	Email:	
<u>Detailed Description of Operations:</u>			

\* If multiple locations, named insureds, or FEIN, please list on separate sheet.

### Rating Information:

\$60,000 annual max. per employee

Class Code	Classification Description	# Of Employees		Annual Payroll by Class
		Full-Time	Part-Time	

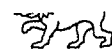
### Loss Information (First Dollar Losses): 3 COMPLETE YEARS REQUIRED

Policy Year	Carrier	Line of Coverage	Total Incurred	Number of Claims	Valuation Date	Premium
		<input type="checkbox"/> WC <input type="checkbox"/> N/S				
		<input type="checkbox"/> WC <input type="checkbox"/> N/S				
		<input type="checkbox"/> WC <input type="checkbox"/> N/S				
		<input type="checkbox"/> WC <input type="checkbox"/> N/S				
		<input type="checkbox"/> WC <input type="checkbox"/> N/S				

### PEI Coverage Requested:

Check boxes for requested quote options:

Coverage A: Medical/Wage Replacement	<input type="checkbox"/> \$300,000 <input type="checkbox"/> \$500,000 <input type="checkbox"/> \$1,000,000
Coverage B: Employer's Liability	<input type="checkbox"/> \$300,000 <input type="checkbox"/> \$500,000 <input type="checkbox"/> \$1,000,000
Coverage Period	<input type="checkbox"/> 104 weeks <input type="checkbox"/> 156 weeks
Self-Insured Retention	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000
Payment Option	<input type="checkbox"/> Monthly <input type="checkbox"/> Annual



**General Information:**

	Y	N		Y	N
Have you had any OSHA violations in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	Are employee healthcare plans provided?	<input type="checkbox"/>	<input type="checkbox"/>
Have you filed for bankruptcy in the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	Do you use sub-contractors?	<input type="checkbox"/>	<input type="checkbox"/>
Do you own, lease or charter aircraft or watercraft?	<input type="checkbox"/>	<input type="checkbox"/>	Are all forklift operators certified?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any employees under 18 or over 65?	<input type="checkbox"/>	<input type="checkbox"/>	Do you currently have medical facilities chosen to handle employee injuries?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use leased or temporary employees?	<input type="checkbox"/>	<input type="checkbox"/>	Maximum height exposure		
Do you have any 1099 employees?	<input type="checkbox"/>	<input type="checkbox"/>	Maximum weight of material handling		
<u>Explain all "yes" answers:</u>					

**Automobile Exposure:** *Indicate the number of automobiles owned, operated, or leased by type and radius.*

Radius of Operation	Number of Commercial Units					
	Private Passenger	Light	Medium	Heavy	X-Heavy	Tractors
0-50	_____	_____	_____	_____	_____	_____
51-200	_____	_____	_____	_____	_____	_____
Over 200	_____	_____	_____	_____	_____	_____

Do you run MVR's at least annually on all drivers?  Yes  No

Are employees required to drive their own vehicles for business purposes?  Yes  No

Minimum Standards for Drivers:

Minimum Age: \_\_\_\_\_ Maximum Age: \_\_\_\_\_

Minimum commercial truck driving experience: \_\_\_\_\_ years

Maximum number of accidents permitted: \_\_\_\_\_ (number) in the past \_\_\_\_\_ years.

Maximum number of violations permitted: \_\_\_\_\_ (number) in the past \_\_\_\_\_ years.

**Safety Program:**

	Y	N		Y	N
Do you have a written safety manual? When was it last updated? _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you have an alcohol/drug-testing program?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an employee-training program?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a safety committee?	<input type="checkbox"/>	<input type="checkbox"/>
Are safety meeting held on a regular basis? Frequency: _____	<input type="checkbox"/>	<input type="checkbox"/>	Are documented, post-accident investigations conducted?	<input type="checkbox"/>	<input type="checkbox"/>
Do you conduct periodic self-inspections? Frequency: _____	<input type="checkbox"/>	<input type="checkbox"/>	Is there an appointed Safety Director?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a safety incentive program?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any other safety controls in place that assist you in controlling losses? Please list or attach on separate page.	<input type="checkbox"/>	<input type="checkbox"/>

**ERISA Information:**

-Your nonsubscription policy will include a customized ERISA plan, which will be issued by our vendor for you.

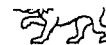
-This specific ERISA Plan is a requirement of the U.S. Specialty Insurance Primary Employer's Indemnity program. It is your responsibility to implement the ERISA Plan to all current and future employees.

Please initial the box signifying that you understand your obligation. Initial:

-Are affiliated companies to be covered?  Yes  No

-Percent of Common Ownership: \_\_\_\_\_%

-Is the company an Interstate Motor Carrier for Hire?  Yes  No



As per the policy provisions, we have the right to audit your payroll records at any time. If it is determined that premiums have been unpaid, we shall be entitled to recover such underpayments.

1. The applicant requests coverage for a policy of insurance as described above. The applicant also agrees to be bound by all of the terms, conditions and limitations of the policy applied for. The applicant further understands and agrees that:
  - a. Neither the Request for Coverage, nor the payment of any monies to be applied, shall guarantee insurance to become effective. In order for insurance to take effect on the date specified, the "Company" must accept and issue a policy.
  - b. The Insured/Employer will agree to pay the required premiums to the "Company" when due.
2. Acceptance of this request/application is subject to all of the following: (a) Company's requirements; (b) Terms of the policy;(c) Company verification of the quoted premium.
3. The Company will notify the Insured/Employer of any approval or disapproval of this request. Any notice/binder of approval will specify the policy effective date and schedule of coverage.
4. The undersigned Insured/Employer understands that he/she may be subject to on-site loss control/safety inspections. Periodic loss control/safety inspections may be required as a contingency for continuation of coverage. The Insured/Employer also understands and agrees that he/she will be required to comply with any/all loss control/safety recommendations as a contingency for continuation of coverage.
5. The undersigned Insured/Employer has reviewed with his agent (who signs below) and understands the coverage, limits, terms, conditions and exclusion of this application and the policy. This application shall become a part of the policy.
6. The undersigned Insured/Employer understands this coverage is written on an Indemnity/Reimbursement basis and he/she will be reimbursed in accordance with the policy for approved amounts paid to employees and/or providers for on-the-job injuries.
7. The undersigned Insured/Employer understands coverage is written on a Split Limit basis. All coverage afforded under this policy shall not exceed the coverage amount specified under Coverage A and Coverage B for any one person or occurrence per the policy terms and conditions.

Applicant Signature (Officer): \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_

The undersigned agent warrants he/she has not represented the above coverage as anything other than an employer reimbursement policy for on-the-job employee-related injuries.

Agent of Record: \_\_\_\_\_ Date: \_\_\_\_\_

Agency/Recording Agent Printed Name: \_\_\_\_\_

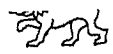
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

License I.D. Number: \_\_\_\_\_

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A NON-SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH SHOULD OTHERWISE ACCRUE UNDER 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.

Managing General Agent Name: \_\_\_\_\_



**U.S. SPECIALTY INSURANCE – PRIMARY EMPLOYER'S INDEMNITY**

**Disclosure and Acknowledgment Concerning Workers' Compensation**

This will acknowledge that is solicitation of my business insurance, the agent named below (herein referred to as the "Agent") explained to me the following facts about the Texas Workers' Compensation Act (the "Act"). The following facts were discussed, and as an employer, I am aware of their importance. To my knowledge, no statements contrary to the following statements were made by the Agent to anyone employed by, or representing, the employer.

- 1. Workers' Compensation Insurance is a "No Fault" system that affords coverage for my employees and protection for me, which no alternative insurance plan can duplicate.
- 2. It is my responsibility, should I elect not to purchase Workers' Compensation Insurance, to notify the TEXAS WORKERS' COMPENSATION COMMISSION (TWCC) at the time of such election by filing the appropriate form (currently the TWCC FORM 5). I must also annually file the appropriate form (currently the TWCC FORM 5) with the TWCC on the anniversary date of the original filing or if I have canceled my workers' compensation policy, on the anniversary of the cancellation date of the workers' compensation policy. I am aware the penalty for failure to properly file can be as much as \$500 per day. I also must notify my workers' compensation carrier, in the manner provided by the law, at the time of my election. All notices and elections must be made by certified mail, return receipt requested.
- 3. Agent has advised me that if I become a "non-subscriber" under the Act, I should seek the advice of competent legal counsel in meetings the provisions of the Act. Agent has advised me to seek legal advise for the current law as it applies to my situation.
- 4. I am aware that as a non-subscriber, should I purchase an "alternative" insurance product that provides injury medical benefits for my employees, I come under the Employee Retirement Income Security Act of 1974 (ERISA). It is in my best interest to have a written employee injury benefit plan, and to file this plan under ERISA with the U.S. Department of Labor. Such insurance and plan do not preempt a personal injury negligence lawsuit.
- 5. I understand that an approved safety plan is required for coverage to become effective and continue in force. Agent has advised me that a workplace safety program could help reduce the frequency and severity of on-the-job injuries and could also help us meet our responsibility to provide a "reasonably safe place to work" for our employees.

Agent has shown me an alternative workplace injury insurance plan. I acknowledge the option I have selected is solely my choice and the alternative plan I have chosen was NOT represented by Agent to any person being a substitute for statutory workers' compensation insurance. Agent did not induce me or any representative of my company to reject Workers' Compensation.

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I have read the above and acknowledge that Agent has discussed each of these items with me.

_____	_____	_____
Applicant's Signature	Applicant's Name (printed)	Date
_____	_____	_____
Agent's Signature	Agent's Name (printed)	Date

# ADMITTED ERISA PLAN WORK SHEET

## ERISA Plan Work Sheet

Include Arbitration Agreement:  Yes  No

1. Company Legal Name: \_\_\_\_\_
2. Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
3. Federal Tax ID Number: \_\_\_\_\_
4. Mailing Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
5. Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_
6. Phone: \_\_\_\_\_ Fax: \_\_\_\_\_
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  No
9. Number of covered employees: \_\_\_\_\_  
Union employees covered?  Yes  No
10. Spanish Language Notice needed for Employees?  Yes  No
11. Are affiliated or subsidiary companies covered?  Yes  No  
% \_\_\_\_\_ Common Ownership.  
(*Attach additional sheets showing all above information for each, with percentage (%) of common ownership.*)
12. Name/Address of person to be named Plan Administrator. (*A position of trust*)  
Administrator Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
13. 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 ID Number(s): \_\_\_\_\_  
Describe plan(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_