

Contact Information for Processing

Company Name: _____

Executive Contact: _____

Administrative/Billing Contact: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Mailing Address: _____

(if different from physical address)

Federal Tax ID Number: _____

Down Payment in the amount of \$ _____

Frequent cancellations may result in the policy being cancelled.

Information below this line to be completed by the writing agent.

Insurance Agent: _____

Signature _____ Date _____



COMPANION LIFE INSURANCE COMPANY
7909 Parklane Road, Suite 200
Columbia, SC 29223

APPLICATION FOR BLANKET OCCUPATIONAL ACCIDENT INSURANCE

Requested Plan Effective Date: _____

Name of Policyholder/Employer (full/corporate name under which business operates):

Circle One: Corporation Partnership Other Tax ID # _____

Street Address: _____

City/Town: _____ County: _____ State: _____ Zip: _____

Covered Affiliated Companies: (if any): _____

Years in Business: _____ Nature of Business: _____

Radius of Operation: _____ Loading/Unloading % _____ Strapping/Tarping % _____

Do you handle, store or engage in transport of hazardous materials (including but not limited to explosive, caustic, poisonous, or flammable materials)? _____ If yes please explain. _____

Are all employees (W2) and contract labor (1099) based in Texas? _____

Do you contract companies or Owner Operators that have employees or contract labor working for them? _____ Please explain: _____

Benefit Plan:

Maximum Combined Benefit Amount: _____ [\$500,000 - \$2,000,000] per Eligible Person per Accident

Combined Benefit Period: _____ [75 - 150] weeks

AD&D Maximum Benefit Amount: _____ [\$150,000 - \$250,000] per Eligible Person per Accident

Weekly Accident Indemnity Benefit Amount: _____ [50% - 90%] of weekly earnings up to \$600 maximum

Elimination Period: _____ [7 - 21] days

Aggregate Limit of Liability: \$2,000,000 per Accident

Combined Deductible Amount: (circle one) \$0 \$500 \$1,000 \$2,500 \$5,000 \$10,000

Continuous Total Disability (to full retirement age) ___ Yes ___ No (\$200,000 Maximum)

Occupational Disease, Cumulative Trauma ___ Yes ___ No (\$50,000 Maximum 52 week period)

Waiver of Subrogation: ___ Yes ___ No

PLEASE COMPLETE ALL PAGES OF THIS FORM. THE COMPANY CANNOT ISSUE A POLICY UNLESS ALL PAGES HAVE BEEN COMPLETED.

EMPLOYER CERTIFICATION

THE COMPANY CANNOT ISSUE A POLICY UNLESS THIS SECTION OF THE APPLICATION IS COMPLETED.

We, the undersigned Employer, hereby certify the following:

1. We are applying to Companion Life Insurance Company (the Company) for Accident Insurance. We fully acknowledge and understand that acceptance of this request is subject to all of the Company's requirements and verification of quoted premium. The insurance applied for shall not be effective until the application has been approved and accepted by the Company in writing and the Coverage Effective Date has been assigned. A Policy and Schedule of Benefits will be issued.
2. We understand that **100% of all eligible employees** must be covered and that this will be verified using tax and employment records. We also understand that all 1099 Contractors must be covered and that may be verified by audit.
3. In order for employee or contractor insurance to take effect, each employee or contractor must satisfy the eligibility requirements of the Policy.
4. We agree to pay the required premiums to the Company when due.
5. We have reviewed the sales material and the application. These materials, taken together, describe the coverage terms, conditions, limitations, and exclusions of the Accident Insurance for which we are applying, all of which have been explained to us by the broker/agent whose signature appears below.
6. We understand the coverage terms, conditions, limitations, and exclusions of the Accident Insurance for which we are applying and we agree to be bound by them.
7. WE ACKNOWLEDGE AND FULLY UNDERSTAND EACH OF THE FOLLOWING ITEMS:
 - a. The coverage for which application is being made does not insure any casualty or general liability risk of the Employer. This coverage is not intended to nor will it provide the Employer with any protection or defense against any suit which may be brought by an employee or anyone else.
 - b. Neither the Company nor the undersigned broker/agent has represented the coverage as anything other than an employee benefit which offers no indemnity for the Employer's liability.
 - c. **THIS IS NOT A PROGRAM OF WORKERS' COMPENSATION INSURANCE. WE DO NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS COVERAGE. AND IF WE ARE A NON-SUBSCRIBER, WE LOSE CERTAIN COMMON LAW DEFENSES TO SUIT AS WELL AS CERTAIN LIMITATIONS ON LIABILITY THAT WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. WE MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.**
8. I am authorized by the Employer to review and to sign this Certification.
9. Companion Life Insurance Company and its representative(s) are authorized to contact me by mail or telephone to discuss this certification. **THE COMPANY CANNOT ISSUE A POLICY UNLESS THIS SECTION OF THE APPLICATION IS COMPLETED.**

Employer Authorized Signature

Title

Date

Broker or Agent Signature

Date

Mail Application to:

Physical Address:



Limited Employers' Liability

Questionnaire

Policyholder Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Contact Person: _____ Title: _____

Telephone Number: (____) _____ - _____ . Email Address: _____

Fax Number: (____) _____ - _____ . Cell Number: (____) _____ - _____ .

The amount reimbursed under this **Limited Employer's Liability Coverage** and / or the **Contingent Liability** will accumulate to the **Combined Single Limit** together with the **Underlying Accident Coverage** on a per person and / or **Occurrence** as shown in the **Declarations**.

Payments or reimbursements made under the **Limited Employer's Liability Coverage** or the **Contingent Liability Coverage** will be applied toward the **Combined Single Limit** per person and / or **Occurrence**.

I hereby acknowledge that all statements and answers contained, including the attached data are true and complete. I understand that the **Limited Employer's Liability and Contingent Liability** contracts are delivered as a surplus lines coverage applicable under state law. I also understand that no coverage will become effective until an application has been signed and approved by the Insurance Company.

Policyholder: _____

Application Completed by: (Print Name) _____

Signature: _____ Title: _____

CONTINGENT LIABILITY APPLICATION

POLICYHOLDER INFORMATION

Motor Carrier Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Contact Person: _____ Title: _____
Telephone Number: _____ Fax Number: _____
USDOT Number: _____

Please list the states in which the motor carrier operates: _____

If the motor carrier has a current in-force Contingent WorkersøCompensation policy, a Contingent Liability policy or any other similar coverage, please provide the following details: Not applicable.

<u>Contingent WorkersøComp</u>	<u>Contingent Liability</u>	<u>Other:</u> _____
Insurer Name: _____	Insurer Name: _____	Insurer Name: _____
Policy Number: _____	Policy Number: _____	Policy Number: _____
Term: _____	Term: _____	Term: _____
Expiring Rate: _____	Expiring Rate: _____	Expiring Rate: _____
State of Domicile _____	State of Domicile _____	State of Domicile _____

Has any prior Workersøcompensation, Contingent WorkersøCompensation, Contingent Liability, or similar coverage been declined, cancelled or non-renewed in the past three years? Yes No

If yes please explain: _____

Has there ever been a loss under WorkersøCompensation, Contingent Liability, or similar coverage where an owner-operator or contract driver has been deemed an employee? Yes No If yes, please provide the details of each loss. (attach a separate sheet if necessary)

Date: _____	Description: _____	Amount of Loss: \$ _____
Date: _____	Description: _____	Amount of Loss: \$ _____
Date: _____	Description: _____	Amount of Loss: \$ _____

Have there been any citations for Occupational Safety and Health Administration (OSHA) violations in the last five years? Yes No If yes, please provide the details: _____

Please answer the following questions regarding the relationship of the independent contractor drivers to the trucking company or motor carrier:

Do the drivers sign an independent contractor agreement?

Yes No If yes, please provide a copy of the agreement.

Is the driver responsible for providing the truck?

Yes No

Is the driver responsible for maintenance of the truck?

Yes No

Is the driver responsible for the operating costs of the truck, including fuel, repairs, supplies, physical damage insurance and personal expenses?

Yes No

Is the driver responsible for hiring and supervising the necessary personnel to operate the truck?

Yes No

Is the driver compensated on a basis other than time expended in the performance of work?

Yes No

Is the driver responsible for determining the time, means, and method of performance of the assignment?

Yes No

Application completed by: _____
(Risk manager or the person responsible for insurance procurement)

On Behalf of Motor Carrier: _____

Signature of Authorized Person: _____ Date: _____

Print Name: _____ Title: _____

Applicant Name: _____

Federal Employer Tax ID Number or Social Security Number: _____

I verify that (I) the applicant named above has had no known losses in the previous (3) years.

I verify that (I) the applicant named above has had the following employee occupational losses as listed:

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

Signature of Applicant: _____

Title: _____

Date: _____

Census for Occupational Accident Program

Company Name: _____

Date: _____

Policy #: _____

Failure to notify our office of any changes (new hires, terminations, etc.)
in writing within 30 days can result in claim denial and/or policy termination.

	Employee Name	W2 or 1099	Social Security Number	Birth Date	Hire Date	Term. Date	Job Title
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
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25							

ASSURANCE RESOURCES INC.

ERISA PLAN WORKSHEET

Company's Legal Name: _____

President of Company: _____

Physical Address: _____

Mailing Address: _____

Telephone #: _____ Fax #: _____

Federal Tax ID#: _____

Contact Person & Title (The ERISA Plan Administrator):

Number of Employees: _____ Plan Effective Date: _____

Insurance Agent Information:

Agent Name: _____

Physical Address: _____

Telephone # _____ Fax # _____

The Plan Identification number will be "_____" unless you have another employee welfare plan, such as a group health plan, which is designated "_____." If you have another welfare benefit plan please indicate what the Plan Identification Number is here. _____