SUBMIT

WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY)

AGENCY NAME AND ADDRESS American Marine Insurance 2700 Newport Blvd, Ste. 190 Newport Beach, CA 92663	**COMPANY:** **UNDERWRITER:** **APPLICANT NAME:** **OFFICE PHONE:** **MOBILE PHONE:** **MAILING ADDRESS (including ZIP + 4 or Canadian Postal Code)** **YRS IN BUS:** **SIC:** **NAICS:** **WEBSITE ADDRESS:**
PRODUCER NAME: **CS REPRESENTATIVE NAME:** **OFFICE PHONE (A/C, No, Ext)** 800-228-6779 **MOBILE PHONE:** **FAX (A/C, No):** **E-MAIL ADDRESS:** info@americanmarineinsurance.com **CODE:** **SUB CODE:** **AGENCY CUSTOMER ID:**	**E-MAIL ADDRESS:** ☐ SOLE PROPRIETOR ☐ CORPORATION ☐ LLC ☐ TRUST ☐ PARTNERSHIP ☐ SUBCHAPTER "S" CORP ☐ JOINT VENTURE ☐ OTHER **CREDIT BUREAU NAME:** **ID NUMBER:** **FEDERAL EMPLOYER ID NUMBER** **NCCI RISK ID NUMBER** **OTHER RATING BUREAU ID OR STATE EMPLOYER REGISTRATION NUMBER**

STATUS OF SUBMISSION

☐ QUOTE ☐ ISSUE POLICY
☐ BOUND (Give date and/or attach copy)
☐ ASSIGNED RISK (Attach ACORD 133)

BILLING / AUDIT INFORMATION

BILLING PLAN	PAYMENT PLAN	AUDIT
☐ AGENCY BILL	☐ ANNUAL ☐	☐ AT EXPIRATION ☐ MONTHLY
☐ DIRECT BILL	☐ SEMI-ANNUAL	☐ SEMI-ANNUAL ☐
	☐ QUARTERLY % DOWN:	☐ QUARTERLY

LOCATIONS

LOC #	STREET, CITY, COUNTY, STATE, ZIP CODE

POLICY INFORMATION

PROPOSED EFF DATE	PROPOSED EXP DATE	NORMAL ANNIVERSARY RATING DATE	☐ PARTICIPATING ☐ NON-PARTICIPATING	RETRO PLAN

PART 1 - WORKERS COMPENSATION (States)	PART 2 - EMPLOYER'S LIABILITY	PART 3 - OTHER STATES INS	DEDUCTIBLES (N / A in WI)	AMOUNT / % (N / A in WI)	OTHER COVERAGES
	$ EACH ACCIDENT		☐ MEDICAL		☐ U.S.L. & H. ☐ MANAGED CARE OPTION
	$ DISEASE-POLICY LIMIT		☐ INDEMNITY		☐ VOLUNTARY COMP ☐
	$ DISEASE-EACH EMPLOYEE		☐		☐ FOREIGN COV ☐

DIVIDEND PLAN/SAFETY GROUP	ADDITIONAL COMPANY INFORMATION

SPECIFY ADDITIONAL COVERAGES / ENDORSEMENTS (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

TOTAL ESTIMATED ANNUAL PREMIUM - ALL STATES

TOTAL ESTIMATED ANNUAL PREMIUM ALL STATES	TOTAL MINIMUM PREMIUM ALL STATES	TOTAL DEPOSIT PREMIUM ALL STATES
$ 0.00	$ 0.00	$ 0.00

CONTACT INFORMATION

TYPE	NAME	OFFICE PHONE	MOBILE PHONE	E-MAIL
INSPECTION				
ACCTNG RECORD				
CLAIMS INFO				

INDIVIDUALS INCLUDED / EXCLUDED

PARTNERS, OFFICERS, RELATIVES (Must be employed by business operations) TO BE INCLUDED OR EXCLUDED (Remuneration/Payroll to be included must be part of rating information section.) Exclusions in Missouri must meet the requirements of Section 287.090 RSMo.

STATE	LOC #	NAME	DATE OF BIRTH	TITLE/ RELATIONSHIP	OWNER-SHIP %	DUTIES	INC/EXC	CLASS CODE	REMUNERATION/PAYROLL

STATE RATING SHEET # 1 **OF** 1 **SHEETS** **AGENCY CUSTOMER ID:** _____

STATE RATING WORKSHEET

FOR MULTIPLE STATES, ATTACH AN ADDITIONAL PAGE 2 OF THIS FORM

RATING INFORMATION - STATE:

LOC #	CLASS CODE	DESCR CODE	CATEGORIES, DUTIES, CLASSIFICATIONS	# EMPLOYEES		SIC	NAICS	ESTIMATED ANNUAL REMUNERATION/ PAYROLL	RATE	ESTIMATED ANNUAL MANUAL PREMIUM
				FULL TIME	PART TIME					

PREMIUM

STATE:	FACTOR	FACTORED PREMIUM		FACTOR	FACTORED PREMIUM
TOTAL	N / A	$			$
INCREASED LIMITS		$	SCHEDULE RATING *		$
DEDUCTIBLE *		$	CCPAP		$
		$	STANDARD PREMIUM		$
EXPERIENCE OR MERIT MODIFICATION		$	PREMIUM DISCOUNT		$
		$	EXPENSE CONSTANT	N / A	$
ASSIGNED RISK SURCHARGE *		$	TAXES / ASSESSMENTS *	N / A	$
ARAP *		$			$

* N / A in Wisconsin

TOTAL ESTIMATED ANNUAL PREMIUM	MINIMUM PREMIUM	DEPOSIT PREMIUM
$	$	$

REMARKS (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

AGENCY CUSTOMER ID: _____

PRIOR CARRIER INFORMATION / LOSS HISTORY

PROVIDE INFORMATION FOR THE PAST 5 YEARS AND USE THE REMARKS SECTION FOR LOSS DETAILS

☐ LOSS RUN ATTACHED

YEAR	CARRIER & POLICY NUMBER	ANNUAL PREMIUM	MOD	# CLAIMS	AMOUNT PAID	RESERVE
	CO:					
	POL #:					
	CO:					
	POL #:					
	CO:					
	POL #:					
	CO:					
	POL #:					
	CO:					
	POL #:					

NATURE OF BUSINESS / DESCRIPTION OF OPERATIONS

GIVE COMMENTS AND DESCRIPTIONS OF BUSINESS, OPERATIONS AND PRODUCTS: MANUFACTURING - RAW MATERIALS, PROCESSES, PRODUCT, EQUIPMENT; CONTRACTOR - TYPE OF WORK, SUB-CONTRACTS; MERCANTILE - MERCHANDISE, CUSTOMERS, DELIVERIES; SERVICE - TYPE, LOCATION; FARM - ACREAGE, ANIMALS, MACHINERY, SUB-CONTRACTS.

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	Y / N
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT / WATERCRAFT?	
2. DO / HAVE PAST, PRESENT OR DISCONTINUED OPERATIONS INVOLVE(D) STORING, TREATING, DISCHARGING, APPLYING, DISPOSING, OR TRANSPORTING OF HAZARDOUS MATERIAL? (e.g. landfills, wastes, fuel tanks, etc)	
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?	
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?	
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?	
6. ARE SUB-CONTRACTORS USED? (If "YES", give % of work subcontracted)	
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INSURANCE? (If "YES", payroll for this work must be included in the State Rating Worksheet on Page 2)	
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?	
9. ANY GROUP TRANSPORTATION PROVIDED?	
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?	
11. ANY SEASONAL EMPLOYEES?	
12. IS THERE ANY VOLUNTEER OR DONATED LABOR? (If "YES", please specify)	

AGENCY CUSTOMER ID: _____

GENERAL INFORMATION (continued)

EXPLAIN ALL "YES" RESPONSES	Y / N
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?	
14. DO EMPLOYEES TRAVEL OUT OF STATE? (If "YES", indicate state(s) of travel and frequency)	
15. ARE ATHLETIC TEAMS SPONSORED?	
16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?	
17. ANY OTHER INSURANCE WITH THIS INSURER?	
18. ANY PRIOR COVERAGE DECLINED / CANCELLED / NON-RENEWED IN THE LAST THREE (3) YEARS? **(Missouri Applicants - Do not answer this question)**	
19. ARE EMPLOYEE HEALTH PLANS PROVIDED?	
20. DO ANY EMPLOYEES PERFORM WORK FOR OTHER BUSINESSES OR SUBSIDIARIES?	
21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?	
22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME? If "YES", # of Employees: _____	
23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST FIVE (5) YEARS? (If "YES", please specify)	
24. ANY UNDISPUTED AND UNPAID WORKERS COMPENSATION PREMIUM DUE FROM YOU OR ANY COMMONLY MANAGED OR OWNED ENTERPRISES? IF YES, EXPLAIN INCLUDING ENTITY NAME(S) AND POLICY NUMBER(S).	

REMARKS (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

APPLICABLE IN TENNESSEE AND VERMONT: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO ANY PARTY TO A WORKERS COMPENSATION TRANSACTION FOR THE PURPOSE OF COMMITTING FRAUD. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, DC, FL, HI, MA, NE, OH, OK, OR, VT or WA; in LA, ME, TN and VA, insurance benefits may also be denied)

IN THE DISTRICT OF COLUMBIA, WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES.

IN MASSACHUSETTS, NEBRASKA, OREGON AND VERMONT, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, MAY BE COMMITTING A FRAUDULENT INSURANCE ACT, WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO CRIMINAL AND CIVIL PENALTIES.

IN WASHINGTON, IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

APPLICANT'S SIGNATURE (Must be Officer, Owner or Partner)	DATE	PRODUCER'S SIGNATURE	NATIONAL PRODUCER NUMBER