



Combined Group Insurance Services, Inc.
Non-Subscription Application

All questions on questionnaire must be completed in full to receive consideration for quotation.

RETAIL AGENCY				
Retail Agency Name & Address	Agent Number	Retail Agent Name	Phone Number	
		Retail Agent E-mail		
CSR's Name	CSR's Phone number	CSR's Email		
WHOLESALE AGENCY (Note to wholesale agents: Retail Agency and Wholesale Agency contact information must be completed)				
Wholesale Agency Name & Address	Agent Number	Wholesale Agent Name	Phone number	
		Wholesale Agent Email		
BASIC INFORMATION (please note, if the insured has been in business for less than 3 years, a letter of management experience is required)				
Complete Legal Name (enter additional named insureds on pg. 2)	Proposed Effective Date	Years in Business	FEIN	
Mailing Address (enter all physical locations on pg. 2)	Applicant's Website Address			
[] Sole Proprietorship, Name of SP _____				
[] Corporation [] Partnership [] LLC [] Other				
COMPLETE DESCRIPTION OF OPERATIONS and EMPLOYEE DUTIES				
GENERAL INFORMATION (Explain "Yes" answers on separate page)			Yes	No
1	Does insured manufacture, store, sell, handle or transport any explosives, asbestos products, nuclear or hazardous materials?			
2	Do you have any employees subject to the USL&H Act or FELA?			
3	Do you own, lease or charter watercraft or industrial aid aircraft?			
4	Does insured manufacture, store, sell, handle or transport any petro or hazardous chemical products?			
5	Do you use any owner/operators?			
6	Do you use any temporary or leased employees?			
7	Have you filed for bankruptcy in the last 5 years?			
RATING INFORMATION (included executive officer payroll shall be subject to a maximum of \$62,400 annually)				
	Classification	NCCI Code	Annual Payroll	# of Empl.
			\$	
			\$	
			\$	
			\$	
			\$	
Show additional payroll on separate page and include with submission.				
EXECUTIVE OFFICERS TO BE EXCLUDED (Executive officers included unless names are provided below)				
#	Name/Title	#	Name/Title	
1		4		
2		5		
3		6		

LOSS INFORMATION

Policy Year	Total Incurred	# of Claims	Type of Loss	Premium	Payroll	# of Empl.
Current Year	\$		[] N.S. [] W.C.	\$	\$	
	\$		[] N.S. [] W.C.	\$	\$	
	\$		[] N.S. [] W.C.	\$	\$	
	\$		[] N.S. [] W.C.	\$	\$	
	\$		[] N.S. [] W.C.	\$	\$	

Show details of each claim over \$25,000 on a separate page, along with action taken to prevent reoccurrence.

DWC5 FILING

Combined Group Insurance Services, Inc. will file your annual DWC-5 form with The Texas Department of Insurance upon binding/renewal of your policy. The information you provide on the application will be used to file the DWC5.

Please provide the NAICS code for your industry (required for DWC5 filing) _____.
 This information can be obtained at www.naics.com

[] We, the insured, will file the DWC5 form with TDI per State Filing Requirements.

**By marking the above box, the insured, has chosen to file the DWC5 with The Texas Department of Insurance and provide us, Combined Group Insurance Services, Inc., with a copy confirming the filing. If this box is not marked, Combined Group Insurance Services, Inc. will file your DWC5 with TDI per State Filing Requirements. The information you provide on this application will be used on the DWC5 form.

RESPONSIBLE REPORTING ENTITY

A federal law that took effect July 1, 2009, requires all businesses that have any type of liability insurance for work-related injuries to register with the Department of Health and Human Services. Insureds must report regularly on job-related injuries beginning January 1, 2010. There are no exceptions. As a courtesy to our insureds, we will report your claims to Medicare at no additional cost to you. If you have not already registered, please do so at <https://www.cob.cms.hhs.gov/Section111/>.

ELIGIBILITY-RISK INFORMATION

1	Number of non-pay cancellations for the past 12 months?	
2	Number of employees who drive or are a passenger of a vehicle for company business while working?	
3	Number of company owned vehicles?	
	Are MVR's checked?	[] Yes [] No
	How often?	
4	Travel Radius?	mi
	Do four or more employees ever ride in one vehicle?	[] Yes [] No
5	Maximum height an employee will work at, while standing on a non-fixed structure?	Ft
6	Maximum manual weight of material handling by an employee without any assistance?	lbs
7	Number of employees who operate a forklift? <i>(Please complete forklift supplemental if client has forklift operators.)</i>	
8	For chartered, leased, or owned aircraft: please provide the number of Texas employees per flight (including pilot if employed by insured). <i>(Please complete Pilot & Aircraft Questionnaire if client is requesting aircraft coverage.)</i>	
9	Current Worker's Comp Mod? (If currently in WC, please provide the Mod. worksheet)	

NAMED INSUREDS, DBAs & LOCATIONS (list every location including location on pg. 1)

Acceptable to show the same named insured for multiple locations			
Insured's Name	Street, City, State Zip	FEIN #	# of Empl.

Show additional named insureds & locations on separate page and include with submission.

CLAIMS ADMINISTRATION (Anchor will act as TPA on SIR's less than \$50,000)

Contact information of the employee responsible for submitting claims within your organization	Name:	Self-Administer <input type="checkbox"/> Outside TPA <input type="checkbox"/>
	Phone:	(only available if SIR is \$50,000 or greater)
	Email:	Name of Outside TPA:

ACCOUNTING

Contact information of the employee responsible for remitting premium invoices within your organization.	Name:	Billing Address
	Phone:	
	Email:	

SAFETY

Contact information of the employee responsible for safety within your organization.	Name:	
	Phone:	
	Email:	

ERISA INFORMATION (accurate completion is required to receive consideration for quotation)

Shortly after binding coverage, you will receive a new ERISA injury benefit plan and mandatory arbitration policy for negligence liability claims, for Combined Group Insurance Services, Inc. **You must provide Combined Group proof of rollout to all covered employees within 30 days of policy inception or Notice of Cancellation will be issued.**

- ERISA Plan Number (3-digit, 500 series number assigned by your company to this benefit plan: consecutively number all health & welfare plans, starting with 501; if incomplete or incorrect data entered, we will use number 501) _____
- Is your company or any affiliated company defined under Texas law as a "Motor Carrier," which subjects the entity to regulation by the Department of Transportation, requiring that minimum benefits be provided to employees? A "Motor Carrier" defined as: "person or entity that operates one or more vehicles that transport persons or cargo and whose primary business is transportation for hire between two or more municipalities..." [] Yes [] No
- Contact information for Employee Questions and Receipt of Legal Filings:
 Name: _____ Phone #: _____
 Address: _____ Fax #: _____
 City: _____ State: _____ Zip: _____ Email address: _____
- Do you need a Spanish translation of the ERISA and arbitration documents for employees? [] Yes [] No
- Name of current legal counsel relating to "non-subscriber" issues (if available): _____

SAFETY PROGRAM (Explain "Yes" answers on separate page)

	Yes	No
1 Do you have a formal written safety program?		
2 Do you have an Alcohol/Drug testing program?		
3 Do you have an employee training program?		
4 Do you have a prescreening program?		
5 Have you had any OSHA violations in the last 5 Years?		
6 Do you have a formal Driver Safety Program?		

FOR HEALTHCARE ACCOUNTS ONLY

What percentage of the risk's operations are

Home Health Non-Medical		Home Health – Medical/Skilled Nursing		Personal Care Provider	
Physical Therapist or Occupational Therapist		Skilled Nursing Facility		Hospitals	
Hospice/Palliative Care		Assisted Living Facility			

Does the insured have documented, defined duties limiting which services employees can or cannot perform? Yes No

CURRENT COVERAGE

Carrier	CSL Limit	Per Person Limit
Legal Included [] Yes [] No	SIR	AD&D Limit

COVERAGE ALTERNATIVES

Please check the requested limits below to receive quote (please note, if insured does not meet the underwriting guidelines of one product the underwriter may quote the other product as an alternative. Please refer to specimen policy for details of each at www.combinedgroup.com as there are significant differences in coverage).

LIMITS (check boxes for requested quote options)

CEI Coverage Requested	1	2	5	10	25
Combined Single Limit (millions)	1	2	5	10	25
Disability Benefit Period (weeks)	104	156	260		
Accidental Death and Dismemberment Limit	100,000	150,000	200,000	250,000	
Total Disability Benefit Limit per week	500	600	700	800	900
Self-Insured Retention (minimum \$1,000)	\$				

Alternate Coverage Requested	V.I.P.	Occ. Acc.			
Combined Single Limit (millions)	500,000	1,000,000			
Disability Benefit Period (weeks)	104	156			
Accidental Death and Dismemberment Limit	100,000	150,000	200,000	250,000	
Total Disability Benefit Limit per week	500	600	700	800	900
Self-Insured Retention (minimum \$1,000)	\$				

This is not a workers compensation policy. You do not become a subscriber to the Workers Compensation system by purchasing this policy. You lose those benefits that would accrue under the Workers Compensation Act. By signing this application, you warrant that you will comply with the Workers Compensation Law as it pertains to non-subscribers and that the required notices will be filed and posted. By signing this application, you confirm that you have been provided with and inspected a specimen copy of the chosen policy and understand the carrier's ERISA plan and arbitration requirements. We recommend that you consult with your legal advisor to ensure that you fully understand the coverage provided. You also agree that, should coverage be issued based upon this application, this application shall become a material and integral part of the policy and the statements made herein shall be construed as your representations and warranties.

Anyone who knowingly and with intent to defraud any insurance company or other persons, files a statement containing 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.

 Authorized Signature of Applicant Title Date