COMBINED INDEPENDENT AGENCIES
American Fidelity Occ Acc Application

*****All pages of this application must be completed in full to receive consideration for quotation*****

Retail Agency Name & Address	Agent Number	Retail Agent Name / Phone Number
		Retail Agent E-mail
CSR's Name	Phone number	CSR'S E-mail
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 E-mail

BASIC INFORMATION *Attach additional named insureds, FEIN #'s, locations and the number of employees at each location on a seperate sheet.*

Complete **Legal** Name	Proposed Effective Date	Years in Business
Mailing Address (please list billing address on pg. 2)	Applicant's Website address	FEIN
	[ ] 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	#	Explain "Yes" answers on separate page	Yes	No
1	Does insured manufacture, store, sell, handle or transport any explosives, asbestos products, nuclear or hazardous			5	Does insured manufacture, store, sell, handle or transport any petro or hazardous chemical products?		
2	Do you have any employees subject to the USL&H Act or FELA?			6	Do you use any owner/operators?		
3	Do you own, lease or charter watercraft or industrial aid aircraft?			7	Do you use any temporary or leased employees?		
4	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)

Classifications	NCCI Code	Estimated Annual Payroll	# of Empl.
		$	
		$	
		$	
		$	

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 (For 50 lives & over and trucking: 3 year loss History and Payroll required. If the insured has been in business for less than 3 years a letter of management experience required.)

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.

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? _____ miles 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? _____ Are they certified? Yes ☐ No ☐
8) Current Worker's Comp Mod _____ **(If currently in WC please provide the Mod. worksheet)**

COVERAGE REQUESTED

Combined Single indemnity Limit	☐ $500,000 ☐ $1,000,000
Coverage 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 ☐ 1000
Self-Insured Retention **(minimum $1000)**	$

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

Name and telephone number of the employee responsible for submitting claims within your organization	Name: Phone:

ACCOUNTING

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

RRE: Responsible Reporting Entity (This section must be completed upon binding in order for you to comply with Federal regulations)

A new 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 www.Section111.cms.hhs.gov. Register and provide us with the following information:

RRE #: **PIN:** **Date Registered Online:**

ERISA INFORMATION:

NOTE: An ERISA Plan is not required for American Fidelity, however if you would like to purchase an ERISA Plan for an additional $100 fee, please complete the following information. ☐ Yes, I would like to add an ERISA Plan to my policy.

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

1. 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) _____
2. 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 ☐
3. Contact information for Employee Questions and Receipt of Legal Filings:
   Name: _____ Email address: _____
   Address_____ Phone#: _____
   City_____State_____Zip_____ Fax#: _____
4. Do you need a Spanish translation of the ERISA and arbitration documents for employees? Yes ☐ No ☐
5. Name of current legal counsel relating to "non-subscriber" issues (if available): _____
6. Do you want Mandatory Arbitration? (**Optional for Occ Acc only**) Yes ☐ No ☐

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, that 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