Combined Group Insurance Services, Inc.

Clear All Fields

Non-Subscription Application

All sections on application 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, 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	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 (Five year loss History and Payroll required for Republic CSIL over $1M)

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 ***This section to be completed ONLY for policies with an effective date of 09/01/2012 and after

As of 09/01/12, 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. **File DWC5 online**

**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.

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

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?	
	Are they certified?	☐ Yes ☐ No
8	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.

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.**

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: _____ Phone #: _____

   Address: _____ Fax #: _____

   City: _____ State: _____ Zip: _____ Email address: _____

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? (**Option for Occ Acc only**) ☐ Yes ☐ No

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: Phone: Email:	

ACCOUNTING

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

SAFETY

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

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?	☐	☐

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 doe not meet the underwriting guidelines of one product the underwriter may quote the other product as an alternative. Please refer to specimen policy for detail of each at www.combinedgroup.com as there are significant differences in coverage).

LIMITS (check boxes for requested quote options)

☐ **CEI Coverage Requested**	☐ **North American Capacity**	☐ **Republic Vanguard**					
Combined Single Limit (millions)	☐ 1	☐ 2*	☐ 5*	☐ 10*	☐ 25*		*Only Available for NAC
Disability Benefit Period (weeks)	☐ 104*	☐ 156	☐ 260*				*Only Available for NAC
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 $1,000**)	$						
☐ **Alternate Coverage Requested**	☐ **V.I.P.**	☐ **Occ. Acc.**					
Combined Single Limit	☐ 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	☐ 1000	
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 _____

Submit by Email