CAMICO

WORKERS COMPENSATION INSURANCE APPLICATION

Program available through:
CAMICO Insurance Services
Tel: 800.652.1772

CAMICO

Workers Compensation

General Information

1. Firm Name: _____

2. Contact Person: _____
   (Person designated and authorized by the Firm to receive any and all notices concerning this insurance.)

3. Contact Person Title: _____ 4. Contact Person E-mail: _____

5. Primary Mailing Address: _____
   Mailing Address City State Zip

6. Telephone: _____ 7. Fax: _____

8. Entity Type: ❒ Sole Proprietorship ❒ Partnership / LLP ❒ Corporation ❒ LLC ❒ PC ❒ Other (list): _____
   (If partnership, please provide a list of all partners on a separate sheet)

9. Year Established (yyyy): _____

Workers Compensation Questionnaire

10. FEIN Number: _____ 11. Effective Date: _____

12. Do you currently have a workers compensation policy? ❒ Yes ❒ No
    If "Yes", please attach a copy of the policy declarations page and any endorsements.

13. Number of workers compensation losses in last 3 years: _____
    If any losses, please complete the attached Loss Supplement (Page 2).

14. Number of Employees: Full Time: _____ Part Time: _____ WC Experience Modifier (if known): _____

15. Payroll information:

	State	Location #	Class Code	Zip Code	Payroll
Example	*CA*	*1*	*8803*	*xxxxx*	*$ xx,xxx*
		1			$
		2			$
		3			$

16. Are any employees leased from another entity? ❒ Yes ❒ No

17. Do you own or operate any aircraft in the course of business? ❒ Yes ❒ No

18. Do any employees travel outside of the country as part of their work? ❒ Yes ❒ No

19. Do you have any volunteer labor? ❒ Yes ❒ No

20. Do you have more than 50% ownership interest in any other business? ❒ Yes ❒ No
    If "Yes", please list: _____

21. Are all workstations ergonomically designed at all locations? ❒ Yes ❒ No
    If "No", please explain: _____
    _____

22. Are all employees provided with training/education on ergonomic issues? ❒ Yes ❒ No
    If "No", please explain: _____
    _____

23. Should any officers be included/excluded on the workers compensation policy?

Include/Exclude	Name	Position	% Owned	Class Code	Payroll	State
					$	
					$	
					$	
					$	
					$	
					$	

24. Do you currently use QuickBooks Payroll? ❒ Yes ❒ No
If "Yes," you could be eligible for electronic direct payments

Signature

The undersigned proprietor, authorized partner of the partnership, or authorized stockholder of the corporation represents that the following statements are understood and agreed to by the applicant:

By signing this application, the undersigned represents that he or she has made inquiries of all Firm members as appropriate and that all Firm members are bound by the representations made on this application, any supplemental application, and any supplemental data and documents provided.

Signing this application or tendering premium does not bind the applicant or the company to issue insurance coverage, but it is agreed that this application shall be the basis of the contract should a policy be produced.

Name: (Please Print) _____

Signature: _____ Date: _____

Position/Title: _____

Applicant/Firm: _____

Please send completed application and below supplement to:

Sales Department
CAMICO Insurance Services
1800 Gateway Drive, Suite 300
San Mateo, CA 94404

Call: 1.800.652.1772
E-mail: inquiry@camico.com
Fax: 1.800.496.9910

Supplement

Workers Compensation Loss History Supplement

1. For any losses in the last 3 years, please attach runs or describe below if there have been any losses.

Date of Loss	Medical / Indemnity	Description	Loss Amount