



Employer's Comp Associates, Inc.
Phone: (972) 931-2026 or (800) 299-5250
Fax: (972) 931-2126

Type of Proposal(s) Requested:
 Occupational Accident Only
 Occupational Accident w/Legal
 Employer's Excess Indemnity

Please fax this completed form, your inforce TX Agent's Insurance license and Errors & Omissions DEC page to Employer's Comp Associates, Inc.

Applicant Name _____ Requested Effective Date _____
 Address _____ CITY _____ ST _____ ZIP _____ Nature of Business _____
 Number of years in business: _____ Tax ID# _____ Date of workers' comp coverage rejection: _____
 Has worker's comp or occupational accident coverage ever been canceled, refused or non-renewed? Yes No
 If Yes, please explain: _____
 Business Type: Corporation Partnership Other: _____
 Is applicant subject to LPG or TxDOT Regulations? Yes No. Within what radius does applicant haul?: _____
 Does applicant handle, store, or engage in transport of hazardous materials (including but not limited to explosive, caustic, poisonous or flammable materials)? Yes No. If Yes, please explain: _____
 Please specify commodities hauled: _____
 What percentage of loads are manually loaded or unloaded (use 0% if no manual (un)loading)? _____% Loaded _____% Unloaded
 Does applicant perform any work at heights over 24 ft.? Yes No. If Yes, please explain: _____
 Are Owners, Officers or Partners to be covered? Yes No. Are any affiliate companies to be covered? Yes No. If yes, please provide Legal Name, Address and number of employees at each location.

# of Full-Time EES 1099	# of Part-Time EES 1099	Classification Code	Annual Payroll by Class (Including Tips)	Classification or Description

Total Number of Employees _____ Total Payroll \$ _____ Waiver of Subrogation? Yes No
 Current Worker's Comp or Accident Premium \$ _____ Occupational Disease & Cumulative Trauma? Yes No

Benefits to be Quoted: LIMITS VARY BY PRODUCT. PLEASE CALL FOR OTHER OPTIONS.

CSL Benefit: _____ Deductible: _____ Excess Limits: _____
 (\$100,000 - \$1,000,000 CSL) (\$1,000 - \$500,000 deductible) (\$1,000,000 to \$5,000,000 Limits available)
 Benefit Period: ___ 52 Wks ___ 104 Wks ___ 156 Wks Weekly Income: (75% up to \$600) _____ Waiting Period: _____ days

Please submit 3 years (hard copy) current valued loss history: Valuation Date of loss information: _____

Year	Carrier	Total Losses	Description of Each Loss in Excess of \$5,000 (Use separate sheet if necessary)

- | | |
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| 1. Has this applicant (or affiliate) been in the Texas Workers' Compensation System in the last 3 years? If yes, have they had an experience modification factor of 1.50% or higher? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Has the applicant (or affiliate) ever had an Employer's Liability claim? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Has the applicant (or affiliate) ever had an Occupational Disease (e.g. Black Lung, silicosis, lead poisoning, cancer, etc.) or Cumulative Trauma (e.g. carpal tunnel, stress, etc.) claim? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Does the applicant have Employer's Excess Indemnity coverage? Carrier Name: _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If the answer to #2 or #3 is YES, please give a complete descriptions, dates, and amounts of claims on a separate sheet.

Agent and Applicant hereby acknowledge that: (a) all answers and statements contained herein, including any attached data, are true and complete; (b) Insurer will rely solely on the information provided in this Fax-A-Quote, along with any attached data, in considering whether to provide the requested insurance coverage; and (c) this Fax-A-Quote shall become a part of the Policy should coverage be bound.

Agent: _____ **Phone:** _____
Address: _____ **Fax:** _____

Agent Signature: _____ Applicant Signature: _____