

Application for Employer’s Primary Indemnity Coverage

Application is hereby made for coverage(s), as specified per the signed attached quotation, to become effective on _____, at 12:01 AM Central Standard Time at the address described below and provided that the initial premium is paid in full and the Company approves this application.

1. Legal Name of Applicant _____
dba _____ Federal Tax ID Number _____

2. Contact Person _____ Title _____

3. Mailing Address _____ City _____ State _____ Zip _____
Street Address _____ Phone _____
City _____ State _____ Zip _____ Fax _____

5. Are owners/officers/partners to be covered? Yes/No Are they on the State Employment Commission Report? Yes/No

6. Are any affiliate companies to be covered? Yes/No If yes, please provide Legal Name, Address and number of employees at each location: _____

Please list on a separate sheet of paper all Texas locations including complete physical address, from which the applicant conducts business operations, please include number of employees per location.

7. Does the applicant currently have an ERISA Plan? Yes/No **If yes, please provide a copy of the full plan document and the Summary Plan Description (SPD).**

Does the applicant have any employees who are subject to:

- | | | |
|--|-----|----|
| A. U.S. Longshore & Harbor Workers’ Act? | Yes | No |
| B. Jones Act? | Yes | No |
| C. Federal Employer’s Liability Act? | Yes | No |

Does the applicant have a written Safety/Loss Control Program? Yes/No If Yes, provide the following:

Who developed program? Name _____
Address _____ City _____ State _____ Zip _____
Phone _____ Fax _____

When was program initiated? _____ When was program last updated? _____

Please provide the following information concerning the current loss prevention practices:

A. Safety:

Does the safety/loss control program include:

- | | |
|----------------------------------|---------------------------|
| 1. A written safety manual | Yes/No |
| 2. Safety Director? | Yes/No Full or part-time? |
| 3. Safety incentive program? | Yes/No |
| 4. Alcohol/drug testing program? | Yes/No |
| 5. Safety Committee? | Yes/No |
| 6. Safety meetings? | Yes/No |
| 7. Periodic self-inspections? | Yes/No Frequency? _____ |

B. Training:

Does the training program include:

- | | |
|--|---------------------------|
| 1. Written training program for new employees? | Yes/No |
| 2. Training Director? | Yes/No Full or part-time? |
| 3. Ongoing employee training? | Yes/No Frequency? _____ |

C. Other Procedures:

- 1. Bodily Injury reporting and record keeping? Yes/No
- 2. Bodily Injury investigation? Yes/No

The Surplus Lines Tax & Stamping Fee will be payable monthly on all billed premiums & fees. No coverage is in effect until approved in writing by the Company by way of a binder. The Payroll should be most recent 30 day period available (the prior calendar month's payroll).

As per the Policy's provisions, the Company may audit your payroll records at any time. If it is determined that premiums have been underpaid, the Company shall be entitled to recover such underpayments.

- A) The applicant requests coverage for a Policy of insurance as described above. The applicant also agrees to be bound by all the terms, conditions and limitations of the Policy applied for. The applicant further understands and agrees that: 1) Neither this Request for Coverage nor the payment of any moneys to be applied shall guarantee insurance to become effective. In order for insurance to take effect on the date specified, the Company must accept and issue a binder of coverage. 2) The applicant will agree to pay the required premiums to the Company when due.
- B) Acceptance of the request/application is subject to all of the following: (1) Company's requirements; (2) Terms of the Policy; (3) Company verification of the quoted premium; and (4) Company's verification of an acceptable ERISA document.
- C) The Company will notify the applicant of any approval or declination of this application.
- D) The undersigned applicant understands that he or she may be subject initially to an on-site loss control/safety inspection by a certified safety consultant, as a contingency for coverage acceptance. The applicant also understands and agrees that he or she will be required to comply with any/all loss control/safety recommendations as a continuation of coverage.
- E) The undersigned applicant has reviewed with Agent (who signed below) and understands the coverage, limits, terms, conditions and exclusions of this application and the Policy. The applicant understands that the Agent is not authorized by the Company to bind coverage. Further, no statement made by the Agent will bind the Company unless the statement is reduced to writing and signed by the Company's duly authorized Officer. This application shall become a part of the Policy.
- F) The undersigned applicant understands this coverage is written on an Indemnity/Reimbursement basis and he or she will be reimbursed in accordance with the Policy for approved amounts paid to employees and/or Providers for on-the-job injuries.
- G) The undersigned applicant understands this coverage is written on a Combined Single Limit (CSL) basis. All coverage afforded under this Policy shall not exceed the CSL amount for any one person.

Applicant Signature (Officer) _____
Title _____ Date _____

The undersigned Agents warrants he or she has not represented the above coverage, as anything other than an employer reimbursement Policy for on-the-job employee related injuries.

Agent of Record _____ Date _____

Agency/Agent Printed Name _____
Address _____ City _____ State _____ Zip _____
Phone _____ Fax _____

THIS INSURANCE CONTRACT IS WITH AN INSURER NOT LICENSED TO TRANSACT INSURANCE IN THIS STATE AND IS ISSUED AND DELIVERED AS A SURPLUS LINES COVERAGE PURSUANT TO THE TEXAS INSURANCE STATUTES. THE STATE BOARD OF INSURANCE DOES NOT AUDIT THE FINANCES OR REVIEW THE SOLVENCY OF THE SURPLUS LINES INSURER PROVIDING THIS COVERAGE, AND THE INSURER IS NOT A MEMBER OF THE PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION CREATED UNDER THE INSURANCE CODE, ARTICLE 21.28-C. THE INSURANCE CODE, ARTICLE I. 14-2, REQUIRES PAYMENT OF 4.85 PERCENT TAX ON GROSS PREMIUM.

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

Disclosure and Acknowledgment Concerning Workers' Compensation

This will acknowledge that in solicitation of my business insurance, the Agent named below (herein referred to as "Agent"), explained to me the following facts about the Texas Workers' Compensation Act (the "Act"). The following facts were discussed, and as an employer I am aware of their importance. To my knowledge, no statements contrary to the following statements were made by the Agent to anyone employed by, or representing, the Named Insured.

1. Workers' Compensation Insurance is a "No-Fault" system that affords coverage for my employees and protections for me which no alternative insurance plan can duplicate.
2. It is my responsibility, should I elect not to purchase workers' compensation insurance, to notify the Texas Department of Insurance, Division of Workers' Compensation ("DWC") at the time of such election by filing the appropriate form (currently the DWC Form 5). I must also annually file the appropriate form (currently DWC Form 5) with the DWC on the anniversary date of the original filing or if I have canceled my workers' compensation policy, on the anniversary of the cancellation date of the workers' compensation policy. I am aware of the penalty for failure to properly file can be as much as \$500 per day. I also must notify my workers' compensation carrier, in the manner provided by the law, at the time of my election. All notices and elections must be made by certified mail, return receipt requested.
3. Agent has advised me that if I become a "non-subscriber" under the Act, I should seek the advice of competent legal counsel in meeting the provisions of the Act. Agent has advised me to seek legal advice for the current law as it applies to my situation.
4. I am aware that as a non-subscriber, should I purchase an "alternative" insurance product that provides Injury medical benefits for my employees, I come under the Employee Retirement Income Security Act of 1974 (ERISA). It is in my best interest to have a written employee injury benefit plan, and to file this plan under ERISA with the U.S. Department of Labor. Such insurance and plan do not preempt a personal injury negligence lawsuit.
5. I understand that an approved safety program could help reduce the frequency and severity of on-the-job injuries and could also help us meet our responsibility to provide a "reasonably safe place to work" for our employees.

Agent has shown me an alternative work place Injury insurance plan. I acknowledge the option I have selected is solely my choice and the alternative plan I have chosen was not represented by Agent to any person as being a substitute for statutory workers' compensation insurance. Agent did not induce me or any representative of my company to reject Workers' Compensation.

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I read the above and acknowledge the Agent has discussed each of these items with me.

Signed this _____ day of _____, 20____.

Agent Signature

Firm Name (please print)

Witness

Signature - Officer/Owner

ADDENDUM TO APPLICATION FOR EMPLOYER’S PRIMARY INDEMNITY COVERAGE

Request for Exclusion of Certain Officers/Owners/Partners

_____ (the “Company”) hereby requests that individual officers/owners/partners of the Company who have executed the attached “Officer/Owner/Partner Request for Exclusion From Coverage” Form, be excluded from coverage under the Lexington Insurance Company Employer’s Primary Indemnity Coverage Policy for which the Company has applied. Company does not wish to cover such officers/owners/partners under its benefit Plan covering employment-related Injuries, Diseases and conditions. Company recognizes that Lexington Insurance Company will not provide any reimbursement to Company for benefits provided by Company to such officers/owners/partners. Company further recognizes that no legal indemnity coverage shall be provided by Lexington Insurance Company to Company with respect to any Injury, Disease, or condition suffered by any such officers/owners/partners as a result of employment with Company. Lexington Insurance Company shall not provide Company any reimbursement of indemnification for any liability, by settlement, judgment or otherwise, of Company to any such officers/owners/partners. Lexington Insurance Company shall not provide reimbursement of indemnification to Company for any attorney’s fees, costs or other expenses incurred by Company in defending itself against any claims of such officers/owners/partners. The exclusion from coverage of officers/owners/partners shall be effective on the _____ day of _____, 20____.

Company Name

Authorized Signature

Printed Name

Title

Date

OFFICER/OWNER/PARTNER REQUEST FOR EXCLUSION FROM COVERAGE

I, _____, _____ of _____
(Title) (Company Name)

(the "Company"), hereby request that I be excluded from coverage under the Company's benefit Plan covering employment related Injuries, Diseases and/or conditions. I further wish that no premiums be paid by Company to Lexington Insurance Company for any Employer's Primary Indemnity Coverage Policy coverage for any Injuries, Occupational Disease, or Cumulative Trauma that I may suffer in the Scope of Employment with Company.

Authorized Signature

Date

ERISA PLAN WORKSHEET

Company's Legal Name: _____

President of Company: _____

Physical Address: _____

Mailing Address: _____

Telephone Number: (_____) _____ Fax: (_____) _____

Email Address: _____

Federal Tax I.D. No.: _____

Contact Person and Title (the ERISA Plan Administrator):

Insurance Agent (Name, Agency, Address, Telephone & Fax Number):

Number of Employees: _____

Effective Date of ERISA Plan: _____

The Plan Identification Number will be "501" unless you have another employee welfare plan, such as a group health plan, which is designated "501." If you have another welfare benefit plan(s), what is the Plan Identification Number(s)?

Loss Verification

Applicant Name: _____

Federal Employer Tax ID Number or Social Security Number: _____

I verify that (I) the applicant named above has had no known losses in the previous (3) years.

I verify that (I) the applicant named above has had the following employee occupational losses as listed:

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

Signature of Applicant: _____

Title: _____

Date: _____