Occupational Accident Quote Request

Coverage Type		Requested Effective Date	
Client Name		Nature Of Business	
Address		City	State / Zip
Years In Business		Tax ID No.	Date of Workers Comp Rejection
If Yes Explain:			
Has Workers Compensation or Occupational Accident ever been cancelled, refused or non renewed?	◯ YES	◯ NO	
If Yes Explain:			
Business Type:		Are Owners, Partners or Officers to be covered?	
Is Applicant Subject to LPG or Texas Dot Regulations?		Within What Radius Does Applicant Haul?	
Does applicant handle, store, or transport hazardous materials including but not limited to explosive, caustic, poisonous or flammable materials?	◯ YES	◯ NO	Please specify commodities hauled:
If Yes Explain:			
What percentage of loads are MANUALLY loaded or unloaded. Use 0% if no manual (un)loading	Unloaded		Loaded
Does Applicant perform any work at heights over 24ft. ?		If Yes Explain:	
Benefits To Be Quoted:	CLS	Deductible	Benefit Period
Excess Limits		Waiting Period	Weekly Income 75% to $600
Please submit 3 years (hard copy) of currently valued loss history		Date of Loss Information:	

Year	Carrier	Total Losses	Description of Each Loss in Excess of $5,000 Use sep. sheet if necessary

1. Has the applicant (or affiliate) been in the Texas Workers Compensation system in the last three Years?	☐ No	☐ Yes
2. If yes, have they had and experience modification factor of 200% or more?	☐ No	☐ Yes
3. Has the applicant (or affiliate) ever had an Employer's Liability claim?	☐ No	☐ Yes
4. Has the applicant (or affiliate) ever had a Cumulative Trauma (e.g. carpal Tunnel, stress, etc.) claim?	☐ No	☐ Yes
5. Has the applicant (or affiliate) ever had an Occupational Disease (eg. black lung, silicosis, lead poison, cancer etc.)	☐ No	☐ Yes

If the answer to questions three, four or five is YES, please give a complete description, 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 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 quote request shall become part of the Policy should coverage be bound.

Agent:	Phone:	Fax:	Address:
Agent Signature:		Applicant Signature:	

Occupational Accident Quote Census Page

Please Provide Legal Name, Address and number of Employees at each Location.

Location Name		Location Street		City & Zip	

No. Of Full Time W-2's	1099	No. of Part-time W-2's	1099	Classification Code	Annual Payroll by Class (Including Tips)	Classification or Description

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