

Affiliated Marketing Group
2925 Briarpark, Ste 155
Houston, TX 77042
713 977 0611 voice
713 977 3877 fax
800 947 8106 toll free
Attention: Angela Moore

Fax-A-Quote

Type of Proposal Requested:

- Occupational Accident only
- Occupational Accident w/Legal
- Employer's Excess Indemnity

Please fax this completed form, your inforce TX insurance license, and E & O dec page to **Affiliated Marketing Group**. For assistance, please call 713 977 0611

Applicant Name _____ Requested Effective Date _____

Address _____ City _____ 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 W-2's	1099	# of Part-time W-2's	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 available) (\$1,000 - \$500,000 deductible available) (\$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) currently 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)

- | | |
|--|--|
| 1. Has the 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 200% or more? | <input type="checkbox"/> Yes <input type="checkbox"/> No
<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 |

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: _____