



## **Affiliated Marketing Group**

A LIFEMARK PARTNER

2925 Brairpark, Suite 155    713-977-0611  
Houston, TX 77042        800-947-8106  
life@affiliatedmarketing.com

## **The following items must be obtained in order to obtain a quote with Legal Liability:**

1. All spaces on the EPIC request form must be completed. This form must be signed by the agent and the client.
2. Federal Tax I.D. #
3. Hard Copy loss runs for the past (3) years.
4. In the event, the client has no previous coverage, a letter from the owner, on their letterhead, stating what losses (amount paid and type of injury) or “no losses”. (See Lexington statement of no loss)
5. Fax request to 713-977-3877

Incomplete submissions will hold up the underwriting process. We need to know as much about the client in order expedite the underwriting process and to get you the quote in a timely manner.

**We at Affiliated Marketing Group appreciate the opportunity to work with you and your clients and to give you the service you deserve.**

**Thank you.**



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**Type of Proposal Requested:**

- Occupational Accident only
- Occupational Accident w/Legal

Please fax this completed form, your in-force insurance license, and Errors & Omissions declarations page to: **AFFILIATED MARKETING GROUP FAX: 713 977 3877**

Applicant Name Requested \_\_\_\_\_ Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_

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? \_\_\_\_\_

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: \_\_\_\_\_ miles

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: \_\_\_\_\_

| # of Full-Time EES 1099 | # of Part-Time EES 1099 | Classification Code | Annual Payroll by Class | Classification or Description |
|-------------------------|-------------------------|---------------------|-------------------------|-------------------------------|
|                         |                         |                     |                         |                               |
|                         |                         |                     |                         |                               |
|                         |                         |                     |                         |                               |
|                         |                         |                     |                         |                               |

Total Number of Employees \_\_\_\_\_ Total Payroll \$ \_\_\_\_\_ Waiver of Subrogation?  Yes  No

Current Work 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: \_\_\_\_\_ Waiting Period: \_\_\_\_\_ days

(\$100,000 - \$1,000,000 CSL available) (\$1,000 - \$500,000 deductible available)

Benefit Period: \_\_\_\_\_ Weekly Income Limit: \_\_\_\_\_ (75% up to \$600 standard to most policies)

**Please submit 3 years currently valued loss history below:** Valuation Date of loss information:

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

1. If this applicant (or affiliate) is currently in the Texas Workers' Compensation System, do they have an experience modification factor of 200% or more?  Yes  No

2. Has the applicant (or affiliate) ever had an Employer's Liability claim?  Yes  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?  Yes  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 : \_\_\_\_\_ FAX: \_\_\_\_\_

Agent Signature: \_\_\_\_\_

(Required)

Applicant Signature: \_\_\_\_\_

(Required)