Application for Employer's Indemnity Policy

Underwritten by Dallas Fire Insurance Company
14160 Dallas Parkway, suite #500
Dallas, TX 75254

ADMITTED PRODUCT

Application is hereby made for the coverage specified to become effective on ______________________ at 12:01 A.M. 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 Code _________
4. Street Address: ____________________ Phone: ____________________
   City: ____________________ State ________ Zip Code ____________ County: ____________________
5. Nature of Business: ____________________
6. Applicant is ❑Corporation ❑Partnership ❑Sole Proprietorship ❑Other (explain): ____________________
7. Are any affiliated companies to be covered? ❑Yes ❑No If YES, please provide Legal Name and Address: ________
   ____
   ____________________ No. of employees at each location: ____________________
8. How long has the company been in business? ______________ Date of Act Rejection? ____________________
9. What are the companies hours of operation? ____________________
10. Has insurance of this type (Employer's Indemnity/PEI) been canceled, refused or non-renewed by any company during the past Three (3) years? ❑Yes ❑No If YES, please provide details: ____________________
    ____
11. Does the applicant manufacture, store distribute, sell, handle or transport any of the following?

Chemicals	❑ Yes	❑ No	Details: ____________________
Pharmaceuticals	❑ Yes	❑ No	Details: ____________________
Drugs	❑ Yes	❑ No	Details: ____________________
Explosives	❑ Yes	❑ No	Details: ____________________
Gasoline	❑ Yes	❑ No	Details: ____________________
Fuel Oils	❑ Yes	❑ No	Details: ____________________
Hazardous Wastes	❑ Yes	❑ No	Details: ____________________
Nuclear Materials	❑ Yes	❑ No	Details: ____________________
Nuclear Wastes	❑ Yes	❑ No	Details: ____________________
Asbestos Materials	❑ Yes	❑ No	Details: ____________________

12. Does the applicant now (or have future plans to) own, lease or charter any of the following: Provide details for all YES Answers.

A. Watercraft	❑ Yes	❑ No	Year: ______	Make: ____________________	Seating Capacity: __________
B. Air Craft	❑ Yes	❑ No	Year: ______	Make: ____________________	Seating Capacity: __________

13. Are employees required to drive their own vehicles for business purposes? ❑ Yes ❑ No
if YES, please provide
details:____
____

14. Are owners/officers to be covered? ❑ Yes ❑ No
Are they on the State Employment Commission Report? ❑ Yes ❑ No
Number of Employees:____________________
Coverage Period:____________________
Deductible Amount:____________________

Contractual Liability Limit (Part B)
Accident/Disease
Each Employee:____________________
Each Accident:____________________

Class	Texas W/C Code	Payroll	Payroll Rate	Total for Class
Total Payroll				
	Composite Rate			
		Premium Subtotal:		
		Annual Policy Fee:		
		Initial Payment		

Payment Mode:

Monthly ❑

Annually ❑

Part B Coverage includes:

Employer Liability

Unlimited Defense

When paying monthly, make checks payable to: **Healthcare Resource Group**

When making annual payments, make checks payable to: **Accident Insurance Services, Inc.**

As per the policy provisions, we have the right to audit your payroll records any time. If it is determined that premiums have been underpaid, we shall be entitled to recover such underpayments.

1. The applicant requests coverage for a policy of insurance as described above. the applicant also agrees to be bound by all of the terms, conditions and limitations of the policy applied for. The applicant further understands and agrees that:

   a. Neither this Request for Coverage, nor the payment of any monies 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 policy.

   b. The Insured/Employer will agree to pay the required premiums to the "Company" when due.

   c. Failure to comply with ERISA requirements regarding distribution of the Summary Plan Description to all employees (new and existing) will result in reduced benefits as per Section I (B-1) that states "We have the sole discretion to determine whether amounts sought to be reimbursed under this coverage are reasonable".

2. Acceptance of this request/application is subject to all of the following: (a) Company's requirements; (b) Terms of the policy; (c) Company verification of the quoted premium.

3. The Company will notify the Insured/Employer of any approval or disapproval of this request. Any notice/binder of approval will specify the policy effective date and schedule of coverage.

4. The undersigned Insured/Employer understands that he/she may be subject to on-site loss control inspections. Periodic loss control/safety inspections may be required as a contingency for continuation of coverage. The Insured/employer also understands and agrees that he/she will be required to comply with any/all loss control/safety recommendations as a contingency for continuation of coverage.

5. The undersigned Insured/Employer has reviewed with his agent (who signs below) and understands the coverage, limits, terms, conditions and exclusions of this application and the policy. This application shall become a part of the policy.

6. The undersigned Insured/Employer understands this coverage is written on an Indemnity/Reimbursement basis and he/she will be reimbursed in accordance with the policy for approved amounts paid to defend you against any claim or lawsuit coming under this insurance.

7. The undersigned Insured/employer understands that all coverage afforded under this policy shall not exceed the coverage amount specified in the policy for any one person.

Applicant Signature (Officer):______________________________
Title:______________________________ Date:______________________________

The undersigned agent warrants he/she has not represented the above coverage as anything other than an employer reimbursement policy for on-the-job related claims or lawsuits.

Agent of Record:______________________________ Date:______________________________

Agency/Recording Agent Printed Name:______________________________
Phone:______________________________ Fax:______________________________

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 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 employer.

1. Workers' Compensation Insurance is a "No Fault" system that affords coverage for my employees and protection 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 WORKERS' COMPENSATION COMMISSION (TWCC) at the time of such election by filing the appropriate form (currently the TWCC Form 5). I must also annually file the appropriate form (currently TWCC Form 5) with the TWCC 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 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. The 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. The 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 and "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. The Agent has advised me that a workplace 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.

The Agent has shown me an alternative workplace 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 the Agent to any person as being a substitute for Statutory workers' compensation insurance. The Agent did not induce me or any representative of my company to reject Workers' Compensation.

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

Signed this________________day of____________________,__________.

Recording Agent Signature	Firm Name (Please Print)
Witness	Signature-Officer/Owner