U.S. Risk Brokers, Inc.
"A World of Markets Within Your Reach"

214.265.7090
Fax: 877.388.7768
Toll Free: 800.232.5830

8401 N. Central Expressway, Suite 1000 Dallas, TX 75225

TEXAS NON-SUBSCRIBER OCCUPATIONAL ACCIDENT INSURANCE POLICY APPLICATION

Application is hereby made for coverage (s), as specified per the signed attached quotation, 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 approved this application.

1. **Legal Name of Applicant:** _____

   DBA: _____ **FEIN:** _____

   Corporation ☐ Partnership ☐ Sole Proprietor ☐ LLC ☐ Other_____

   Phone: _____ **Email:** _____

2. **Mailing Address:** _____ **City:** _____

   State / Zip: _____

3. **Street Address:** _____ **City:** _____

   State / Zip: _____

4. **Contact Person:** _____ **Title:** _____

5. **Has applicant rejected WC?** ☐ Yes ☐ No **Date of rejection of the Act:** _____

6. **Are Owners/Officers/Partners to be covered?** ☐ Yes ☐ No

   Are they on the State Employment Commission Report? ☐ Yes ☐ No

7. **Are any affiliate companies to be covered?** ☐ Yes ☐ No **Provide below or attach list if needed:**

Legal Entity Name	FEIN	Legal Entity Name	FEIN
1.		3.	
2.		4.	

8. **List all locations to be covered or attach list if needed:**

#	Location (Street Address)	City	Zip Code	# of Employees
1.				
2.				
3.				
4.				
5.				
6.				

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

10. **List all applicable classifications for the applicant: P/T employees = working less than 20 hours/week**

Class Code	Description	F/T	PT	Annual Payroll

11. **Terms and Coverage Limits Available:**

Combined Single Limit:

100,000 ☐	750,000 ☐	3,000,000 ☐	6,000,000 ☐	9,000,000 ☐
300,000 ☐	1,000,000 ☐	4,000,000 ☐	7,000,000 ☐	10,000,000 ☐
500,000 ☐	2,000,000 ☐	5,000,000 ☐	8,000,000 ☐	

Deductible or SIR:

500 ☐	5,000 ☐	50,000 ☐	150,000 ☐	500,000 ☐
1,000 ☐	10,000 ☐	75,000 ☐	200,000 ☐	1,000,000 ☐
2,500 ☐	25,000 ☐	100,000 ☐	250,000 ☐	Other_____

AD&D Limit:

100,000 ☐	150,000 ☐	250,000 ☐	300,000 ☐	350,000 ☐

Benefit Period: 1 Year ☐ 2 Years ☐ 3 Years ☐

Elimination Period: 0 Days ☐ 5 Days ☐ 7 Days ☐ 14 Days ☐ 21 Days ☐

Maximum Weekly Wage Replacement Benefit:

200 ☐	400 ☐	600 ☐	800 ☐	1,000 ☐
300 ☐	500 ☐	700 ☐	900 ☐	

12. **General Information:**

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 Employers' Liability Act: ☐ Yes ☐ No

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"subject to" – continued: Explain all "Yes" answers below:

D. Heights over 15 feet – List Maximum ☐ Yes ☐ No _____

E. List maximum weight of material handling _____

F. Loading or Unloading ☐ Yes ☐ No _____

G. Explosives, caustic or hazardous materials ☐ Yes ☐ No _____

Has applicant ever had or been threatened with:

H. OD/CT Claim ☐ Yes ☐ No _____

I. Employers' Liability Loss or Claim ☐ Yes ☐ No _____

J. OSHA Violation within last 5 years ☐ Yes ☐ No _____

Do any of the following apply?

K. Filed Bankruptcy in last 5 years ☐ Yes ☐ No _____

L. Own, lease or charter aircraft or watercraft ☐ Yes ☐ No _____

M. Have employees under 18 or over 65 ☐ Yes ☐ No _____

N. Use leased or temporary employees ☐ Yes ☐ No _____

O. Use 1099 independent contractors ☐ Yes ☐ No _____

P. Use sub-contractors ☐ Yes ☐ No _____

Q. Use forklift operators ☐ Yes ☐ No _____

If "Yes", are all operators certified? ☐ Yes ☐ No _____

R. Provide employee healthcare plans ☐ Yes ☐ No _____

S. Currently have medical facilities chosen to handle employee injuries ☐ Yes ☐ No _____

If "Yes", please list below or attach separate list if needed:

_____

_____

_____

13. Does the applicant have a written Safety / Loss Control Program? ☐ Yes ☐ No **If yes:**

Who developed Program? Name: _____

Address: _____ City / State / Zip: _____

Phone: _____ Email: _____

When was the Program initiated? _____ When was the Program last updated? _____

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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 ☐ FT ☐ PT

3 Safety Incentive Program? ☐ Yes ☐ No

4 Alcohol / Drug Testing Program? ☐ Yes ☐ No

5 Capacity Testing Prior to Hire ☐ Yes ☐ No

6 Safety Committee? ☐ Yes ☐ No

7 Safety Meetings? ☐ Yes ☐ No

8 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 ☐ FT ☐ PT

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

14. Automobile Exposure:

Indicate the number of automobiles owned, operated or leased; by type and radius.

		Number of Commercial Units				
Radius of Operations	Private Passenger	Light	Medium	Heavy	X-Heavy	Tractors
0 - 50						
51 - 200						
Over 200						

Is the entity subject to:

Texas DOT Requirements ☐ Yes ☐ No TX DOT Number:_____

US DOT Requirements ☐ Yes ☐ No US DOT Number:_____

LPG Requirements ☐ Yes ☐ No Radius of Operations:_____

Do you run MVR's at least annually on all drivers? ☐ Yes ☐ No

Are employees required to drive their own vehicles for business purposes? ☐ Yes ☐ No

Commodities Transported: _____

Do drivers load or unload? ☐ Yes ☐ No

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Do you handle, store or transport explosive, caustic or hazardous materials? ☐ Yes ☐ No

If yes, please explain: _____

Minimum Standards for Drivers:

Minimum Age: _____ Maximum Age: _____

Minimum commercial truck driving experience: _____(years)

Maximum number of accidents permitted: _____(number) in the past _____ years

Maximum number of violations permitted: _____(number) in the past _____ years

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 the most recent 30 day period available (the prior calendar month's payroll) to determine monthly payroll or multiplied by 12 to determine annual.

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

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The undersigned Agent 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: _____ **Email:** _____

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.

FRAUD WARNING:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

WARRANTY STATEMENT
The undersigned authorized officer of the Applicant declares that the statements set forth herein are true. The undersigned authorized officer agrees that if the information supplied on the application changes between the date of the application and the effective date of the insurance, he/she (undersigned) will immediately notify the insurer of such changes, and the insurer may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance. Signing of this application does not bind the Applicant to the insurer to complete the insurance.

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DISCLOSURE AND ACKNOWLEDGEMENT CONCERNING WORKERS' COMPENSATION

This will acknowledge that in solicitation of the Essex Insurance Company Texas Non-Subscriber Occupational Accident Policy, 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 me.

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 $25,000 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 occupational injury benefits for my employees, I may come under the Employee Retirement Income Security Act of 1974 (ERISA). I understand that it may be in my best interest to have a written occupational 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 a safety program could help reduce the frequency and severity of on-the-job injuries and could also help me meet my responsibility to provide a "reasonably safe place to work" for our employees.

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. I have sought, or been given the opportunity to seek, competent legal counsel to advise me on this decision.

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.

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

Signed this _____ Day of _____ , 20_____

_____	_____
Agent Name (please print)	Employer Name (please print)
_____	_____
Agent Signature	Signature – Officer / Owner
_____	_____
Witness	Name and Title (please print)

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LOSS VERIFICATION FORM

Applicant Name: _____

FEIN # or Soc. Sec. Number: _____

☐ I verify that (I) the applicant, named above has had no known employee occupational losses in the (three) years prior to the date indicated below.

☐ I verify that (I) the applicant, named above has had the following employee occupational losses or claims as listed below:

Year	**Carrier**	**Date Losses Valued as of**	**Total *Incurred* Losses (*Paid + Outstanding*)**	**Description of Each Loss in Excess of $5,000** (use a separate sheet if necessary)

☐ I verify that there have been no significant changes to the loss information provided to the Company at the time of underwriting the requested insurance coverage.

The undersigned applicant verifies that all statements and any attached data regarding loss information provided to the company to date is accurate and has not been altered or falsified in any manner.

_____
Signature of Applicant Date

_____
Applicant Title

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ADDENDUM TO TEXAS NON-SUBSCRIBER OCCUPATIONAL ACCIDENT INSURANCE POLICY APPLICATION

Request for Exclusion of Certain Officers/Owners/Partners

Applicant hereby requests that the individual officers/owners/partners of the named applicant listed below be excluded from coverage under the Essex Insurance Company Texas Non-Subscriber Occupational Accident Insurance Policy for which the applicant has applied. The applicant recognizes that Essex Insurance Company will not provide any reimbursement for benefits provided to such officers/owners/partners by the applicant. The applicant further recognizes that no employer's indemnity coverage shall be provided by Essex Insurance Company with respect to any occupational injury, disease, or condition suffered by any such officers/owners/partners as a result of employment with the applicant. Essex Insurance Company shall not provide any reimbursement or indemnification for any liability by settlement, judgment or otherwise, to any such officers/owners/partners. Essex Insurance Company shall not provide reimbursement or indemnification for any attorney's fees, costs or other expenses incurred by the applicant in defending itself against any claims of such officers/owners/partners. The exclusion of coverage for officers/owners/partners shall be effective on the

_____ day of _____, 20_____

Applicant	Print Applicant Name
Authorized Signature	Title
Date	

OFFICER / OWNER / PARTNER REQUEST FOR EXCLUSION FROM COVERAGE

The undersigned officers/owners/partners hereby request to be excluded from coverage under the Essex Insurance Company Texas Non-Subscriber Occupational Accident Insurance Policy for which Applicant has applied. It is further requested that no premiums be paid by Applicant to Essex Insurance Company for any Employer's Primary Indemnity Coverage Policy which provides coverage for Occupational Injuries, Occupational Disease, or Cumulative Trauma suffered in the Scope of Employment with Applicant.

Printed Name and Title	Signature of Officer / Owner / Partner	Date
Printed Name and Title	Signature of Officer / Owner / Partner	Date
Printed Name and Title	Signature of Officer / Owner / Partner	Date
Printed Name and Title	Signature of Officer / Owner / Partner	Date
Printed Name and Title	Signature of Officer / Owner / Partner	Date

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ERISA PLAN INFORMATION SHEET

1. **Policy Inception Date:** _____ **Expiration Date:** _____
2. **Legal Name of applicant:** _____
3. **FEIN Number:** _____
4. **Physical Address: (Please attach schedule of locations if more than one (1) location.)**

   Street Address: _____

   City / State / Zip: _____
5. **Mailing Address (if different):**

   P.O. Box or Street Address: _____

   City / State / Zip: _____
6. **Has applicant rejected WC? Yes ☐ No ☐ Date of rejection of the Act:** _____
7. **Contact Name for Employee Questions:** _____
8. **Contact Phone Number:** _____ **Email:** _____

Name and Address of applicant's Company Representative or Agent for Service of Legal Process:

9. **Name:** _____
10. **Street Address:** _____
11. **City / State / Zip:** _____
12. **ERISA Plan Number:** _____ **(3-digit, 500 series number assigned by Insured to this benefit plan)**

Combined Single Limits of Policy:

13. **Per any one person:** $ _____
14. **Per any one occurrence:** $ _____
15. **Annual Aggregate:** $ _____
16. **Policy's Combined Coverage Period:** _____ **weeks**

Weekly Indemnity Benefits (for ERISA Plan – see note below):

17. **Elimination Period:** _____ **days**
18. **Benefit Percentage:** 75 %
19. **Maximum Per Week:** $ _____
20. **Was Coverage for Occupational Disease and Cumulative Trauma Purchased?** ☐ **Yes** ☐ **No**
21. **Medicare Responsible Reporting Entity (RRE) Number:** _____

Note: The insurance policy has a 7 or 14 day Elimination Period, and indemnifies up to 75% of pay. The Insured has also bound coverage based on a Maximum Per Week Benefit. However, the Insured may elect to self-fund benefits based on a shorter elimination period, a higher percentage of pay, and/or a higher maximum benefit per week. Any benefits paid by the Insured under its ERISA plan that are greater than the benefits specified under the insurance policy will neither count toward satisfaction of the policy's Deductible nor be indemnified under the policy.