ONE80 INTERMEDIARIES
CPro Associates

V062022

CLEAR FORM

Nonsubscription Application

(Please Type Information)

Type of Proposal Requested
- ☐ Occupational Accident w/Legal
- ☐ Occupational Accident only

Applicant Information

Applicant's Name: _____ Requested Effective Date: _____

Texas Physical Address (NO P.O. Box): _____ City: _____ State: _____ Zip: _____

Number of years in business: _____ Website: _____ Years of workers' comp rejection: _____

Detailed description of operations: _____

_____

Business Type: ☐ Corporation ☐ Partnership ☐ Individual ☐ LLC Tax ID: _____

List any Owners, Officers and Partners to be excluded (use separate sheet if necessary): _____

*On a separate sheet list all affiliates to be covered including Tax ID#.

General Information

Check YES by any of the following that apply. ***If not checked YES, applicant represents and warrants the answer is "NO".***
*If yes, please explain with detail. *Use separte sheet as necessary.*

- ☐ YES Has there been any OSHA violations in the past 3 years?
- ☐ YES Maximum weight of material loaded without assistance exceeds 50lbs?
- ☐ YES Do Employee's drive forklifts? *If Yes, are they certified? ☐ YES
- ☐ YES Is outside work performed over 24 feet?
- ☐ YES Transportation of goods in excess of 250 miles one way? *If Yes, include commodities hauled.
- ☐ YES Hazardous materials transported, handled or stored?
- ☐ YES Is there non-commercial Aircraft/Watercraft exposure?
- ☐ YES Does applicant have a formal written safety plan, pre-screening program and employee training?
- ☐ YES If currently a non-subscriber, ALL employees have acknowledged recepit of the ERISA Plan and mandatory arbitration?
- ☐ YES Has workers comp or occupational accident coverage been canceled, refused or non-renewed?

◦ *DETAIL answer to all "YES" answers (use separate sheet as necessary)*

# of Employees		Classification Code	Annual Payroll by Class (unlimited)	Description
W2	1099			

Current Worker's Comp or Accident Premium: $ _____ Current Insurer and SIR: _____

Current Experience Modification Rate: _____

BENEFITS TO BE QUOTED

EL Limits: Please Select
($1,000,000 - $10,000,000) EL limit available

SIR: Please Select
($1,000 - $1,000,000) SIR available

AD&D Limits: Please Select
($100,000 - $250,000) limits available

Benefit Period: Please Select
(106 - 260 weeks) benefit period available

Weekly Disability Limit: Please Select
($600 - $1000 weeks) benefit available

Waiver of Subrogation? ☐ Yes ☐ No
(additional premium of 2%+)

Applicant acknowledges 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 application, and attached data, in considering whether to provide insurance coverage; and (c) this application shall become a material and integral part of the policy and the statements made herein shall be construed as your representations and warranties.

Applicant Signature: _____ **Date:** _____