EMPLOYER'S COMP ASSOCIATES, INC.

Fax-A-Quote

Type of Proposal Requested:
- ❑ *Occupational Accident only*
- ❑ *Occupational Accident w/Legal*

Please fax this completed form, your inforce insurance license, and Errors & Omissions dec page to: Employer's Comp Associates, Inc. at (972) 931-2126.
For assistance, please call (972) 931-2026 or (800) 299-5250.

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? ❑ 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 <u>manually</u> 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 Worker's Comp or Accident Premium $____________ Occupational Disease & Cumulative Trauma? ❑ Yes ❑ No

<u>Benefits to be Quoted</u>: *LIMITS VARY BY PRODUCT. PLEASE CALL FOR OTHER OPTIONS.*

CSL Benefit: ______________________ *($100,000 - $1,000,000 CSL available)*

Deductible: ______________________ *($1,000 - $500,000 deductible available)*

Waiting Period: ______________ days

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 (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:** ______________________

Address: ______________________ **Fax:** ______________________

Agent Signature: ______________________ **Applicant Signature:** ______________________

Note: To quote your case, we need a fax copy of your applicable inforce TX Agent's License and a fax copy of your E&O dec page.