

**Service Lloyds Insurance Company**

Nonsubscription Application  
Atten: Gina Hawkins Fax # 512-485-2718

Applicant Name \_\_\_\_\_ Requested Effective Date: \_\_\_\_\_  
Address \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Complete description of operations: \_\_\_\_\_

Number of years in business: \_\_\_\_\_ Phone # \_\_\_\_\_ Tax ID# \_\_\_\_\_

Ownership to equal 100% \_\_\_\_\_

If a corporation, list all officers \_\_\_\_\_ List individual owner/spouse, partner/spouses,  
or officers to be covered: \_\_\_\_\_ List individual owner/spouse,  
partner/spouse, or officers to be excluded: \_\_\_\_\_

Business Type: \_\_\_\_\_ Corporation \_\_\_\_\_ Partnership \_\_\_\_\_ Individual \_\_\_\_\_ 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 percent of loads are manually loaded or unloaded? \_\_\_\_\_

Does applicant perform any work at heights above 2 stories? \_\_\_\_\_ Yes \_\_\_\_\_ No. If Yes, please explain what type work and how high \_\_\_\_\_

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

Waiver of Subrogation. \_\_\_\_\_ Yes \_\_\_\_\_ No Blanket \_\_\_\_\_ Specific \_\_\_\_\_ (give name & address) \_\_\_\_\_

Are 1099 workers' to be covered under the policy? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, list the name(s) of those workers' as they must be endorsed onto the policy to afford coverage \_\_\_\_\_

CIRCLE BENEFIT LEVELS REQUESTED:

Per Accident: \$1,000,000, \$2,000,000 \$3,000,000 Per Employee: \$1,000,000, \$2,000,000, \$3,000,000 Aggregate: \$3,000,000, \$5,000,000

Deductible: \$1,000, \$2,500, \$5,000, \$10,000, negotiated (for accounts over \$100K in premium)

Note: OD/CT included. EL Included (defense cost outside policy limits). Benefit period 156 weeks. Waiting period 7 days.

Please summarize losses below and submit 3 years currently valued loss runs: (valuation date of loss information within past 60 days)

Year: \_\_\_\_\_ Carrier: \_\_\_\_\_ Incurred Losses: \_\_\_\_\_ Description of Each Loss in Excess of \$10,000  
(Use separate sheet if necessary)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

1. Attach a copy of current experience modifier. If not experience rated, please indicate reason: \_\_\_\_\_
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
4. Any bankruptcies in past 5 years?  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.

**Safety Information:**

1. Does applicant have a written safety/loss control program currently being enforced?  Yes  No

If yes, attach a copy of the Table of Content for the program.

2. Does the safety program include the following:
  - a. Written Safety Manual  Yes  No
  - b. Safety Incentive Program  Yes  No
  - c. Safety Meetings  Yes  No how frequently \_\_\_\_\_
  - d. Safety Director  Yes  No Name of Director \_\_\_\_\_
  - e. Periodic Self-Inspections?  Yes  No
  - f. Safety Committee  Yes  No
  - g. Alcohol/drug Testing  Yes  No.
  - h. Pre-employment  Yes  No.
  - i. Post accident  Yes  No
  - j. Bodily Injury Reporting and Record Keeping  Yes  No Bodily Injury Investigation  Yes  No
3. Has applicant ever had any OSHA violations?  Yes  No
4. Has any OSHA recommendations not been met?  Yes  No  
If yes to question 3 or 4, please explain \_\_\_\_\_

Are there any other businesses owned or operated by this entity or any of its owners/officers, which has not been included?  
 Yes  No If yes, please explain \_\_\_\_\_

Has workers' compensation coverage or occupational accident coverage ever been cancelled, refused or non-renewed?  
 Yes  No. If yes, Explain: \_\_\_\_\_

Does applicant currently have an ERISA plan?  Yes  No If yes, will applicant use their current plan?  Yes  No.  
If yes, provide a copy of the full plan document and the Summary Plan Description (SPD).

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 application, along with any verbal or attached data, in considering whether to provide the requested insurance coverage.

Agent: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_

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

*Note: A quote can be provided without signature; however, if binding is requested, both the insured and agent must sign the application form, as well as the policyholder disclosure notice of terrorism insurance coverage form. The agent has no binding authority.*

*This is not an insurance binder. The above information is only a request to quote or bind occupational accident insurance. This is not a request for workers' compensation insurance. If the employer purchases a policy for general liability/ workers' occupational accident insurance the employer loses defenses and benefits, which would otherwise be afforded under the Workers' Compensation laws of the state of Texas. Required filings and postings must be made.*

REQUEST TO BIND

AND CERTIFICATION

According to the policy provisions, Service Lloyds, or its representative, may audit your payroll records at any time during normal business hours and up to three (3) years after the policy has expired. If it is determined that premiums have been overpaid, then the company will refund that portion of the premium. If found that the premiums have been underpaid, the company shall be entitled to collect that amount.

- A. The applicant, by signing below, requests coverage based on the quote provided. The applicant agrees to all terms and conditions outlined in the policy. The applicant further agrees and understands that the request for coverage and payment of premium does not constitute coverage unless accepted by the company and a binder confirmation issued, which will then become effective on the date stated on the binder.
- B. The policy, if issued, will be subject to the following requirements, including loss control, and implementation of the ERISA document with the Summary Plan Description (SPD) being distributed to all employees within 10 days of receipt, and to all new hires by first day of employment.
- D. The applicant agrees, upon being issued a binder/policy for coverage, to promptly notify Service Lloyds Insurance Company of any changes in operation, ownership, or management of insured, including newly acquired entities or merger/consolidation of businesses.
- E. The undersigned insured and agent understands that this policy is subject to coverage limitations, terms, conditions, and exclusions as shown in the policy and that no payment or coverage's will be afforded under the policy if the policy limit or benefit period has been exhausted.
- F. The applicant understands and agrees that Service Lloyds will use the faxed copy of the check for automatic check handling and draft the applicants account to put coverage in place. Check must be made payable to Service Lloyds.
- G. The applicant attests by signing below that no material misrepresentation has been made on any pages or attachments for a request to quote, the application, including attachments, or certification and request to bind.

Applicant's Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_  
(officer, if corp.; or owner if partnership or individual)

The undersigned agent warrants he/she has not represented the above coverage as anything other than occupational accident insurance, an alternative to workers' compensation, for on-the-job injuries to employees, subject to policy limitations/exclusions.

Agent's Signature: \_\_\_\_\_

Print Agency and Agent Name: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax \_\_\_\_\_ E-mail \_\_\_\_\_

## POLICYHOLDER DISCLOSURE NOTICE OF TERRORISM INSURANCE COVERAGE

Coverage for acts of terrorism will be included in your current policy, unless rejected. You should know that, effective November 26, 2002, under your existing coverage, any losses caused by certified acts of terrorism would be partially reimbursed by the United States under a formula established by federal law. Under this formula, the United States pays 90% of covered terrorism losses exceeding the statutorily established deductible paid by the insurance company providing the coverage. The portion of your annual premium that is attributable to coverage for acts of terrorism is: \$50 for 0-50 employees; \$100 for 51-100 employees, \$250 for 101-150 employees, \$275 for 151-200 employees, and \$300 for over 200 employees.

I ACKNOWLEDGE THAT I HAVE BEEN NOTIFIED THAT UNDER THE TERRORISM RISK INSURANCE ACT OF 2002, ANY LOSSES CAUSED BY CERTIFIED ACTS OF TERRORISM UNDER MY POLICY COVERAGE WILL BE PARTIALLY REIMBURSED BY THE UNITED STATES AND I HAVE BEEN NOTIFIED OF THE AMOUNT OF MY PREMIUM ATTRIBUTABLE TO SUCH COVERAGE.

I ACCEPT this coverage

I REJECT this coverage and no premium will be charged

Policyholder/Applicant's Signature

\_\_\_\_\_

Name (print)

Date \_\_\_\_\_

Name of Insurer: SERVICE LLOYDS INSURANCE COMPANY