CLEAR FORM

QUICK QUOTE - APPLICATION

Email to: underwriters@jackson-lloyd.com

Jackson-Lloyd Select Risk P.O. Box 187, Longview, Texas 75606 Ph. 800-657-5242 Fax 800-933-8662

Applicant Name: _____ **Proposed Eff Date**: _____

☐ Corp. ☐ Partnership ☐ LLC ☐ Ind. FEIN _____ Yrs in Bus: _____ All entities of applicant included above? ☐ Yes ☐ No

Mailing address: _____ Web Address: _____

Locations: _____

Description of Operations/Exposures: _____

1. **Does the applicant have any:** ☐ Employees working out of their homes ☐ Labor interchange with entities not included above ☐ 24 hour operations ☐ USL&H, Jones Act or FELA exposures ☐ Aircraft exposure ☐ None of these.

2. **Does the applicant manufacture, handle, sell, or transport any of the following:** ☐ Chemicals ☐ Flammables ☐ Explosives ☐ Fuels ☐ Drugs ☐ Hazardous Wastes ☐ None of these.

3. **Does the applicant have the following in place:** ☐ Self-Inspections for safety ☐ Safety program ☐ Safety director ☐ Employee training provided ☐ Safety meetings ☐ Drug/Alcohol testing ☐ None of these

4. **Does the applicant perform any of the following operations:** ☐ Underground/Tunneling – Max _____ ft. ☐ Work at heights above 15 feet – Max _____ ft. ☐ Neither of these.

5. **Has the applicant had:** ☐ OSHA inspections/recommendations/violations ☐ Employers Liability loss ☐ None of these.

Automobile Exposure (Company owned vehicles)

Radius of Use (miles)	Private Passenger	Light Commercial	Medium Commercial	Heavy Commercial	X-Heavy Commercial	Tractor-Trailer
0-50						
51-200						
Over 200						

Do employees drive personal vehicles for business purposes? ☐ Yes ☐ No

Loss History - Must provide at least the past 3 years loss history. Loss runs must be valued within the past 60 days. If no prior coverage, a statement of losses must be attached. ☐ Loss runs attached ☐ Statement of losses attached

Current Coverage: Carrier _____ Limit _____ SIR/Deductible _____
Premium _____ Renewal Date_____ Weekly Disability Benefit _____ Benefit Period _____
Requested Coverage: Limit _____ SIR _____ Weekly Disability Benefit _____ Benefit Period _____
Rating Information: Owners / Executive Officers: ☐ Included ☐ Excluded Owner's Name: _____

Would you like to utilize your existing ERISA/ADR Plan? ☐ Yes ☐ No **If no, do you agree to implement the ERISA and ADR Plans issued to you?** ☐ Yes ☐ No **Plan Administrator's Name** _____

Do you have or want to cover, any 1099 employees that work for you? ☐ Yes ☐ No **If so, proof of remuneration will be required.**

Occupation	Class Code	F/T Employees	P/T Employees	Total in Class	Annual Payroll or Earnings
Owners / Executive Officers	**8809**			0	
				0	
				0	
				0	
				0	
Total		0	0	0	0.00

***Please note – Payroll for each employee should be capped at $62,400. Also, overtime should be calculated on straight pay.**

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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.

By signing this application form the applicant confirms that he or she has been provided with and inspected a specimen copy of the policy, and understands their rejection of the Texas Worker's Compensation Act status and the coverages and limitations of the policy.

If Coverage is issued based upon information provided in this application, the applicant understands and agrees that this application shall form a part of the policy, and the statements herein shall be construed as material representations of the applicant. Any person who knowingly and with intent to defraud any insurance company or another 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.

I also hereby agree and understand that the Texas Occupational Shield / Texas Accident Shield ("the policies") being provided by Crum and Forster Specialty Insurance Company is not materially or substantially similar to the coverage prescribed under The Texas Workers' Compensation Law and Act ("the Law"). I also agree and understand the policy is neither an alternative, not a replacement for Workers' Compensation or Employers' Liability as prescribed by that Law.

I understand that Crum and Forster Specialty Insurance Company and Jackson-Lloyd Select Risk Insurance are not rendering any legal advice in connection with this transaction. I acknowledge that there have been no oral representations made by Jackson-Lloyd Select Risk regarding terms, conditions or coverage of the policy.

I further understand that by not carrying Workers' Compensation or Employers' Liability coverage, I may be giving up some defenses under that law in any lawsuit brought by one of my employees for a work-related accident.

We hereby accept the proposal as per the attached quotation from Jackson-Lloyd Select Risk and Crum and Forster Specialty Insurance Company. We understand that this policy does not replace or provide coverage under Texas Workers' Compensation or Employers' Liability Insurance.

_____
Full Employer/Holder Name (PRINTED)

_____
DBA, if any (PRINTED)

_____
Name / Title (PRINTED)

Applicant's Email Address: _____

Applicant's Signature: _____ **Title:** _____ **Date:** _____

Contact Person: _____ **Phone:** _____ **Fax:** _____

Agency Name: _____ **Agency Contact:** _____

Phone: _____ **Fax:** _____ **E-mail Address:** _____

Agent's Signature: _____ **Title:** _____ **Date:** _____

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