



WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY)

AGENCY		COMPANY Global Aerospace, Inc.			UNDERWRITER				
		APPLICANT NAME							
MAILING ADDRESS (including ZIP +4)				E-MAIL ADDRESS					
PHONE (A/C, No, Ext):	YRS IN BUS	SIC	NAICS	<input type="checkbox"/>	INDIVIDUAL	<input type="checkbox"/>	CORPORATION	<input type="checkbox"/>	LLC
FAX (A/C, No):				<input type="checkbox"/>	PARTNERSHIP	<input type="checkbox"/>	SUBCHAPTER "S" CORP		
E-MAIL ADDRESS:	CREDIT BUREAU NAME:				ID NUMBER:				
CODE:	SUB CODE:								
AGENCY CUSTOMER ID		FEDERAL EMPLOYER ID NUMBER		NCCI ID NUMBER		OTHER RATING BUREAU ID OR STATE EMPLOYER REGISTRATION NUMBER			

STATUS OF SUBMISSION**BILLING/AUDIT INFORMATION**

<input type="checkbox"/> QUOTE	<input type="checkbox"/> ISSUE POLICY	BILLING PLAN		PAYMENT PLAN		AUDIT	
<input type="checkbox"/> BOUND (Give date and/or attach copy)		<input type="checkbox"/> AGENCY BILL	<input type="checkbox"/> ANNUAL	<input type="checkbox"/>	<input type="checkbox"/> AT EXPIRATION	<input type="checkbox"/> MONTHLY	
<input type="checkbox"/> ASSIGNED RISK (Attach ACORD 133)		<input type="checkbox"/> DIRECT BILL	<input type="checkbox"/> SEMI-ANNUAL		<input type="checkbox"/> SEMI-ANNUAL		
			<input type="checkbox"/> QUARTERLY	%DOWN:	<input type="checkbox"/> QUARTERLY		

LOCATIONS

LOC #	STREET, CITY, COUNTY, STATE, ZIP CODE

POLICY INFORMATION

PROPOSED EFF DATE	PROPOSED EXP DATE	NORMAL ANNIVERSARY RATING DATE	<input type="checkbox"/>	PARTICIPATING	RETRO PLAN							
			<input type="checkbox"/>	NON-PARTICIPATING								
PART 1 - WORKERS COMPENSATION (States)	PART 2 - EMPLOYER'S LIABILITY		PART 3 - OTHER STATES INS	DEDUCTIBLES	AMOUNT %	OTHER COVERAGES						
	\$	EACH ACCIDENT					<input type="checkbox"/>	MEDICAL	<input type="checkbox"/>	U.S.L. & H	<input type="checkbox"/>	MANAGED CARE OPTION
	\$	DISEASE-POLICY LIMIT					<input type="checkbox"/>	INDEMNITY	<input type="checkbox"/>	VOLUNTARY COMP		
\$	DISEASE-EACH EMPLOYEE				<input type="checkbox"/>	FOREIGN COV						
DIVIDEND PLAN/SAFETY GROUP			ADDITIONAL COMPANY INFORMATION									

RATING INFORMATION

STATE	LOC #	CLASS CODE	DESCR CODE	CATEGORIES, DUTIES, CLASSIFICATIONS	# EMPLOYEES		ESTIMATED ANNUAL REMUNERATION	RATE	ESTIMATED ANNUAL PREMIUM
					FULL TIME	PART TIME			
									\$
									\$
									\$
									\$
									\$
STATE:	FACTOR	FACTORED PREMIUM				FACTOR	FACTORED PREMIUM	SPECIFY ADDITIONAL COVERAGES / ENDORSEMENTS	
TOTAL		\$	EXPENSE CONSTANT			N/A	\$		
INCREASED LIMITS		\$	TAXES / ASSESSMENTS			N/A	\$		
DEDUCTIBLE		\$					\$		
		\$	ESTIMATED ANNUAL PREMIUM			N/A	\$		
EXPERIENCE OR MERIT MODIFICATION		\$							
LOSS CONSTANT	N/A	\$							
ASSIGNED RISK SURCHARGE		\$							
ARAP		\$							
		\$							
SCHEDULE RATING		\$							
CCPAP		\$	TOTAL EST ANNUAL PREMIUM	N/A	\$				
STANDARD PREMIUM		\$	MINIMUM PREMIUM	\$					
PREMIUM DISCOUNT		\$	DEPOSIT PREMIUM	\$					

INDIVIDUALS INCLUDED/EXCLUDED

PARTNERS, OFFICERS, RELATIVES TO BE INCLUDED OR EXCLUDED. (Remuneration to be included must be part of rating information section.)									
STATE	LOC #	NAME	DATE OF BIRTH	TITLE/ RELATIONSHIP	OWNER- SHIP %	DUTIES	INC/EXC	CLASS CODE	REMUNERATION

PRIOR CARRIER INFORMATION/LOSS HISTORY

PROVIDE INFORMATION FOR THE PAST 5 YEARS AND USE THE REMARKS SECTION FOR LOSS DETAILS						<input type="checkbox"/>	LOSS RUN ATTACHED
YEAR	CARRIER & POLICY NUMBER		ANNUAL PREMIUM	MOD	# CLAIMS	AMOUNT PAID	RESERVE
	CO:		\$			\$	
	POL #:						
	CO:		\$			\$	
	POL #:						
	CO:		\$			\$	
	POL #:						
	CO:		\$			\$	
	POL #:						
	CO:		\$			\$	
	POL #:						

NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS

GIVE COMMENTS AND DESCRIPTIONS OF BUSINESS, OPERATIONS AND PRODUCTS: MANUFACTURING-- RAW MATERIALS, PROCESSES, PRODUCT, EQUIPMENT. CONTRACTOR-- TYPE OF WORK, SUB-CONTRACTS. MERCANTILE--MERCHANDISE, CUSTOMERS, DELIVERIES. SERVICE--TYPE, LOCATION. FARM--ACREAGE, ANIMALS, MACHINERY, SUB-CONTRACTS.

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	YES	NO	EXPLAIN ALL "YES" RESPONSES	YES	NO
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT/WATERCRAFT?	<input type="checkbox"/>	<input type="checkbox"/>	18. ANY PRIOR COVERAGE DECLINED/ CANCELLED/NON-RENEWED (Last 3 years)? NOT APPLICABLE IN MO	<input type="checkbox"/>	<input type="checkbox"/>
2. DO/HAVE PAST, PRESENT OR DISCONTINUED OPERATIONS INVOLVE(D) STORING, TREATING, DISCHARGING, APPLYING, DISPOSING, OR TRANSPORTING OF HAZARDOUS MATERIAL? (e.g. landfills, wastes, fuel tanks, etc)	<input type="checkbox"/>	<input type="checkbox"/>	19. ARE EMPLOYEE HEALTH PLANS PROVIDED?	<input type="checkbox"/>	<input type="checkbox"/>
			20. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS/SUBSIDIARY?	<input type="checkbox"/>	<input type="checkbox"/>
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?	<input type="checkbox"/>	<input type="checkbox"/>	21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?	<input type="checkbox"/>	<input type="checkbox"/>
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?	<input type="checkbox"/>	<input type="checkbox"/>	22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME?	<input type="checkbox"/>	<input type="checkbox"/>
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?	<input type="checkbox"/>	<input type="checkbox"/>	23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST 5 YEARS?	<input type="checkbox"/>	<input type="checkbox"/>
6. ARE SUB-CONTRACTORS USED? (IF YES, GIVE % OF WORK SUBCONTRACTED)	<input type="checkbox"/>	<input type="checkbox"/>	24. ANY UNDISPUTED AND UNPAID WORKERS COMPENSATION PREMIUM DUE FROM YOU OR ANY COMMONLY MANAGED OR OWNED ENTERPRISES? IF YES, EXPLAIN INCLUDING ENTITY NAME(S) AND POLICY NUMBER(S).	<input type="checkbox"/>	<input type="checkbox"/>
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INS.?	<input type="checkbox"/>	<input type="checkbox"/>			
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?	<input type="checkbox"/>	<input type="checkbox"/>	CONTACT INFORMATION		
9. ANY GROUP TRANSPORTATION PROVIDED?	<input type="checkbox"/>	<input type="checkbox"/>	IN- SPECTION	PHONE:	
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?	<input type="checkbox"/>	<input type="checkbox"/>		NAME:	
11. ANY SEASONAL EMPLOYEES?	<input type="checkbox"/>	<input type="checkbox"/>		E-MAIL:	
12. IS THERE ANY VOLUNTEER OR DONATED LABOR?	<input type="checkbox"/>	<input type="checkbox"/>	ACCTNG RECORD	PHONE:	
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?	<input type="checkbox"/>	<input type="checkbox"/>		NAME:	
14. DO EMPLOYEES TRAVEL OUT OF STATE?	<input type="checkbox"/>	<input type="checkbox"/>		E-MAIL:	
15. ARE ATHLETIC TEAMS SPONSORED?	<input type="checkbox"/>	<input type="checkbox"/>	CLAIMS INFO	PHONE:	
16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?	<input type="checkbox"/>	<input type="checkbox"/>		NAME:	
17. ANY OTHER INSURANCE WITH THIS INSURER?	<input type="checkbox"/>	<input type="checkbox"/>		E-MAIL:	

APPLICABLE IN TENNESSEE: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO ANY PARTY TO A WORKERS COMPENSATION TRANSACTION FOR THE PURPOSE OF COMMITTING FRAUD. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

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 [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, HI, NE, OH, OK, OR, TN or VT; in DC, LA, ME and VA, insurance benefits may also be denied)

REMARKS (Attach additional sheets if more space is required)

APPLICANT'S SIGNATURE	DATE	PRODUCER'S SIGNATURE	NATIONAL PRODUCER NUMBER
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