AGENCY CUSTOMER ID: _____

ACORD®

WORKERS COMPENSATION INSURANCE PLAN
ASSIGNED RISK SECTION

DATE (MM/DD/YYYY)

THIS FORM ALONG WITH AN ACORD 130 WORKERS COMPENSATION APPLICATION CONSTITUTE AN APPLICATION FOR WORKERS COMPENSATION INSURANCE PLAN (ASSIGNED RISK) COVERAGE. THIS FORM MUST BE ATTACHED TO AN ACORD 130 FOR SUBMISSION. PLEASE REFER TO THE STATE SPECIFIC INSTRUCTIONS PAGE FOR SPECIFIC REQUIREMENTS.

APPLICANT NAME	PROPOSED EFF DATE

SUPPLEMENTAL INFORMATION

PAYROLL OFFICE NAME, ADDRESS AND TELEPHONE NUMBER (A PO BOX ADDRESS ALONE IS NOT ACCEPTABLE. PLEASE PROVIDE DRIVING INSTRUCTIONS IF A ROUTE ADDRESS IS SHOWN.)

STATE DEVELOPING HIGHEST PAYROLL:

EXPLAIN ALL "YES" RESPONSES IN THE REMARKS SECTION	YES	NO
1. HAS THERE BEEN PREVIOUS WORKERS COMPENSATION COVERAGE: IN THIS STATE? IN ANY OTHER STATE? - IF NO TO BOTH QUESTIONS, WAS THIS DUE TO: ☐ NEW BUSINESS ☐ SELF INSURED-INDEP ☐ SELF INSURED-GROUP ☐ # EMPLOYEES	☐ ☐	☐ ☐
2. IS THERE ANY UNPAID WORKERS COMPENSATION PREMIUM DUE OR IN DISPUTE FROM YOU OR ANY COMMONLY MANAGED OR OWNED ENTERPRISES? IF YES, EXPLAIN, INCLUDING ENTITY NAME(S) AND POLICY NUMBER(S).	☐	☐
3. YEAR APPLICANT'S BUSINESS BEGAN:		
4. HAS THERE BEEN A NAME CHANGE, CONSOLIDATION, MERGER, ACQUISITION, SALE, PURCHASE OR TRANSFER OF ASSETS OR OWNERSHIP CHANGE DURING THE PAST FIVE (5) YEARS? IF YES, PROVIDE A COMPLETED ERM-14 FORM.	☐	☐
5. IS APPLICANT RELATED THROUGH COMMON MANAGEMENT OR OWNERSHIP TO ANY ENTITY NOT LISTED ON THE ACORD 130 FORM, WHETHER COVERAGE IS REQUIRED OR NOT? IF YES, PROVIDE A COMPLETED ERM-14 FORM.	☐	☐
6. DO YOU LEASE WORKERS FROM A PROFESSIONAL EMPLOYER ORGANIZATION (PEO)? IF YES, REFER TO WCIP INSTRUCTIONS.	☐	☐
7. DO YOU LEASE WORKERS TO A CLIENT COMPANY? IF YES, REFER TO WCIP INSTRUCTIONS.	☐	☐
8. ARE YOU SEEKING TO COVER THE LEASED WORKERS? IF YES, REFER TO WCIP INSTRUCTIONS.	☐	☐
9. DO YOU PROVIDE TEMPORARY ARRANGEMENT SERVICES TO OTHER EMPLOYERS? IF YES, PROVIDE A TEMPORARY LABOR CONTRACTOR EMPLOYEE FORM.	☐	☐
10. DO YOU HAVE A FRANCHISE OR LICENSING AGREEMENT? IF YES, PROVIDE A COPY OF THE AGREEMENT.	☐	☐
11. IS COVERAGE REQUESTED FOR A SPORTS TEAM? IF YES, PROVIDE NAME OF SPORTS TEAM AND DOMICILED STATE. NAME OF SPORTS TEAM: _____ DOMICILED STATE: _____	☐	☐
12. DO TRUCKING CLASSIFICATIONS APPLY? IF YES, COMPLETE QUESTIONS 13 - 20.	☐	☐
13. DO YOU OR YOUR EMPLOYEES REGULARLY OPERATE FROM A BASE TERMINAL(S) WHICH IS (ARE) USED TO LOAD, UNLOAD, STORE OR TRANSFER FREIGHT? IF YES, PLEASE PROVIDE A LIST OF TERMINAL ADDRESSES:	☐	☐

#	STREET	CITY	COUNTY	ST	ZIP CODE
1					
2					
3					

14. CAN EACH DRIVER'S STATE OF MAJORITY DRIVING TIME BE ESTABLISHED THROUGH VERIFIABLE RECORDS OR LOGS?			☐	☐
15. PLEASE PROVIDE A LIST OF ALL DRIVERS / HELPERS AND THEIR STATE OF RESIDENCE:				

	DRIVER NAME	TERMINAL # (SEE ABOVE)	MAJORITY DRIVING STATE	RESIDENCE STATE
1				
2				
3				

16. WHAT TYPE(S) OF GOODS ARE BEING HAULED?		
17. DO YOU OWN THESE GOODS?	☐	☐
18. IS APPLICANT UNDER EXCLUSIVE CONTRACT WITH ANY RETAIL STORE(S)? IF YES, PROVIDE COPY OF CONTRACT(S).	☐	☐
19. IS APPLICANT UNDER EXCLUSIVE CONTRACT WITH ANY POSTAL SERVICE? IF YES, PROVIDE COPY OF CONTRACT(S).	☐	☐
20. WITHIN WHAT MILE RADIUS IS HAULING DONE? # MILES: _____		

AGENCY CUSTOMER ID: _____

INSURANCE COMPANIES WHO HAVE OFFERED/REFUSED INSURANCE	YES	NO
21. HAVE YOU RECEIVED ANY OFFERS OF VOLUNTARY COVERAGE? (INCLUDE MULTI-LINE OR RETROSPECTIVE RATING PLAN, IF APPLICABLE) IF YES, PROVIDE FULL DETAILS INCLUDING PLAN TERMS.	☐	☐

22. INDICATE THE NUMBER OF INSURANCE COMPANIES WHICH HAVE REFUSED THE APPLICANT COVERAGE IN THE LAST 60 DAYS (OR IN ACCORDANCE WITH STATE SPECIFIC GUIDELINES): ☐

LIST COMPANY NAMES, REPRESENTATIVE NAMES, TELEPHONE NUMBERS AND DATES OF REFUSALS. REFER TO WCIP TO VERIFY REQUIREMENTS.

COMPANY NAME	REPRESENTATIVE NAME	TELEPHONE NUMBER	DATE OF REFUSAL	COMMENTS

PREMIUM PAYMENT (Refer to WCIP instruction sheet for state requirements)	YES	NO
23. IS THE PREMIUM FINANCED THROUGH A THIRD PARTY PREMIUM FINANCE COMPANY? IF YES, A COPY OF THE AGREEMENT MUST BE PROVIDED.	☐	☐
24. IN APPLICABLE JURISDICTIONS ON QUALIFYING RISKS, IS THE LOSS SENSITIVE RATING PROGRAM (LSRP) CONTINGENCY DEPOSIT BEING PAID IN FULL AT THIS TIME?	☐	☐

BELOW PAYMENT METHOD FOR MAIL-IN OR PHONE-IN APPLICATIONS ONLY. NOT APPLICABLE FOR PREMIUM PAYMENTS SUBMITTED THROUGH NCCI'S RESIDUAL MARKET APPLICATION PROCESSING SYSTEM SERVICE *(RMAPS® SERVICE)*

☐ **SUBMISSION METHOD #1 - MAIL-IN PAYMENT**

CHECK # _____ **PREMIUM PAYMENT AMOUNT** $ _____.00

1. All checks must be made payable to NCCI, Inc. and accompany completed and signed ACORD 130 and 133 forms.
2. The following checks are acceptable for premium payments: Applicant's, Producer's, Finance Company(s), Cashier's or Money Order.
3. Third party checks are NOT acceptable for premium payments.

☐ **SUBMISSION METHOD #2 - ELECTRONIC PAYMENT (EFT)**

ACCOUNT NAME: _____

BANK/ABA # _____ **ACCOUNT #** _____ **PREMIUM PAYMENT AMOUNT** $ _____.00

1. To ensure accuracy, a voided check or deposit slip (of the payor) must be sent to NCCI, Inc., accompanied by completed and signed ACORD 130 and 133 forms.
2. By submitting this information, applicant authorizes NCCI to debit the account name/number above for the amount of this transaction via an Electronic Funds Transfer (EFT). Applicant further agrees that all premium transactions must be processed and accepted by NCCI and the account listed above to be considered received by the Plan Administrator.

REMARKS (Attach additional sheets if more space is required)

AGENCY CUSTOMER ID: _____

APPLICANT'S STATEMENT

The undersigned Applicant hereby certifies that he/she has read and understands the questions and statements in this application, which is comprised of both the ACORD 130 and ACORD 133 forms. In consideration of coverage being afforded under the applicable Workers Compensation Insurance Plan developed or administered by NCCI (WCIP or Plan), by signing below, the Applicant also certifies that any and/or all responses provided in or to this application, which is comprised of both the ACORD 130 and ACORD 133 forms, are true and accurate and Applicant further understands and agrees that:

- Since he/she has been unable to secure workers compensation coverage in a regular manner through any other insurance carrier or provider, this coverage is being afforded under the applicable WCIP, and that the applicable rates and rating programs charged may be higher than those in the voluntary market.
- Coverage is NOT bound until the completed and signed application is received with the appropriate initial or estimated annual deposit premium and eligibility is determined by the Plan Administrator.
- Provided that Applicant is determined to be eligible and in good faith entitled to WCIP insurance, based upon the information provided herein or otherwise available to the Plan Administrator, coverage will be bound in accordance with WCIP rules. See the WCIP for applicable binding rules.
- In approved jurisdictions, NCCI's Voluntary Coverage Assistance Program ***(VCAP® Service)*** applies to all employers seeking coverage under the Workers Compensation Insurance Plan, and:
  - Is integrated with and operates as a supplemental program to NCCI's WCIP; and
  - Operates in conjunction with NCCI's Residual Market Application Processing System ***(RMAPS® Online Application Service)***; and
  - Is designed as a depopulation tool to provide an additional source for producers and employers to secure workers compensation coverage in the voluntary market; and
  - All applications (electronic, phone-in, or mail-in) submitted to the Plan Administrator are reviewed to determine if they meet any of the preselected criteria specified by a participating voluntary carrier; and
  - If the Applicant meets the criteria of an authorized voluntary carrier ***(VCAP® User)*** and an offer of voluntary coverage is provided, the Applicant, its representative, and/or the producer, must accept a reasonable offer of voluntary coverage in accordance with the WCIP and ***VCAP® Service*** provisions, and further Applicant will be deemed ineligible for coverage under the WCIP if Applicant does not accept such reasonable offer of voluntary coverage; and
  - If an application does not meet any ***VCAP® User's*** criteria, the application will continue through NCCI's ***RMAPS® Online Application Service.***

If deemed eligible under the WCIP and as further consideration of policy issuance under the WCIP, by signing below, the undersigned Applicant also agrees:

- To maintain a complete record of all payroll transactions in such form as the insurance company may reasonably require and that such record will be available to the company at the designated address; and
- To comply substantially with all laws, orders, rules, and regulations in force and effect issued by the public authorities relating to the welfare, health, and safety of employees; and
- To comply with all reasonable recommendations made by the insurance company relating to the welfare, health, and safety of employees; and
- To take no action in any form to evade the application of an experience rating modification determined in accordance with the applicable experience rating rules, as determined by NCCI, Inc.; and
- To comply with all WCIP rules and procedures and policy terms and conditions, including without limitation, those relating to audits, inspections, loss prevention, and/or premium payments, to maintain WCIP eligibility and coverage.

The undersigned Applicant also certifies that he/she has no outstanding bona fide dispute as provided in NCCI's WCIP with any producer or company in regard to: (a) payroll records; (b) the amount of premium charged; (c) the payment of premium; (d) the carrying out of any recommendation made for the purpose of safeguarding employees; (e) the handling of any claim or accident report except the following:

In applicable jurisdictions where the NCCI's Loss Sensitive Rating Plan (LSRP) has been approved for use, the undersigned applicant further understands and agrees that by signing below, I (applicant) acknowledge that the Loss Sensitive Rating Plan (LSRP) has been explained to me, and I agree to be bound by the terms of such plan if my standard premium meets or exceeds the premium eligibility requirement. If these conditions are met, an additional LSRP contingency deposit premium equal to 20% of standard premium will be required; and

- At the time of application, LSRP has been explained to applicant by the Producer submitting this application on behalf of the applicant; and
- The above referenced additional LSRP contingency deposit premium is in addition to the initial or deposit premium required in accordance with the WCIP.

The undersigned Applicant further understands and agrees that violation of or non-compliance with any of the above agreements or certifications may result in cancellation of a policy of insurance issued under a Workers Compensation Insurance Plan and/or ineligibility for coverage under a Workers Compensation Insurance Plan.

APPLICANT'S NAME (PRINT OR TYPE)	
SIGNATURE (MUST BE AN OFFICER, OWNER OR PARTNER)	DATE (MM/DD/YYYY)

REMEMBER: BOTH THE ACORD 130 AND 133 APPLICATIONS MUST BE SIGNED BY THE APPLICANT AND THE DESIGNATED PRODUCER

PRODUCER'S CERTIFICATION

THE PRODUCER ALSO CERTIFIES THAT HE/SHE HAS BEEN AUTHORIZED TO SUBMIT THE APPLICATION ON BEHALF OF THE APPLICANT AND THAT ALL INFORMATION PROVIDED ON THE ACORD 130 AND 133 IS TRUE AND ACCURATE TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF.

AGENCY FEIN	AGENCY LICENSE NUMBER	AGENCY PHONE NUMBER (A/C,No, Ext)	AGENCY FAX NUMBER (A/C,No)

PRODUCER RESIDENT LICENSE NUMBER	STATE	EXPIRATION DATE	PRODUCER NON-RESIDENT LICENSE NUMBER	STATE	EXPIRATION DATE

PRODUCER NAME (PRINT OR TYPE):	PRODUCER SIGNATURE	DATE (MM/DD/YYYY)
E-MAIL ADDRESS:		