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ACORD™ WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY)

AGENCY	PHONE (A/C, No, Ext): 1-800-992-6999 FAX (A/C, No): 1-800-999-3987	COMPANY	UNDERWRITER
Legends Environmental Insurance Services, LLC. 2165 N. Glassell Street Orange, CA 92865 www.legends-enviro.com		APPLICANT NAME	INTERNET ADDRESS
		MAILING ADDRESS (including ZIP code)	
		YRS IN BUS / SIC	☐ INDIVIDUAL ☐ PARTNERSHIP ☐ CORPORATION ☐ SUBCHAPTER "S" CORP ☐ LLC ☐ OTHER:
CODE: SUB CODE:		CREDIT BUREAU NAME:	ID NUMBER:
AGENCY CUSTOMER ID		FEDERAL EMPLOYER ID NUMBER / NCCI ID NUMBER	OTHER RATING BUREAU ID OR STATE EMPLOYER REGISTRATION NUMBER

STATUS OF SUBMISSION

☐ QUOTE ☐ ISSUE POLICY
☐ BOUND (Give date and/or attach copy)
☐ ASSIGNED RISK (Attach ACORD 133)

BILLING/AUDIT INFORMATION

BILLING PLAN	PAYMENT PLAN		AUDIT	
☐ AGENCY BILL	☐ ANNUAL	☐ OTHER:	☐ AT EXPIRATION	☐ MONTHLY
☐ DIRECT BILL	☐ SEMI-ANNUAL		☐ SEMI-ANNUAL	☐ OTHER:
	☐ QUARTERLY	% DOWN:	☐ QUARTERLY	

LOCATIONS

#	STREET, CITY, COUNTY, STATE, ZIP CODE

POLICY INFORMATION

PROPOSED EFF DATE	PROPOSED EXP DATE	NORMAL ANNIVERSARY RATING DATE	☐ PARTICIPATING ☐ NON-PARTICIPATING	RETRO PLAN

PART 1 - WORKERS COMPENSATION (States)	PART 2 - EMPLOYER'S LIABILITY	PART 3 - OTHER STATES INS	DEDUCTIBLES	AMOUNT/%	OTHER COVERAGES
	$ EACH ACCIDENT		☐ MEDICAL		☐ U.S.L. & H. ☐ MANAGED CARE OPTION
	$ DISEASE-POLICY LIMIT		☐ INDEMNITY		☐ VOLUNTARY COMP
	$ DISEASE-EACH EMPLOYEE				☐ FOREIGN COV

DIVIDEND PLAN/SAFETY GROUP	ADDITIONAL COMPANY INFORMATION

RATING INFORMATION

STATE	LOC	CLASS CODE	DESCR CODE	CATEGORIES, DUTIES, CLASSIFICATIONS	# EMPLOYEES FULL TIME	# EMPLOYEES PART TIME	ESTIMATED ANNUAL REMUNERATION	RATE	ESTIMATED ANNUAL PREMIUM

SPECIFY ADDITIONAL COVERAGES/ENDORSEMENTS

	FACTOR	FACTORED PREMIUM
TOTAL		$
INCREASED LIMITS		$
DEDUCTIBLE		$
		$
EXPERIENCE MODIFICATION		$
LOSS CONSTANT	N/A	$
ASSIGNED RISK SURCHARGE		$
ARAP		$
		$
PREMIUM DISCOUNT		$
EXPENSE CONSTANT	N/A	$
		$
TOTAL EST ANNUAL PREMIUM	N/A	$

MINIMUM PREMIUM $ DEPOSIT PREMIUM $

INDIVIDUALS INCLUDED/EXCLUDED

PARTNERS, OFFICERS, RELATIVES TO BE INCLUDED OR EXCLUDED. (Remuneration to be included must be part of rating information section.)

#	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 ☐ 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
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT/WATERCRAFT?	☐	☐
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)	☐	☐
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?	☐	☐
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?	☐	☐
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?	☐	☐
6. ARE SUB-CONTRACTORS USED? (IF YES, GIVE % OF WORK SUBCONTRACTED)	☐	☐
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INS.?	☐	☐
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?	☐	☐
9. ANY GROUP TRANSPORTATION PROVIDED?	☐	☐
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?	☐	☐
11. ANY SEASONAL EMPLOYEES?	☐	☐
12. IS THERE ANY VOLUNTEER OR DONATED LABOR?	☐	☐
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?	☐	☐
14. DO EMPLOYEES TRAVEL OUT OF STATE?	☐	☐
15. ARE ATHLETIC TEAMS SPONSORED?	☐	☐

EXPLAIN ALL "YES" RESPONSES	YES	NO
16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?	☐	☐
17. ANY OTHER INSURANCE WITH THIS INSURER?	☐	☐
18. ANY PRIOR COVERAGE DECLINED/ CANCELLED/NON-RENEWED (Last 3 years)? NOT APPLICABLE IN MO	☐	☐
19. ARE EMPLOYEE HEALTH PLANS PROVIDED?	☐	☐
20. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS/SUBSIDIARY?	☐	☐
21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?	☐	☐
22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME?	☐	☐
23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST 5 YEARS?	☐	☐
24. ANY UNDISPUTED AND UNPAID WORKERS COMPENSATION PREMIUM DUE FROM YOU OR ANY COMMONLY MANAGED OR OWNED ENTERPRISES? IF YES, EXPLAIN INCLUDING ENTITIY NAME(S) AND POLICY NUMBERS(S).	☐	☐

CONTACT INFORMATION

IN-SPECTION	PHONE: NAME:
ACCTNG RECORD	PHONE: NAME:
CLAIMS INFO	PHONE: NAME:

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

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

Legends
ENVIRONMENTAL INSURANCE SERVICES, LLC.
2165 N. Glassell Street Orange, CA 92865 Office: 800-992-6999 Fax: 800-999-3987

Legends Microbial and EPL Disclosure Form

Policyholder/Applicant Microbial Insurance Disclosure/Options

Dear Valued Policyholder/Applicant,

This letter is to inform you of the potential microbial risk associated with your business. As a Consultant and/or Contractor performing services that could result in a Microbial claim, we must inform you that this coverage is available to you for an additional premium. This form is also to serve as due notice thereof. It is at your discretion as to whether or not you wish purchase said microbial coverage, however we do advise that you do so. If you choose not to pursue coverage for any potential microbial exposure you may have, then please be advised that we have formally notified you of the availability and offered to quote this exposure for you and/or your company. Also in the event of a microbial claim is filed against you or your company and you elected **not** to pursue a quote/coverage for your microbial exposure, the claim will **not** be paid by us or the carrier. It will become your sole responsibility to defend and pay said claim.

Please check the appropriate box below and return this form with your application for insurance.

☐	Accept	I hereby elect to pursue coverage for my microbial exposure
☐	Decline	I hereby do **not** elect to pursue coverage for my microbial exposure

Policy Holder/Applicant Employer Practices Liability Insurance Disclosure/Options

Dear Valued Policyholder/Applicant,

This section of the form is to inform you of your potential risk associated with your Employment Practices Liability (EPL). If you have employees we must inform you that your General Liability will not cover you in the event of a claim being filed by an employee regarding wrongful termination, sexual harassment, discrimination, defamation and unfair hiring/firing practices. If you have employees you will need to have an EPL policy in place for these exposures. This letter is to notify you that this coverage is available to you and or your company for an additional premium. If you choose **not** to receive a quote/coverage on this exposure, please be advised that you will have **no coverage** in the event an EPL related claim being filed against you or your company.

Please check the appropriate box below and return this form with your application for insurance. If you elect to receive an EPL quote, an application for this exposure will be sent to you.

☐	Accept	I hereby elect to pursue coverage for my EPL exposure
☐	Decline	I hereby do **not** elect to pursue coverage for my EPL exposure

Please sign, date and return this form with your submission. Quotes and/or coverage cannot be bound without receiving this form signed and dated by you the Policyholder/Applicant.

_____ Policyholder/Applicants Signature

_____ Print Your Name

_____ Date

_____ Title

_____ Company Name

_____ Company Address