



# Insurance



**PEARL® INSURANCE**

**Plan Administrator:**

1200 E. Glen Ave., Peoria Heights, IL 61616-5348

**Questions:** please call 800.622.0344

## WORKERS' COMPENSATION APPLICATION

Your Name \_\_\_\_\_ Date \_\_\_\_\_

Company Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State (or Province) \_\_\_\_\_ Country \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_ Fax Number ( ) \_\_\_\_\_ Email \_\_\_\_\_

Date new coverage needs to be effective \_\_\_\_ / \_\_\_\_ / \_\_\_\_

For internal use only. Email address will never be sold or shared.

### DESCRIBE YOUR BUSINESS

Legal Entity  Corporation  Limited Liability Company  Partnership  Individual  Other \_\_\_\_\_

Please provide a complete description of your business \_\_\_\_\_

Annual Sales/Receipts \$ \_\_\_\_\_ Year Business Purchased/Began \_\_\_\_\_ Federal Employer ID Number \_\_\_\_\_ (If applicable)

Are there any other businesses that are owned or operated by you that are not to be covered by this policy?  Yes  No If Yes, please describe on separate page.

### ADDITIONAL LOCATION

Street: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### WORKERS' COMPENSATION

Annual Payroll \$ \_\_\_\_\_ Number of Employees: Full-Time \_\_\_\_\_ Part-Time \_\_\_\_\_ Leased/Contracted \_\_\_\_\_ Desired Effective Date \_\_\_\_\_

Select your desired coverage amount:  \$100K / \$500K / \$100K  \$500K / \$500K / \$500K  \$1M / \$1M / \$1M (Limits of Liability vary by state mandated requirements.)

Are officers to be included for Workers' Compensation coverage?  Yes  No If Yes, please include payroll in total above and answer the following questions.

Please list the names of the owners/officers and their titles (use a separate sheet of paper, if necessary):

Name \_\_\_\_\_ Title \_\_\_\_\_ Salary \$ \_\_\_\_\_

Name \_\_\_\_\_ Title \_\_\_\_\_ Salary \$ \_\_\_\_\_

Are any employees leased to other companies or businesses on a permanent or temporary basis?  Yes  No

Are any employees leased from a Professional Employment Organization (PEO)?  Yes  No

Does the insured have officers in this state?  Yes  No

Are there states or operations for the named insured that are being excluded from the submission?  Yes  No

Does the customer have any permanent or temporary operations, home-based employees, make deliveries, or use subcontractors that reside in the state you are applying in?  Yes  No

### CLAIMS INFORMATION

Are officers to be included for Workers' Compensation coverage?  Yes  No

Occurrence/Loss Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Description of Occurrence/Loss \_\_\_\_\_

Amount Incurred (Paid + Reserve): \_\_\_\_\_

Has insurance coverage been cancelled, declined or non-renewed in the last 3 years?  Yes  No

Other \_\_\_\_\_

**Please fax completed application to 866.817.9009 or mail to: PO Box 3930., Peoria, IL 61612-9806**

**If you have any questions, please call 800.622.0344.**

Administered by **Pearl Insurance** in all states except in CA (Lic. #OF76076) and AR (Lic. #1322).

AAO-WC-APP

## WORKERS' COMPENSATION APPLICATION

### APPLICATION FRAUD WARNING

Any person who knowingly and with the intent to defraud any insurance company or another person files an application containing materially false information, or conceals for the purpose of misleading, information concerning any fact material there to, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and (NY: substantial) civil penalties.

**Duty of Disclosure:** In addition to providing all basic information necessary to enable us to place the risk, you must ensure that you are complying with your legal duty of disclosure of all material matters relating to the risk. In particular, you must satisfy yourself as to the accuracy and completeness of the information you provide the insurers. In this respect, you must provide all information relating to the risk whether favorable or not, which would influence the judgment of prudent insurer in determining whether they will take the risk, and, if so, for what premium and on what terms. If all such information is not disclosed by you, insurers have the right to void the contract from its commencement, which may lead to claims not being met.

**Signature**

**Date**

PLEASE SIGN AND DATE IN INK

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