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 ____________

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

Date new coverage needs to be effective ____ / ____ / ____

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 seperate 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. #0F76076) and AR (Lic. #1322).

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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