pki Philip King Insurance

☐ Occ Acc Only
☐ Occ Acc with Legal

Applicant Name _____ Requested Effective Date _____

Address CITY _____ ST ____ ZIP _____ Nature of Business _____

Number of years in business: ____ Tax ID# _____ Date of workers' comp coverage rejection: _____

Workers' comp or occupational accident coverage ever been canceled, refused or non-renewed? ☐ Yes ☐ No

If Yes, please explain: _____

Business Type: ☐ Corporation ☐ Partnership ☐ Other: _____

Is applicant subject to LPG or TxDOT Regulations? ☐ Yes ☐ No. Within what radius does applicant haul?: _____

Does applicant handle, store, or engage in transport of hazardous materials (including but not limited to explosive, caustic, poisonous or flammable materials)? ☐ Yes ☐ No. If Yes, please explain: _____

Please specify commodities hauled: _____

What percentage of loads are manually loaded or unloaded *(use 0% if no manual (un)loading)*? _____% Loaded _____% Unloaded

Does applicant perform any work at heights over 15 ft.? ☐ Yes ☐ No. If Yes, please explain: _____

Are Owners, Officers or Partners to be covered? ☐Yes ☐No. Are any affiliate companies to be covered? ☐Yes ☐No. If yes, please provide Legal Name, Address and number of employees at each location.

# of Full-Time EES 1099		# of Part-Time EES 1099		Classification Code	Annual Payroll by Class (Including Tips)	Classification or Description

Total Number of Employees _____ Total Payroll $ _____ Waiver of Subrogation? ☐ Yes ☐ No

Current Worker's Comp or Accident Premium $_____ Occupational Disease & Cumulative Trauma? ☐ Yes ☐ No

Combined Single Limit (per any one Person)
☐ $250,000 ☐ $500,000 ☐ $1,000,000 ☐ $2,000,000 ☐ $5,000,000

Deductible (per any one Person, any one Occurrence)
☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ $100,000 ☐ Other $_____

Benefit Period: _____110 Weeks _____156 Weeks Elimination Period: ☐ 7days ☐ 14 Days (Weekly Indemnity 75% up to $600)

Please submit 3 years (hard copy) current valued loss history: Valuation Date of loss information: _____

Year	Carrier	Total Losses	Description of Each Loss in Excess of $5,000 (Use separate sheet if necessary)

- Has this applicant (or affiliate) been in the Texas Workers' Compensation System in the last 3 years? ☐Yes ☐ No
  If yes, have they had an experience modification factor of 1.50% or higher? ☐Yes ☐ No
- Has the applicant (or affiliate) ever had an Employer's Liability claim? ☐Yes ☐ No
- Has the applicant (or affiliate) ever had an Occupational Disease (e.g. Black Lung, silicosis, lead poisoning, cancer, etc.) or Cumulative Trauma (e.g. carpal tunnel, stress, etc.) claim? ☐ Yes ☐ No
- Does the applicant have a Safety Program? ☐Yes ☐No Do you conduct random drug tests? ☐Yes ☐No

If you answered YES to any of these questions, please give a complete descriptions, dates, and amounts of claims on a separate sheet.

Agent and Applicant hereby acknowledge that: all answers and statements contained herein including any attached data, are true and complete; Insurer will rely solely on the information provided in this Fax-A-Quote, along with any attached data, in considering whether to provide the requested insurance coverage; and this Fax-A-Quote shall become a part of the Policy should coverage be bound.

Agent: _____ **Phone:** _____

Address: _____ **Fax:** _____

Agent Signature: _____ **Applicant Signature:** _____

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