



ENVIRONMENTAL WORKERS COMPENSATION APPLICATION

This application is for use in applying for Workers Compensation coverage.

The following information is required to complete the application as attachments:

- Four (4) years of currently valued, hard copy loss information for prior WC coverage.
- Complete copy of current Worker Compensation Experience Modification form.

APPLICANT INFORMATION

Named Insured:					
Mailing Address:					
City:		State:		Zip:	
Contact Person:				Telephone #:	
Email Address:				Website Address:	
Corporate Entity is:	<input type="checkbox"/> Corporation <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Joint Venture <input type="checkbox"/> Other (Please attach description)				
What Year was the Entity Founded:					
CREDIT BUREAU:		CREDIT BUREAU ID #:			
FEDERAL EMPLOYER ID #:		NCCI RISK ID #:			

LOCATIONS

LOC #	STREET	CITY	STATE	ZIP

POLICY INFORMATION

EFFECTIVE DATE:		EXPIRATION DATE:		ANNIVERSARY RATING DATE:	
EMPLOYER'S LIABILITY LIMITS:	\$			EACH ACCIDENT LIMIT	
	\$			DISEASE-POLICY LIMIT	
	\$			DISEASE-EACH EMPLOYEE LIMIT	
DEDUCTIBLES:	\$			MEDICAL	
	\$			INDEMNITY	
COVERED STATES:			DIVIDEND PLAN/SAFETY GROUP:		
OTHER COVERAGES:	<input type="checkbox"/> U.S.L.&H. <input type="checkbox"/> Voluntary Comp		<input type="checkbox"/> Foreign Coverage <input type="checkbox"/> Managed Care		
TOTAL CURRENT ANNUAL PREMIUM ALL STATES:					
SPECIFY ADDITIONAL COVERAGE/ENDORSEMENTS REQUIRED:					

INCLUDED/EXCLUDED INDIVIDUALS

PARTNERS, OFFICERS, RELATIVES TO BE INCLUDED OR EXCLUDED (Must be employed by business operations)									
STATE	LOC #	NAME	DOB	TITLE	OWNERSHIP %	DUTIES	INC/EXC	CLASS CODE	PAYROLL

GENERAL INFORMATION

Does the insured have any operations, payroll or anticipated work anywhere within the state of NY?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does the applicant have any exposure to USL&H, FELA or other Federal Act?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does the insured lease any employees or utilize any leased labor?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do the insured's operations include any trenching or work more than ten (10) feet below ground surface?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do the insured's operations include any exposure or work taking place over two (2) stories, or sixty (60) feet, above the ground, including on scaffolding?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does the insured utilize sub-contractors without a written contract and certificates of insurance?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Is the insured operating within fifty (50) feet of any railroad?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does any one location have more than 100 employees?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Has the insured ever been cited by OSHA?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Has the insured been in business for at least three (3) years without a lapse in Workers Compensation coverage?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does the insured adhere to an OSHA Medical Surveillance Program for employees engaged in Class I, Class II or Class III asbestos operations, or those utilizing respiratory personal protective equipment?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does the insured require candidate physicals after an offer of employment has been made and prior to employment?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do principals of the insured act as supervisors on job sites?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Is any work performed on barges, vessels, docks, piers, bridges or over navigable waters?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Is the average tenure of employees at least one year?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does the applicant own, operate or lease any aircraft or watercraft?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are there any tax liens or bankruptcies within the prior five (5) years?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does the insured utilize a written Safety Plan that details the proper procedures for worksite emergencies?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does the insured have a safety professional (CIH/CSP) sign-off on their Health/Safety programs?	<input type="checkbox"/> YES <input type="checkbox"/> NO
For how long does the insured retain personnel, workplace and ambient air monitoring results?	

ABATEMENT INFORMATION

Has the insured instituted the new Respiratory Protection Standard provisions and provided the correct PPE based upon the hazards associated with each specific worksite?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Has all hazard-specific training provided to personnel incorporated the proper use of PPE and respiratory equipment and afforded annual fit testing for respirators and refresher training for both PPE and respirators?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Is the abatement license holder for the company an employee of the insured?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does the insured's Health/Safety Plan detail the procedures for each hazard which might be encountered during work activities?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Who is the insured's corporate Respiratory Program Administrator?	NAME:
	TITLE:
	CONTACT #:

CONSULTING INFORMATION

Is the consulting or laboratory professional who qualifies the services and exposures an employee of the insured?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does the insured limit the scope of services depending on the type of substances, materials or wastes a worksite contains?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Please describe any "Accreditations" held by the insured:	
What type and level of certification and training is required of the insured's employees:	

CLAIMS INFORMATION:

Have any claims been made against you or reported under any Workers Compensation policy?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you aware of any fact, circumstance or situation that could reasonably result in a claim being made against you, or any other entity, for which coverage is being sought?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If "YES", please describe or provide attached reference:	

FRAUD WARNING: APPLICABLE TO ALL STATES

Any person who knowing and with intent to defraud any insurance company or other 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

WARRANTY STATEMENT

The undersigned authorized officer of the applicant declares that the statements set forth herein are true. The undersigned authorized officer agrees that if the information supplied on the application changes between the date of the application and the effective date of the insurance, he/she (undersigned) will immediately notify the insurer of such changes, and the insurer may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance. Signing of this application does not bind the applicant or the insurer to complete the insurance.

Notice to applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning fact material thereto, commits a fraudulent insurance act, which is a crime.

The completion of this application does not bind coverage or in any way commit Century Insurance Group to provide insurance coverage to the applicant. The applicant's acceptance of Century Insurance Group's written quotation and binding agreement is required to bind any coverage and issue a policy. It is agreed that this application is the basis of any such issued insurance contract and will be attached as a part of the policy.

SIGNATURE OF OWNER OR OFFICER OF APPLICANT:	
PRINTED NAME & TITLE OF SIGNATORY:	
DATE OF SIGNATURE:	

AGENT/BROKERAGE:	
LICENSE NUMBER:	
ADDRESS OF AGENCY/BROKERAGE:	
CONTACT PERSON & TELEPHONE:	