



U.S. Risk Brokers, Inc.

a member company of U.S. Risk Insurance Group, Inc.
10210 N. Central Expwy., Suite 500, Dallas, TX 75231

Please Note: This application can be filled in online. After completing, please save and email a copy to the broker or underwriter with whom you are working. For contact information please visit us at www.usrisk.com

Occupational Accident without Employers Liability Application

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 Employees	# of Part-Time Employees	# of Full-Time 1099's	# of Part-Time 1099's	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: _____