

PIZZA OWNERS PROGRAM WORKERS COMPENSATION APPLICATION

Business Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____

Telephone: _____ Fax: _____

Restaurant Address: _____

(List additional locations on attached form)

City: _____ State: _____ Zip: _____

Federal Identification No.: _____ State Identification Number: _____

Present insurance carrier: _____

Present policy expiration date: _____

Policy number: _____

New policy effective date: _____

Present experience modification factor: _____ % (If any, attach worksheet)

Employees (excluding owners/executive officers)		
Classification	Number of Employees	Gross Annual Payroll
Restaurant ()		\$
Clerical 8810		\$
Delivery 7380		\$

Owners/Executive Officers			
Name	Coverage for Workers Comp?	Total Annual Income	Class Code
	<input type="checkbox"/> Yes <input type="checkbox"/> No	(If yes) \$	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	(If yes) \$	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	(If yes) \$	

List all employees that are relatives of owner(s):

Name	Relationship to Whom	Resides with Relatives
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

WORKERS COMPENSATION APPLICATION GENERAL INFORMATION

Name of Business: _____

- Is this a new business venture? Yes No
- Does Applicant own, operate or lease aircraft/watercraft? Yes No
- Are athletic teams sponsored? Yes No
- Are employee health plans provided? Yes No
- Are owners covered by major medical policy for non-work related illness or injury? Yes No
- Do you lease employees from or to anyone else? Yes No
- Is applicant engaged in any other type of business? Yes No
- Are sub-contractors used to clean the restaurant? Yes No
- Any sub-contracting work allowed without certificates? Yes No
- Is there a formal safety program followed in restaurant? Yes No
- Does waitress services take all orders at tables or booths? Yes No
- Do you have any employees with disabilities? Yes No
- Do all covered employees with driving duties satisfy MVR standards? Yes No
- If yes, please list: _____

Prior claims reports were ordered from present agent on: _____

CLAIMS STATEMENT (must be completed and SIGNED)

The undersigned understands and agrees that for the purpose of applying for workers compensation insurance:

I confirm that there were NO losses for the past 4 years from date of this statement EXCEPT as indicated below:

Employee Name	Date of Loss	Description of Injury	No. Days Off Work	Loss Amount/ Payroll
				\$
				\$

During the past 3 years, has any coverage been cancelled, non-renewed, declined or placed in non-standard markets? Yes No

Have there been any claims or occurrences that may give rise to a claim for the prior three (3) years? Yes No

If yes, attach summary including date of loss, amount paid and description of loss.

Authorization:

I/We understand that no liability is created or assumed by the insurance company until and unless the policy applied for has been issued.

I/We understand that this application is not the policy and in no way supplements, augments, or changes any of the language of the policy. For specific coverage information, please refer to your policy contract.

I/We affirm that the information contained herein is true to the best of my/our knowledge and that it shall be the basis for which this policy issued. I/We hereby authorize the release of claim information from any prior insurer to the Company or its representatives.

Print Name: _____

Signature: _____ Date: _____

WORKERS COMPENSATION APPLICATION ADDITIONAL LOCATIONS

Business Name: _____

List all additional locations below:

2.			
	City:	State:	Zip:
3.			
	City:	State:	Zip:
4.			
	City:	State:	Zip:
5.			
	City:	State:	Zip:
6.			
	City:	State:	Zip:
7.			
	City:	State:	Zip:
8.			
	City:	State:	Zip:
9.			
	City:	State:	Zip:
10.			
	City:	State:	Zip: