

ACORD™ WORKERS COMPENSATION APPLICATION

DATE

PRODUCER	PHONE (A/C, No, Ext): FAX (A/C, No):	COMPANY	UNDERWRITER
		APPLICANT NAME	INTERNET ADDRESS:
		MAILING ADDRESS (including ZIP code)	
		YRS IN BUS	SIC
		INDIVIDUAL	CORPORATION
		PARTNERSHIP	SUBCHAPTER "S" CORP
		LIMITED CORP	
		OTHER:	
CODE:	SUB CODE:	CREDIT BUREAU NAME:	ID NUMBER:
AGENCY CUSTOMER ID		FEDERAL EMPLOYER ID NUMBER	OTHER RATING BUREAU ID OR STATE EMPLOYER REGISTRATION NUMBER
		NCCI ID NUMBER	

STATUS OF SUBMISSION

BILLING/AUDIT INFORMATION

QUOTE	ISSUE POLICY	BILLING PLAN	PAYMENT PLAN	AUDIT
BOUND (Give date and/or attach copy)		AGENCY BILL	ANNUAL	OTHER:
ASSIGNED RISK (Attach ACORD 133)		DIRECT BILL	SEMI-ANNUAL	AT EXPIRATION
			QUARTERLY	MONTHLY
			% DOWN:	OTHER:
				QUARTERLY

LOCATIONS

STREET, CITY, COUNTY, STATE, ZIP CODE

POLICY INFORMATION

PROPOSED EFF DATE	PROPOSED EXP DATE	NORMAL ANNIVERSARY RATING DATE	PARTICIPATING	RETRO PLAN
PART 1 - WORKERS COMPENSATION (States)		NON-PARTICIPATING		OTHER COVERAGES
\$	EACH ACCIDENT	PART 2 - EMPLOYER'S LIABILITY	DEDUCTIBLES	AMOUNT/%
\$	DISEASE-POLICY LIMIT	PART 3 - OTHER STATES INS	MEDICAL	U.S.L. & H. VOLUNTARY COMP
\$	DISEASE-EACH EMPLOYEE		INDEMNITY	FOREIGN COV
DIVIDEND PLAN/SAFETY GROUP	ADDITIONAL COMPANY INFORMATION			
				MANAGED CARE OPTION

RATING INFORMATION

STATE	LOC	CLASS CODE	DESCR CODE	CATEGORIES, DUTIES, CLASSIFICATIONS	# EMPLOYEES		ESTIMATED ANNUAL REMUNERATION	RATE	ESTIMATED ANNUAL PREMIUM
					FULL TIME	PART TIME			

SPECIFY ADDITIONAL COVERAGES/ENDORSEMENTS		FACTOR	FACTORED PREMIUM
		TOTAL	\$
		INCREASED LIMITS	\$
		DEDUCTIBLE	\$
			\$
		EXPERIENCE MODIFICATION	\$
		LOSS CONSTANT	\$
		ASSIGNED RISK SURCHARGE	\$
		ARAP	\$
			\$
		PREMIUM DISCOUNT	\$
		EXPENSE CONSTANT	\$
			\$
MINIMUM PREMIUM	\$	DEPOSIT PREMIUM	\$
		TOTAL EST ANNUAL PREMIUM	\$

INDIVIDUALS INCLUDED/EXCLUDED

PARTNERS, OFFICERS, RELATIVES TO BE INCLUDED OR EXCLUDED. (Remuneration to be included must be part of rating information section.)								
#	NAME	DATE OF BIRTH	TITLE/RELATIONSHIP	OWNER-SHIP %	DUTIES	INC/EXC	CLASS CODE	REMUNERATION

PRIOR CARRIER INFORMATION/LOSS HISTORY

PROVIDE INFORMATION FOR THE PAST 5 YEARS AND USE THE REMARKS SECTION FOR LOSS DETAILS						LOSS RUN ATTACHED	
YEAR	CARRIER & POLICY NUMBER	ANNUAL PREMIUM	MOD	# CLAIMS	AMOUNT PAID	RESERVE	
	CO: _____ POL #: _____						
	CO: _____ POL #: _____						
	CO: _____ POL #: _____						
	CO: _____ POL #: _____						
	CO: _____ POL #: _____						

NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS

GIVE COMMENTS AND DESCRIPTIONS OF BUSINESS, OPERATIONS AND PRODUCTS: MANUFACTURING-- RAW MATERIALS, PROCESSES, PRODUCT, EQUIPMENT, CONTRACTOR-- TYPE OF WORK, SUB-CONTRACTS. MERCANTILE--MERCHANDISE, CUSTOMERS, DELIVERIES. SERVICE--TYPE, LOCATION. FARM--ACREAGE, ANIMALS, MACHINERY, SUB-CONTRACTS.

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	YES	NO	EXPLAIN ALL "YES" RESPONSES	YES	NO
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT/WATERCRAFT?			16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?		
2. DO/HAVE PAST, PRESENT OR DISCONTINUED OPERATIONS INVOLVE(D) STORING, TREATING, DISCHARGING, APPLYING, DISPOSING, OR TRANSPORTING OF HAZARDOUS MATERIAL? (e.g. landfills, wastes, fuel tanks, etc)			17. ANY OTHER INSURANCE WITH THIS INSURER?		
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?			18. ANY PRIOR COVERAGE DECLINED/ CANCELLED/NON-RENEWED (Last 3 years)? NOT APPLICABLE IN MO		
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?			19. ARE EMPLOYEE HEALTH PLANS PROVIDED?		
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?			20. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS/SUBSIDIARY?		
6. ARE SUB-CONTRACTORS USED? (IF YES, GIVE % OF WORK SUBCONTRACTED)			21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?		
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INS.?			22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME?		
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?			23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST 5 YEARS?		
9. ANY GROUP TRANSPORTATION PROVIDED?			24. ANY UNDISPUTED AND UNPAID WORKERS COMPENSATION PREMIUM DUE FROM YOU OR ANY COMMONLY MANAGED OR OWNED ENTERPRISES? IF YES, EXPLAIN INCLUDING ENTITY NAME(S) AND POLICY NUMBER(S).		
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?			CONTACT INFORMATION		
11. ANY SEASONAL EMPLOYEES?			IN- SPECTION	PHONE:	
12. IS THERE ANY VOLUNTEER OR DONATED LABOR?			NAME:		
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?			ACCTNG RECORD	PHONE:	
14. DO EMPLOYEES TRAVEL OUT OF STATE?			NAME:		
15. ARE ATHLETIC TEAMS SPONSORED?			CLAIMS INFO	PHONE:	
			NAME:		

APPLICABLE IN TENNESSEE: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO ANY PARTY TO A WORKERS COMPENSATION TRANSACTION FOR THE PURPOSE OF COMMITTING FRAUD. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS. ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 SUBJECTS THE PERSON TO CRIMINAL AND (NY: SUBSTANTIAL) CIVIL PENALTIES. (NOT APPLICABLE IN CO, HI, NE, OH, OK, OR, VT; IN DC, LA, ME AND VA, INSURANCE BENEFITS MAY ALSO BE DENIED)

REMARKS

APPLICANT'S SIGNATURE _____ PRODUCER'S SIGNATURE _____

**PHOENIX AVIATION MANAGERS INC.
WORKERS' COMPENSATION SUPPLEMENTAL APPLICATION**

NAME: _____ EFFECTIVE DATE: _____

1. Detailed Description of Business Operations: _____

2. Use of Aircraft by number and type – attach schedule if available/

	Fixed Wing		Rotor Wing
a. Charter, Sales, I & R # _____	Type _____	# _____	Type _____
b. Cargo or package Trans: # _____	Type _____	# _____	Type _____
c. Power/Pipeline patrol: # _____	Type _____	# _____	Type _____
d. Ag/forestry applications: # _____	Type _____	# _____	Type _____
e. P & B, Industrial Aide: Year _____	Make _____	Model _____	#pax seats _____
f. Airlines, commuter # _____	Type _____	# seats _____	# crew _____

3. Location Details:

Location 1. Airport Identifier _____

Name of Entity _____ FEIN _____

Address _____ Zip Code _____

Number of Employees _____ Max. number on duty at one time _____

Location 2. Airport Identifier _____

Name of Entity _____ FEIN _____

Address _____ Zip Code _____

Number of Employees _____ Max. number on duty at one time _____

Location 3. Airport Identifier _____

Name of Entity _____ FEIN _____

Address _____ Zip Code _____

Number of Employees _____ Max. number on duty at one time _____

P.O. Box 440757 – Kennesaw, Georgia 30160
770-590-4950 Phone - 770-590-0599 Fax
sgoins@phoenixaviationmgrs.com

Location 4. Airport Identifier _____

Name of Entity _____ FEIN _____

Address _____ Zip Code _____

Number of Employees _____ Max. number on duty at one time _____

4. List jet or turbine aircraft: _____
5. List total number of pilots/crew: Fixed Wing – FT ____ PT ____ Rotor Wing- FT ____ PT ____
6. Any flight attendants?
7. Maximum number of officers and/or employees in one aircraft at one time.
8. Average number of officers and/or employees in one aircraft at one time.
9. Any international exposure? If so, where and how often? Duration of layovers?
10. Any exposure to U.S. Acts coverage?
 - U.S. Longshore & Harbor Workers Act?
 - The Defense Base Act?
 - Outer Continental Shelf Lands Act?
 - Federal Employer’s Liability Act?
11. Any operations outside the Western Hemisphere?
12. Any antique, experimental or ex-military aircraft?
13. Any aircraft painting?
14. Any aerobatic, exhibition or racing aircraft?
15. Any “scheduled operations”?
16. Any seaplane, fish spotting or maritime exposure?
17. Any rotor wing heavy lift, line stringing or logging operations?
18. Any contracts with U.S. Armed Forces?
19. Any operations from unprepared sites?
20. Any leased or independent contractor employees? _____ Estimated 1099 payroll? _____
21. Describer Safety & Loss Control Program:
 - a. Written statement of safety policy? Yes No
 - b. Written safety program with responsibility assigned? Yes No
 - c. Regular safety meetings with documentation? Yes No
 - d. Compliance with SARA “right to know” statutes? Yes No
 - e. Have you been inspected by OSHA? Yes No

Signed and completed by: _____ Date: _____