WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY): 09/09/22

AGENCY NAME AND ADDRESS	**COMPANY:** David Worker Inc.
Tampa Commercial Insurance 1726 Confederate Drive Syracuse NY 13206	**UNDERWRITER:** N/A **APPLICANT NAME:** David A Smith **OFFICE PHONE:** 516-642-1027 **MOBILE PHONE:** 646-729-3726 **MAILING ADDRESS (including ZIP + 4 or Canadian Postal Code)** 2308 Cantebury Drive, Westbury,NY 11590, New York **YRS IN BUS:** 5 **SIC:** 5541 **NAICS:** 11120 **WEBSITE ADDRESS:** www.mm.com
PRODUCER NAME: Michelen Insurance	
CS REPRESENTATIVE NAME: ABC	
OFFICE PHONE (A/C, No, Ext): 516-642-1028	**E-MAIL ADDRESS:** ecv@gmail.com
MOBILE PHONE: 646-729-3745	[X] SOLE PROPRIETOR [X] CORPORATION [X] LLC [X] TRUST [X] UNINCORPORATED ASSOCIATION
FAX (A/C, No): +44 161 999 8888	[X] PARTNERSHIP [X] SUBCHAPTER "S" CORP [X] JOINT VENTURE [X] OTHER:
E-MAIL ADDRESS: ecv@gmail.com	**CREDIT BUREAU NAME:** Equifax **ID NUMBER:** 23
CODE: 2345 **SUB CODE:** 56	**FEDERAL EMPLOYER ID NUMBER:** 8976 **NCCI RISK ID NUMBER:** 99962 **OTHER RATING BUREAU ID OR STATE EMPLOYER REGISTRATION NUMBER:** 0010
AGENCY CUSTOMER ID: AG123	

STATUS OF SUBMISSION

[X] QUOTE [X] ISSUE POLICY
[X] BOUND (Give date and/or attach copy)
[X] ASSIGNED RISK (Attach ACORD 133)

BILLING / AUDIT INFORMATION

BILLING PLAN
[X] AGENCY BILL
[X] DIRECT BILL

PAYMENT PLAN
[X] ANNUAL [X] Yearly
[X] SEMI-ANNUAL
[X] QUARTERLY % DOWN: 89

AUDIT
[X] AT EXPIRATION [X] MONTHLY
[X] SEMI-ANNUAL [X] Yearly
[X] QUARTERLY

LOCATIONS

LOC #	HIGHEST FLOOR	STREET, CITY, COUNTY, STATE, ZIP CODE
1	14	2308 Cantebury Drive, Westbury,NY 11590
2	15	3 TIMES SQUARE New York New York 10119
3	25	160 MONTAGUE STREET Brookyln Kings 11201

POLICY INFORMATION

PROPOSED EFF DATE	PROPOSED EXP DATE	NORMAL ANNIVERSARY RATING DATE		RETRO PLAN
08/08/2020	08/08/2021	03/11/2021	[X] PARTICIPATING [X] NON-PARTICIPATING	N/A

PART 1 - WORKERS COMPENSATION (States)	PART 2 - EMPLOYER'S LIABILITY	PART 3 - OTHER STATES INS	DEDUCTIBLES (N / A in WI)	AMOUNT / % (N / A in WI)	OTHER COVERAGES
12 2 56 64 11 23 65 8 9 90	$ 20,000 EACH ACCIDENT $ 17,000 DISEASE-POLICY LIMIT $ 12,000 DISEASE-EACH EMPLOYEE	a b c d e f g h i j	[X] MEDICAL [X] INDEMNITY	50,008	[X] U.S.L. & H. [X] MANAGED CARE OPTION [X] VOLUNTARY COMP [X] [X] FOREIGN COV [X]

DIVIDEND PLAN/SAFETY GROUP	ADDITIONAL COMPANY INFORMATION
Yes	Nil

SPECIFY ADDITIONAL COVERAGES / ENDORSEMENTS (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

12,000

TOTAL ESTIMATED ANNUAL PREMIUM - ALL STATES

TOTAL ESTIMATED ANNUAL PREMIUM ALL STATES	TOTAL MINIMUM PREMIUM ALL STATES	TOTAL DEPOSIT PREMIUM ALL STATES
$ 50,000	$ 500	$ 150

CONTACT INFORMATION

TYPE	NAME	OFFICE PHONE	MOBILE PHONE	E-MAIL
INSPECTION	Mike	516-642-1027	646-729-3726	ecv@gmail.com
ACCTNG RECORD	Acting			
CLAIMS INFO				

INDIVIDUALS INCLUDED / EXCLUDED

PARTNERS, OFFICERS, RELATIVES (Must be employed by business operations) TO BE INCLUDED OR EXCLUDED (Remuneration/Payroll to be included must be part of rating information section.) Exclusions in Missouri must meet the requirements of Section 287.090 RSMo.

STATE	LOC #	NAME	DATE OF BIRTH	TITLE/ RELATIONSHIP	OWNER-SHIP %	DUTIES	INC/EXC	CLASS CODE	REMUNERATION/PAYROLL
31	AS	Michael S	09/09/1978	OWNER	50	Owner	E	2120	50,000
23	CA	Jack	02/09/1979	OWNER	40	Owner	F	3178	80,000
87	DE	Tulip	08/11/1979	OWNER	89	OWNER	T	3689	90,000
45	FL	Mark	03/11/1980	OWNER	70	OWNER	L	7895	10,000

STATE RATING SHEET # ____ **OF** ____ **SHEETS** **AGENCY CUSTOMER ID:** AG123

STATE RATING WORKSHEET

FOR MULTIPLE STATES, ATTACH AN ADDITIONAL PAGE 2 OF THIS FORM

RATING INFORMATION - STATE:

LOC #	CLASS CODE	DESCR CODE	CATEGORIES, DUTIES, CLASSIFICATIONS	# EMPLOYEES FULL TIME	# EMPLOYEES PART TIME	SIC	NAICS	ESTIMATED ANNUAL REMUNERATION/ PAYROLL	RATE	ESTIMATED ANNUAL MANUAL PREMIUM
1	2120	64	Breakfast Food	1	1	5541	11120	70,000	2.673	5,432.00
2	1234	89	Category1	2	2	8978	5462	96,000	6.325	7,432.00
3	3564	98	Category2	3	3	9663	7896	78,000	8.654	9,432.00
4	5689	45	Category3	4	4	4512	8579	36,000	9.231	5,462.00
5	9856	65	Category4	5	5	9885	7256	77,000	1.236	1,432.00
6	7845	25	Category5	6	6	2315	5465	69,000	2.564	3,432.00
7	9685	36	Category6	7	7	2052	8965	98,000	6.417	2,432.00
8	7896	65	Category7	8	8	4875	7854	39,000	8.147	6,432.00
9	5847	74	Category8	9	9	6535	4563	56,000	5.456	5,482.00
10	2356	54	Category9	10	10	9865	6396	12,000	2.154	5,489.00
11	9636	56	Category10	11	11	4578	7986	11,000	3.689	8,832.00
12	4875	23	Category11	12	12	3021	3215	15,000	7.896	5,892.00
13	2032	20	Category12	13	13	9636	9687	32,000	8.256	5,898.00
14	3645	78	Category13	14	14	7896	6588	85,000	4.258	5,462.00

PREMIUM

STATE:	FACTOR	FACTORED PREMIUM		FACTOR	FACTORED PREMIUM
TOTAL	N / A	$ 12,000	0THERS3	Yes	$ 96,000
INCREASED LIMITS	Yes	$ 22,000	SCHEDULE RATING *	Yes	$ 18,000
DEDUCTIBLE *	Yes	$ 42,000	CCPAP	Yes	$ 32,000
0THERS1	Yes	$ 62,000	STANDARD PREMIUM	Yes	$ 78,000
EXPERIENCE OR MERIT MODIFICATION	Yes	$ 52,000	PREMIUM DISCOUNT	Yes	$ 89,000
0THERS2	Yes	$ 92,000	EXPENSE CONSTANT	N / A	$ 36,000
ASSIGNED RISK SURCHARGE *	Yes	$ 68,000	TAXES / ASSESSMENTS *	N / A	$ 63,000
ARAP *	Yes	$ 78,000	0THERS4	Yes	$ 02,000

* N / A in Wisconsin

TOTAL ESTIMATED ANNUAL PREMIUM	MINIMUM PREMIUM	DEPOSIT PREMIUM
$ 50,000	$ 500	$ 150

REMARKS (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Acord 130

AGENCY CUSTOMER ID: AG123

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: 12 POL #: 23489	50,000	1	2578	20,000	500
	CO: 13 POL #: 14528	20,000	2	9687	30,000	800
	CO: 17 POL #: 23567	30,000	3	3325	50,000	900
	CO: 18 POL #: 74859	80,000	4	9686	63,000	400
	CO: 11 POL #: 52465	90,000	5	4251	36,000	300

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.

COMMENTS

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	Y / N
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT / WATERCRAFT? AIRCRAFT	Y
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) LANDFILLS	Y
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET? 15 FEET	Y
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER? BRIDGE	Y
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS? NA	
6. ARE SUB-CONTRACTORS USED? (If "YES", give % of work subcontracted) NA	Y
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INSURANCE? (If "YES", payroll for this work must be included in the State Rating Worksheet on Page 2) SUB-CONTRACTORS	Y
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION? NA	N
9. ANY GROUP TRANSPORTATION PROVIDED? NA	Y
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE? group transformation	Y
11. ANY SEASONAL EMPLOYEES? 16 or over 60 years of age	Y
12. IS THERE ANY VOLUNTEER OR DONATED LABOR? (If "YES", please specify) Seasonal	N
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS? NA	N
14. DO EMPLOYEES TRAVEL OUT OF STATE? (If "YES", indicate state(s) of travel and frequency) NA	N
15. ARE ATHLETIC TEAMS SPONSORED? NA	N
16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE? NA	N

AGENCY CUSTOMER ID: AG123

GENERAL INFORMATION (continued)

EXPLAIN ALL "YES" RESPONSES	Y / N
17. ANY OTHER INSURANCE WITH THIS INSURER? NA	N
18. ANY PRIOR COVERAGE DECLINED / CANCELLED / NON-RENEWED IN THE LAST THREE (3) YEARS? (Missouri Applicants - Do not answer this question) NA	N
19. ARE EMPLOYEE HEALTH PLANS PROVIDED? Provided	Y
20. DO ANY EMPLOYEES PERFORM WORK FOR OTHER BUSINESSES OR SUBSIDIARIES? Other businesses	Y
21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS? Lease Employees	Y
22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME? If "YES", # of Employees: _____ Yes work at home	Y
23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST FIVE (5) YEARS? (If "YES", please specify) NA	N
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). NA	N

SIGNATURE

Copy of the Notice of Information Practices (Privacy) has been given to the applicant. (Not required in all states, contact your agent or broker for your state's requirements.)

PERSONAL INFORMATION ABOUT YOU, INCLUDING INFORMATION FROM A CREDIT OR OTHER INVESTIGATIVE REPORT, MAY BE COLLECTED FROM PERSONS OTHER THAN YOU IN CONNECTION WITH THIS APPLICATION FOR INSURANCE AND SUBSEQUENT AMENDMENTS AND RENEWALS. SUCH INFORMATION AS WELL AS OTHER PERSONAL AND PRIVILEGED INFORMATION COLLECTED BY US OR OUR AGENTS MAY IN CERTAIN CIRCUMSTANCES BE DISCLOSED TO THIRD PARTIES WITHOUT YOUR AUTHORIZATION. CREDIT SCORING INFORMATION MAY BE USED TO HELP DETERMINE EITHER YOUR ELIGIBILITY FOR INSURANCE OR THE PREMIUM YOU WILL BE CHARGED. WE MAY USE A THIRD PARTY IN CONNECTION WITH THE DEVELOPMENT OF YOUR SCORE. YOU MAY HAVE THE RIGHT TO REVIEW YOUR PERSONAL INFORMATION IN OUR FILES AND REQUEST CORRECTION OF ANY INACCURACIES. YOU MAY ALSO HAVE THE RIGHT TO REQUEST IN WRITING THAT WE CONSIDER EXTRAORDINARY LIFE CIRCUMSTANCES IN CONNECTION WITH THE DEVELOPMENT OF YOUR CREDIT SCORE. THESE RIGHTS MAY BE LIMITED IN SOME STATES. PLEASE CONTACT YOUR AGENT OR BROKER TO LEARN HOW THESE RIGHTS MAY APPLY IN YOUR STATE OR FOR INSTRUCTIONS ON HOW TO SUBMIT A REQUEST TO US FOR A MORE DETAILED DESCRIPTION OF YOUR RIGHTS AND OUR PRACTICES REGARDING PERSONAL INFORMATION.
(Not applicable in AZ, CA, DE, KS, MA, MN, ND, NY, OR, VA, or WV. Specific ACORD 38s are available for applicants in these states.)

(Applicant's Initials): LV

Applicable in AL, AR, DC, LA, MD, NM, RI and WV: Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD Only.

Applicable in CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Applicable in FL and OK: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)*. *Applies in FL Only.

Applicable in KS: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in KY, NY, OH and PA: Any person who knowingly 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 subjects such person to criminal and civil penalties (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY Only.

Applicable in ME, TN, VA and WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits. *Applies in ME Only.

Applicable in NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicable in OR: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Applicable in PR: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Applicable in UT: Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

THE UNDERSIGNED IS AN AUTHORIZED REPRESENTATIVE OF THE APPLICANT AND REPRESENTS THAT REASONABLE INQUIRY HAS BEEN MADE TO OBTAIN THE ANSWERS TO QUESTIONS ON THIS APPLICATION. HE/SHE REPRESENTS THAT THE ANSWERS ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF HIS/HER KNOWLEDGE.

APPLICANT'S SIGNATURE (Must be Officer, Owner or Partner)	DATE	PRODUCER'S SIGNATURE	NATIONAL PRODUCER NUMBER
Signature	08/08/2022	Signature	762TUGWU

AGENCY CUSTOMER ID: AG123

WORKERS COMPENSATION INSURANCE PLAN
ASSIGNED RISK SECTION

DATE (MM/DD/YYYY): 09/09/22

THIS FORM ALONG WITH AN ACORD 130 WORKERS COMPENSATION APPLICATION CONSTITUTE AN APPLICATION FOR WORKERS COMPENSATION INSURANCE PLAN (ASSIGNED RISK) COVERAGE. THIS FORM MUST BE ATTACHED TO AN ACORD 130 FOR SUBMISSION. PLEASE REFER TO THE STATE SPECIFIC INSTRUCTIONS PAGE FOR SPECIFIC REQUIREMENTS.

APPLICANT NAME	PROPOSED EFF DATE
David A Smith	08/08/2020

SUPPLEMENTAL INFORMATION

PAYROLL OFFICE NAME, ADDRESS AND TELEPHONE NUMBER (A PO BOX ADDRESS ALONE IS NOT ACCEPTABLE. PLEASE PROVIDE DRIVING INSTRUCTIONS IF A ROUTE ADDRESS IS SHOWN.)

2308 Cantebury Drive, Westbury,NY 11590

STATE DEVELOPING HIGHEST PAYROLL:

EXPLAIN ALL "YES" RESPONSES IN THE REMARKS SECTION	YES	NO
1. HAS THERE BEEN PREVIOUS WORKERS COMPENSATION COVERAGE:		
IN THIS STATE?	☒	☐
IN ANY OTHER STATE?	☐	☒
- IF NO TO BOTH QUESTIONS, WAS THIS DUE TO: ☒ NEW BUSINESS ☐ SELF INSURED-INDEP ☒ SELF INSURED-GROUP ☐ # EMPLOYEES		
2. IS THERE ANY UNPAID WORKERS COMPENSATION PREMIUM DUE OR IN DISPUTE FROM YOU OR ANY COMMONLY MANAGED OR OWNED ENTERPRISES? IF YES, EXPLAIN, INCLUDING ENTITY NAME(S) AND POLICY NUMBER(S). NA	☐	☒
3. YEAR APPLICANT'S BUSINESS BEGAN: NA		
4. HAS THERE BEEN A NAME CHANGE, CONSOLIDATION, MERGER, ACQUISITION, SALE, PURCHASE OR TRANSFER OF ASSETS OR OWNERSHIP CHANGE DURING THE PAST FIVE (5) YEARS? IF YES, PROVIDE A COMPLETED ERM-14 FORM.	☐	☒
5. IS APPLICANT RELATED THROUGH COMMON MANAGEMENT OR OWNERSHIP TO ANY ENTITY NOT LISTED ON THE ACORD 130 FORM, WHETHER COVERAGE IS REQUIRED OR NOT? IF YES, PROVIDE A COMPLETED ERM-14 FORM.	☐	☒
6. DO YOU LEASE WORKERS FROM A PROFESSIONAL EMPLOYER ORGANIZATION (PEO)? IF YES, REFER TO WCIP INSTRUCTIONS. NAME OF PROFESSIONAL EMPLOYER ORGANIZATION (PEO):	☐	☒
7. DO YOU LEASE WORKERS TO A CLIENT COMPANY? IF YES, REFER TO WCIP INSTRUCTIONS.	☒	☒
8. ARE YOU SEEKING TO COVER THE LEASED WORKERS? IF YES, REFER TO WCIP INSTRUCTIONS.	☒	☐
9. DO YOU PROVIDE TEMPORARY ARRANGEMENT SERVICES TO OTHER EMPLOYERS? IF YES, PROVIDE A TEMPORARY LABOR CONTRACTOR EMPLOYEE FORM.	☒	☐
10. DO YOU HAVE A FRANCHISE OR LICENSING AGREEMENT? IF YES, PROVIDE A COPY OF THE AGREEMENT.	☒	☐
11. IS COVERAGE REQUESTED FOR A SPORTS TEAM? IF YES, PROVIDE NAME OF SPORTS TEAM AND DOMICILED STATE. NAME OF SPORTS TEAM: NA DOMICILED STATE: NA	☐	☒
12. DO TRUCKING CLASSIFICATIONS APPLY? IF YES, COMPLETE QUESTIONS 13 - 20.	☐	☒
13. DO YOU OR YOUR EMPLOYEES REGULARLY OPERATE FROM A BASE TERMINAL(S) WHICH IS (ARE) USED TO LOAD, UNLOAD, STORE OR TRANSFER FREIGHT? IF YES, PLEASE PROVIDE A LIST OF TERMINAL ADDRESSES:	☒	☒

#	STREET	CITY	COUNTY	ST	ZIP CODE
1	3 TIMES SQUARE	New York	New York		10119
2	160 MONTAGUE STREET	Brookyln	Kings		11201
3					

14. CAN EACH DRIVER'S STATE OF MAJORITY DRIVING TIME BE ESTABLISHED THROUGH VERIFIABLE RECORDS OR LOGS?	☐	☐

15. PLEASE PROVIDE A LIST OF ALL DRIVERS / HELPERS AND THEIR STATE OF RESIDENCE:

	DRIVER NAME	TERMINAL # (SEE ABOVE)	MAJORITY DRIVING STATE	RESIDENCE STATE
1		1		
2				
3				

16. WHAT TYPE(S) OF GOODS ARE BEING HAULED? (e.g., coal, dry goods, explosives, scaffolding, water / waste fluids from oil field sites, etc.)		
17. DO YOU OWN THESE GOODS?	☐	☐
18. IS APPLICANT UNDER EXCLUSIVE CONTRACT WITH ANY RETAIL STORE(S)? IF YES, PROVIDE COPY OF CONTRACT(S).	☐	☐
19. IS APPLICANT UNDER EXCLUSIVE CONTRACT WITH ANY POSTAL SERVICE? IF YES, PROVIDE COPY OF CONTRACT(S).	☐	☐
20. WITHIN WHAT MILE RADIUS IS HAULING DONE? # MILES:		

AGENCY CUSTOMER ID: AG123

INSURANCE COMPANIES WHO HAVE OFFERED/REFUSED INSURANCE	YES	NO
21. HAVE YOU RECEIVED ANY OFFERS OF VOLUNTARY COVERAGE? (INCLUDE MULTI-LINE OR RETROSPECTIVE RATING PLAN, IF APPLICABLE) IF YES, PROVIDE FULL DETAILS INCLUDING PLAN TERMS.	☐	☐

22. INDICATE THE NUMBER OF INSURANCE COMPANIES WHICH HAVE REFUSED THE APPLICANT COVERAGE IN THE LAST 60 DAYS (OR IN ACCORDANCE WITH STATE SPECIFIC GUIDELINES): ☐

LIST COMPANY NAMES, REPRESENTATIVE NAMES, TELEPHONE NUMBERS AND DATES OF REFUSALS. REFER TO WCIP TO VERIFY REQUIREMENTS.

COMPANY NAME	REPRESENTATIVE NAME	TELEPHONE NUMBER	DATE OF REFUSAL	COMMENTS

PREMIUM PAYMENT (Refer to WCIP instruction sheet for state requirements)	YES	NO
23. IS THE PREMIUM FINANCED THROUGH A THIRD PARTY PREMIUM FINANCE COMPANY? IF YES, A COPY OF THE AGREEMENT MUST BE PROVIDED.	☐	☐
24. IN APPLICABLE JURISDICTIONS ON QUALIFYING RISKS, IS THE LOSS SENSITIVE RATING PROGRAM (LSRP) CONTINGENCY DEPOSIT BEING PAID IN FULL AT THIS TIME?	☐	☐

25. INITIAL OR ESTIMATED ANNUAL DEPOSIT PREMIUM IS REQUIRED IN ORDER TO BIND COVERAGE. THE FOLLOWING PAYMENT METHODS MAY BE USED TO SUBMIT THE REQUIRED INITIAL OR DEPOSIT PREMIUM:

1. Credit Card **(for applications submitted ONLINE at ncci.com ONLY)**
2. Electronic funds transfer (EFT) in the form of an Automated Clearing House (ACH) transaction

Note: For 1 and 2 above, refer to instructions provided within NCCI's ***RMAPS® Online Application Service*** payment screens. All payments by credit card and electronic funds transfer must accompany completed and signed ACORD 130 and 133 forms.

3. Check or Money Order **(for MAILED applications ONLY)**
    1. **ONLY** the following types of payment, made payable to NCCI, Inc., are acceptable:
        a. Checks: Applicant's, Cashier's, Producer's, Finance Company's
        b. Money Order
    2. All checks and money orders **MUST** be made payable to NCCI, Inc., and accompany completed and signed ACORD 130 and 133 forms.

NO CREDIT CARD OR BANKING INFORMATION SHOULD BE ENTERED ON THE HARDCOPY ACORD 130 or 133 FORMS. A DELAY IN PROCESSING YOUR APPLICATION MAY OCCUR SHOULD THIS INFORMATION BE INCLUDED ON THE SUBMITTED FORMS.

By submitting this assigned risk workers compensation insurance application, the Applicant authorizes NCCI to debit the account name/number that the undersigned Applicant, or the undersigned Producer on Applicant's behalf, has designated and provided to NCCI, for the amount of this transaction. The Applicant further understands and agrees that all premium transactions and/or premium-related transactions must be processed and accepted by NCCI and the account name/number that the undersigned Applicant, or the undersigned Producer on Applicant's behalf, has designated and provided to NCCI, to be considered received by the Plan Administrator.

REMARKS (Attach additional sheets if more space is required)

AGENCY CUSTOMER ID: AG123

APPLICANT'S STATEMENT

The undersigned Applicant hereby certifies that he/she has read and understands the questions and statements in this application, which is comprised of both the ACORD 130 and ACORD 133 forms. In consideration of coverage being afforded under the applicable Workers Compensation Insurance Plan developed or administered by NCCI (WCIP or Plan), by signing below, the Applicant also certifies that any and/or all responses provided in or to this application, which is comprised of both the ACORD 130 and ACORD 133 forms, are true and accurate and Applicant further understands and agrees that:

- Since he/she has been unable to secure workers compensation coverage in a regular manner through any other insurance carrier or provider, this coverage is being afforded under the applicable WCIP, and that the applicable rates and rating programs charged may be higher than those in the voluntary market.
- Coverage is NOT bound until the completed and signed application is received with the required initial or estimated annual deposit premium and eligibility is determined by the Plan Administrator.
- Provided that Applicant is determined to be eligible and in good faith entitled to WCIP insurance, based upon the information provided herein or otherwise available to the Plan Administrator, coverage will be bound in accordance with WCIP rules. See the WCIP for applicable binding rules.
- In approved jurisdictions, NCCI's Voluntary Coverage Assistance Program ***(VCAP® Service)*** applies to all employers seeking coverage under the Workers Compensation Insurance Plan, and:
  - Is integrated with and operates as a supplemental program to NCCI's WCIP; and
  - Operates in conjunction with NCCI's Residual Market Application Processing System ***(RMAPS® Online Application Service)***; and
  - Is designed as a depopulation tool to provide an additional source for producers and employers to secure workers compensation coverage in the voluntary market; and
  - All applications (electronic, phone-in, or mail-in) submitted to the Plan Administrator are reviewed to determine if they meet any of the preselected criteria specified by a participating voluntary carrier; and
  - If the Applicant meets the criteria of an authorized voluntary carrier ***(VCAP® User)*** and an offer of voluntary coverage is provided, the Applicant, its representative, and/or the producer, must accept a reasonable offer of voluntary coverage in accordance with the WCIP and ***VCAP® Service*** provisions, and further Applicant will be deemed ineligible for coverage under the WCIP if Applicant does not accept such reasonable offer of voluntary coverage; and
  - If an application does not meet any ***VCAP® User's*** criteria, the application will continue through NCCI's ***RMAPS® Online Application Service.***

If deemed eligible under the WCIP and as further consideration of policy issuance under the WCIP, by signing below, the undersigned Applicant also agrees:

- To maintain a complete record of all payroll transactions in such form as the insurance company may reasonably require and that such record will be available to the company at the designated address; and
- To comply substantially with all laws, orders, rules, and regulations in force and effect issued by the public authorities relating to the welfare, health, and safety of employees; and
- To comply with all reasonable recommendations made by the insurance company relating to the welfare, health, and safety of employees; and
- To take no action in any form to evade the application of an experience rating modification determined in accordance with the applicable experience rating rules, as determined by NCCI, Inc.; and
- To comply with all WCIP rules and procedures and policy terms and conditions, including without limitation, those relating to audits, inspections, loss prevention, and/or premium payments, to maintain WCIP eligibility and coverage.

OUTSTANDING BONA FIDE DISPUTE

The undersigned Applicant also certifies that he/she has no outstanding bona fide dispute as provided in NCCI's WCIP with any producer or company in regard to: (a) payroll records; (b) the amount of premium charged; (c) the payment of premium; (d) the carrying out of any recommendation made for the purpose of safeguarding employees; (e) the handling of any claim or accident report except the following:

LOSS SENSITIVE RATING PLAN (LSRP)

In applicable jurisdictions where the NCCI's Loss Sensitive Rating Plan (LSRP) has been approved for use, the undersigned applicant further understands and agrees that by signing below, I (applicant) acknowledge that the Loss Sensitive Rating Plan (LSRP) has been explained to me, and I agree to be bound by the terms of such plan if my standard premium meets or exceeds the premium eligibility requirement. If these conditions are met, an additional LSRP contingency deposit equal to 20% of standard premium will be required; and

- At the time of application, LSRP has been explained to applicant by the Producer submitting this application on behalf of the applicant; and
- The above referenced additional LSRP contingency deposit is in addition to the initial or deposit premium required in accordance with the WCIP.

APPLICANT COMMUNICATIONS

1. By selecting the 'Yes' option adjacent to this #1 section, the undersigned Applicant consents and agrees to receive electronically transmitted information and/or communications issued by NCCI by means of electronic mail (email) messages that may contain electronic documents, including without limitation, any binder/verification pages issued by NCCI, and any notifications or other communications as determined by NCCI, to the email address provided by Applicant, or provided by the Producer on Applicant's behalf, to NCCI. ☐ YES ☐ NO
2. If "Yes" to #1 above, provide the valid email address to which the information, notifications and/or communications issued by NCCI should be electronically sent: ecv@gmail.com
3. By selecting the 'Yes' option adjacent to this #3 section, the undersigned Applicant consents and agrees to receive electronically transmitted policy notifications and/or communications issued by the assigned carrier by means of electronic mail (email) messages that may contain electronic documents, including without limitation, any policy documents, cancellations, endorsements, renewal and/or nonrenewal notices, and any other policy notifications and/or communications as determined by the assigned carrier, but only to the extent that the assigned carrier is able and chooses in its discretion to transmit such policy notifications and/or communications electronically to the Applicant. If the assigned carrier is unable or does not choose to transmit such policy notifications and/or communications electronically, then hard copy policy notifications and/or communications will be provided to the Applicant by the assigned carrier as determined by the assigned carrier, subject to any requirements applicable to the assigned carrier under any applicable laws or regulations. Regardless of the undersigned Applicant's selection under this #3 section to receive electronically transmitted policy notifications and/or communications from the assigned carrier, the assigned carrier must comply with any applicable laws or regulations that require a specific method of delivery for policy notifications, documents, or other information, including without limitation, mailing notices of cancellation and/or nonrenewal of policies by certified mail or certificate of mailing. ☐ YES ☐ NO

AGENCY CUSTOMER ID: AG123

APPLICANT'S STATEMENT (continued)

4. If "Yes" to #3 above, provide the valid email address to which policy notifications and/or communications issued by the assigned carrier should be electronically sent: _____

The undersigned Applicant understands and agrees that by selecting the 'Yes' option for #1 and/or #3 above, NCCI and the assigned carrier are authorized, but neither NCCI nor the assigned carrier separately is required or obligated, to electronically transmit any notifications and/or communications referenced in #1 and/or #3 above to the designated email address provided by or on behalf of the Applicant in #2 and/or #4 above, as applicable. By consenting and agreeing to receive such electronically transmitted notifications and/or communications from NCCI and/or the assigned carrier, the undersigned Applicant releases, indemnifies, and holds harmless NCCI and the assigned carrier from any and all claims pertaining to electronically transmitted notifications and/or communications utilizing the Applicant's designated email address as provided to NCCI and/or the assigned carrier by or on behalf of the Applicant in #2 and/or #4 above, as applicable, and including, without limitation, any changes and/or updates to the undersigned Applicant's email address.

The undersigned Applicant further understands and agrees that he/she shall notify NCCI and the assigned carrier of any and all changes and/or updates to Applicant's email, mailing, and/or physical addresses, immediately upon making, implementing, or having knowledge of any such changes and/or updates.

NON-COMPLIANCE WITH AGREEMENTS OR CERTIFICATIONS

The undersigned Applicant further understands and agrees that violation of or non-compliance with any of the above agreements or certifications may result in cancellation of a policy of insurance issued under a Workers Compensation Insurance Plan and/or ineligibility for coverage under a Workers Compensation Insurance Plan.

APPLICANT'S NAME (PRINT OR TYPE)	
SIGNATURE (MUST BE AN OFFICER, OWNER OR PARTNER)	**DATE (MM/DD/YYYY)**
	08/08/2022

REMEMBER: BOTH THE ACORD 130 AND 133 APPLICATIONS MUST BE SIGNED BY THE APPLICANT AND THE DESIGNATED PRODUCER

PRODUCER COMMUNICATIONS

1. By selecting the 'Yes' option adjacent to this #1 section, the undersigned Producer consents and agrees to receive electronically transmitted information and/or communications issued by NCCI by means of electronic mail (email) messages that may contain electronic documents, including without limitation, any binder/verification pages issued by NCCI, and any notifications or other communications as determined by NCCI, to the email address provided by the Producer to NCCI. ☐ YES ☐ NO

2. If "Yes" to #1 above, provide the valid email address to which the information, notifications and/or communications issued by NCCI should be electronically sent:
   ecv@gmail.com

3. By selecting the 'Yes' option adjacent to this #3 section, the undersigned Producer consents and agrees to receive electronically transmitted policy notifications and/or communications issued by the assigned carrier by means of electronic mail (email) messages that may contain electronic documents, including without limitation, any policy documents, cancellations, endorsements, renewal and/or nonrenewal notices, and any other policy notifications and/or communications as determined by the assigned carrier, but only to the extent that the assigned carrier is able and chooses in its discretion to transmit such policy notifications and/or communications electronically. If the assigned carrier is unable or does not choose to transmit such policy notifications and/or communications electronically, then hard copy policy notifications and/or communications will be provided to the Producer by the assigned carrier as determined by the assigned carrier, subject to any requirements applicable to the assigned carrier under any applicable laws or regulations. Regardless of the undersigned Producer's selection under this #3 section to receive electronically transmitted policy notifications and/or communications from the assigned carrier, the assigned carrier must comply with any applicable laws or regulations that require a specific method of delivery for policy notifications, documents, or other information, including without limitation, mailing notices of cancellation and/or nonrenewal of policies by certified mail or certificate of mailing. ☐ YES ☐ NO

4. If "Yes" to #3 above, provide the valid email address to which policy notifications and/or communications issued by the assigned carrier should be electronically sent: _____

The undersigned Producer understands and agrees that by selecting the 'Yes' option for #1 and/or #3 above, NCCI and the assigned carrier are authorized, but neither NCCI nor the assigned carrier separately is required or obligated, to electronically transmit any notifications and/or communications referenced in #1 and/or #3 above to the designated email address provided by the Producer in #2 and/or #4 above, as applicable. By consenting and agreeing to receive such electronically transmitted notifications and/or communications from NCCI and/or the assigned carrier, the undersigned Producer releases, indemnifies, and holds harmless NCCI and the assigned carrier from any and all claims pertaining to electronically transmitted notifications and/or communications utilizing the Producer's designated email address as provided to NCCI and/or the assigned carrier by the Producer in #2 and/or #4 above, as applicable, and including, without limitation, any changes and/or updates to the undersigned Producer's email address.

The undersigned Producer further understands and agrees that he/she shall notify NCCI and the assigned carrier of any and all changes and/or updates to Producer's email, mailing, and/or physical addresses, immediately upon making, implementing, or having knowledge of any such changes and/or updates.

PRODUCER'S CERTIFICATION

THE PRODUCER ALSO CERTIFIES THAT HE/SHE HAS BEEN AUTHORIZED TO SUBMIT THE APPLICATION ON BEHALF OF THE APPLICANT AND THAT ALL INFORMATION PROVIDED ON THE ACORD 130 AND 133 IS TRUE AND ACCURATE TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF.

AGENCY FEIN	AGENCY LICENSE NUMBER	AGENCY PHONE NUMBER (A/C,No, Ext)	AGENCY FAX NUMBER (A/C,No)
		516-642-1028	+44 161 999 8888

PRODUCER RESIDENT LICENSE NUMBER	STATE	EXPIRATION DATE	PRODUCER NON-RESIDENT LICENSE NUMBER	STATE	EXPIRATION DATE

PRODUCER NAME (PRINT OR TYPE):	PRODUCER SIGNATURE	DATE (MM/DD/YYYY)
E-MAIL ADDRESS:		

REMEMBER: BOTH THE ACORD 130 AND 133 APPLICATIONS MUST BE SIGNED BY THE APPLICANT AND THE DESIGNATED PRODUCER