WORKERS COMPENSATION APPLICATION

AGENCY NAME AND ADDRESS:		**PRODUCER NAME:**	
CS REPRESENTATIVE Name:		**OFFICE PHONE (A/C, No, Ext):**	
MOBILE PHONE:		**FAX (A/C, No):**	**232432**
E-Mail Address:		**CODE:**	
SUB CODE:		**COMPANY:**	**Glocify Technology**
UNDERWRITER:		**APPLICANT NAME:**	**Testing New Prospect Testing New Prospect**
OFFICE PHONE:		**MOBILE PHONE:**	**231231221213**
MAILING ADDRESS (including ZIP + 4 or Canadian Postal Code):		**YRS IN BUS:**	**23432332**
SIC:		**NAICS:**	
Website Address:		**EMAIL ADDRESS:**	**sdafdsdsafdsds@gmail.com**
CREDIT BUREAU NAME:		**ID NUMBER:**	
FEDERAL EMPLOYER ID NUMBER:		**NCCI RISK ID NUMBER:**	
FEDERAL EMPLOYER ID NUMBER:		**OTHER RATING BUREAU ID OR STATE EMPLOYER REGISTRATION NUMBER:**	
BILLING PLAN:		**PAYMENT PLAN:**	
AUDIT:		**PROPOSED EFF DATE:**	
PROPOSED EXP DATE:		**NORMAL ANNIVERSARY RATING DATE:**	
PARTICIPATING:	**NON-PARTICIPATING**	**RETRO PLAN:**	
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:**	
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:**	
DISEASE-POLICY LIMIT:		**DISEASE-EACH EMPLOYEE:**	
DIVIDEND PLAN/SAFETY GROUP:		**ADDITIONAL COMPANY INFORMATION:**	
SPECIFY ADDITIONAL COVERAGES / ENDORSEMENTS (Attach ACORD 101, Additional Remarks Schedule, if more space is required):			

TOTAL ESTIMATED ANNUAL PREMIUM - ALL STATES

TOTAL ESTIMATED ANNUAL PREMIUM ALL STATES	TOTAL MINIMUM PREMIUM ALL STATES	TOTAL DEPOSIT PREMIUM ALL STATES

CONTACT INFORMATION

TYPE	NAME	OFFICE PHONE	MOBILE PHONE	E-MAIL
INSPECTION				
ACCTNG				
RECORD				
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-STATE LOC # SHIP %	DUTIES	INC/EXC	CLASS CODE	REMUNERATION/PAYROLL

RATING INFORMATION - STATE:

LOC #	CLASS CODE	DESCR CODE	CATEGORIES, DUTIES, CLASSIFICATIONS	# Full EMPLOYEES	# Part EMPLOYEES	SIC	NAICS	ESTIMATED ANNUAL REMUNERATION/ PAYROLL	RATE	ESTIMATED ANNUAL MANUAL PREMIUM

PREMIUM

STATE:	FACTOR	FACTORED PREMIUM		FACTOR	FACTORED PREMIUM
TOTAL	N / A				
INCREASED LIMITS			SCHEDULE RATING *		
DEDUCTIBLE *			CCPAP		
			STANDARD PREMIUM		
EXPERIENCE OR MERIT			PREMIUM DISCOUNT		
			EXPENSE CONSTANT	N / A	
ASSIGNED RISK SURCHARGE *			TAXES / ASSESSMENTS *	N / A	
ARAP *					
* N / A in Wisconsin					
TOTAL ESTIMATED ANNUAL PREMIUM		**MINIMUM PREMIUM**		**DEPOSIT PREMIUM**	

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

PRIOR CARRIER INFORMATION / LOSS HISTORY

AGENCY CUSTOMER ID:

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

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	Y / N
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT / WATERCRAFT?	no
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)	no
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?	no
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?	no
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?	no
6. ARE SUB-CONTRACTORS USED? (If "YES", give % of work subcontracted)	no
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)	no
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?	no
9. ANY GROUP TRANSPORTATION PROVIDED?	no
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?	no
11. ANY SEASONAL EMPLOYEES?	no
12. IS THERE ANY VOLUNTEER OR DONATED LABOR? (If "YES", please specify)	no
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?	no
14. DO EMPLOYEES TRAVEL OUT OF STATE? (If "YES", indicate state(s) of travel and frequency)	no
15. ARE ATHLETIC TEAMS SPONSORED?	no
16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?	no
17. ANY OTHER INSURANCE WITH THIS INSURER?	no
18. ANY PRIOR COVERAGE DECLINED / CANCELLED / NON-RENEWED IN THE LAST THREE (3) YEARS? (Missouri Applicants - Do not answer this question)	no
19. ARE EMPLOYEE HEALTH PLANS PROVIDED?	no
20. DO ANY EMPLOYEES PERFORM WORK FOR OTHER BUSINESSES OR SUBSIDIARIES?	no
21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?	no
22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME? If "YES", # of Employees:	no
23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST FIVE (5) YEARS? (If "YES", please specify)	no
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).	no