Fax-A-Quote

Type of Proposal Requested:

☐ *Occupational Accident only*
☐ *Occupational Accident w/Legal*

Fax-A-Quote (Rev. 10/03)

Please fax this completed form, your inforce insurance license, and Errors & Omissions dec page to: at **713-977-9333** For assistance, please call 713-977-9300 or (800) 833-8478.

Applicant Name _____ Requested Effective Date _____

Address _____ Nature of Business _____

Number of years in business: _____ Tax ID# _____ Date of workers' comp coverage rejection: _____

Has worker's 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 24 ft.? ❒ Yes ❒ No. If Yes, please explain: _____

# of Full-Time EES	# of Full-Time 1099	# of Part-Time EES	# of Part-Time 1099	Classification Code	Annual Payroll by Class	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

Benefits to be Quoted: ***LIMITS VARY BY PRODUCT. PLEASE CALL FOR OTHER OPTIONS.***

CSL Benefit: _____ *($100,000 - $1,000,000 CSL available)*

Deductible: _____ *($1,000 - $500,000 deductible available)*

Waiting Period: _____ days

Benefit Period: _____ Weekly Income Limit: _____ (75% up to $600 standard to most policies)

Please submit 3 years currently valued loss history below: Valuation Date of loss information: _____

Year	Carrier	Total Losses	Description of Each Loss in Excess of $5,000 (Use separate sheet if necessary)

1.	If this applicant (or affiliate) is currently in the Texas Workers' Compensation System, do they have an experience modification factor of 200% or more?	❒ Yes ❒ No
2.	Has the applicant (or affiliate) ever had an Employer's Liability claim?	❒ Yes ❒ No
3.	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

If the answer to #2 or #3 is YES, please give a complete descriptions, dates, and amounts of claims on a separate sheet.

Agent and Applicant hereby acknowledge that: (a) all answers and statements contained herein, including any attached data, are true and complete; (b) 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 (c) this Fax-A-Quote shall become a part of the Policy should coverage be bound.

Agent: _____ **Phone:** _____

Address: _____ **Fax:** _____

Agent Signature: X_____ **Applicant Signature: X**_____