Please submit completed form, along with the supplemental application (if required)
to submissions@cidinsurance.com or fax to (619) 593-2008.

ACORD®

WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY)

AGENCY NAME AND ADDRESS	COMPANY:
	UNDERWRITER:
	APPLICANT NAME:
	OFFICE PHONE: / MOBILE PHONE:
	MAILING ADDRESS (including ZIP + 4 or Canadian Postal Code) / YRS IN BUS:
	SIC:
PRODUCER NAME:	NAICS:
CS REPRESENTATIVE NAME:	WEBSITE ADDRESS:
OFFICE PHONE (A/C, No, Ext):	E-MAIL ADDRESS:
MOBILE PHONE:	☐ SOLE PROPRIETOR ☐ CORPORATION ☐ LLC ☐ TRUST ☐ UNINCORPORATED ASSOCIATION
FAX (A/C, No):	☐ PARTNERSHIP ☐ SUBCHAPTER "S" CORP ☐ JOINT VENTURE ☐ OTHER:
E-MAIL ADDRESS:	CREDIT BUREAU NAME: / ID NUMBER:
CODE: SUB CODE:	FEDERAL EMPLOYER ID NUMBER / NCCI RISK ID NUMBER / OTHER RATING BUREAU ID OR STATE EMPLOYER REGISTRATION NUMBER
AGENCY CUSTOMER ID:	

STATUS OF SUBMISSION

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

BILLING / AUDIT INFORMATION

BILLING PLAN	PAYMENT PLAN	AUDIT
☐ AGENCY BILL	☐ ANNUAL ☐	☐ AT EXPIRATION ☐ MONTHLY
☐ DIRECT BILL	☐ SEMI-ANNUAL	☐ SEMI-ANNUAL ☐
	☐ QUARTERLY % DOWN:	☐ QUARTERLY

LOCATIONS

LOC #	HIGHEST FLOOR	STREET, CITY, COUNTY, STATE, ZIP CODE

POLICY INFORMATION

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
	$ EACH ACCIDENT		☐ MEDICAL		☐ U.S.L. & H. ☐ MANAGED CARE OPTION
	$ DISEASE-POLICY LIMIT		☐ INDEMNITY		☐ VOLUNTARY COMP ☐
	$ DISEASE-EACH EMPLOYEE		☐		☐ FOREIGN COV ☐

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-SHIP %	DUTIES	INC/EXC	CLASS CODE	REMUNERATION/PAYROLL

STATE RATING SHEET # ____ OF ____ SHEETS AGENCY CUSTOMER ID: _____

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

PREMIUM

STATE:	FACTOR	FACTORED PREMIUM		FACTOR	FACTORED PREMIUM
TOTAL	N / A	$			$
INCREASED LIMITS		$	SCHEDULE RATING *		$
DEDUCTIBLE *		$	CCPAP		$
		$	STANDARD PREMIUM		$
EXPERIENCE OR MERIT MODIFICATION		$	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)

AGENCY CUSTOMER ID: _____

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	Y / N
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT / WATERCRAFT?	
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)	
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?	
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?	
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?	
6. ARE SUB-CONTRACTORS USED? (If "YES", give % of work subcontracted)	
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)	
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?	
9. ANY GROUP TRANSPORTATION PROVIDED?	
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?	
11. ANY SEASONAL EMPLOYEES?	
12. IS THERE ANY VOLUNTEER OR DONATED LABOR? (If "YES", please specify)	
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?	
14. DO EMPLOYEES TRAVEL OUT OF STATE? (If "YES", indicate state(s) of travel and frequency)	
15. ARE ATHLETIC TEAMS SPONSORED?	

AGENCY CUSTOMER ID: _____

GENERAL INFORMATION (continued)

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

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): _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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 that person to criminal and civil penalties (In Oregon, the aforementioned actions may constitute a fraudulent insurance act which may be a crime and may subject the person to penalties). (In New York, the civil penalty is not to exceed five thousand dollars ($5,000) and the stated value of the claim for each such violation). **(Not applicable in AL, AR, AZ, CO, DC, FL, KS, LA, ME, MD, MN, NM, OK, PR, RI, TN, VA, VT, WA and WV).**

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

Applicable in Colorado: 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 Florida and Oklahoma: 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 (In FL, a person is guilty of a felony of the third degree).

Applicable in Kansas: 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 Maine, Tennessee, Virginia and Washington: 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 or a denial of insurance benefits.

Applicable in Puerto Rico: 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 Utah: 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

Please submit completed applications to submissions@cidinsurance.com or fax to (619) 593-2008

CID Insurance Programs Inc. DBA CID Insurance Services

Payroll Workers' Compensation Supplemental Questionnaire – Property Management

Insured Information:

Named Insured:_____ Effective Date:_____

FEIN# _____ Agency/Broker Firm:_____

Phone # _____ Fax # _____ Email:_____

Employee Benefits:

A. Medical Insurance: Carrier:_____

☐ Employer pays 80% or more of all employees ☐ Employer pays 50% or more of all employees

☐ Employer pays 49% or less of all employees ☐ Benefits provided only to Management and Supervisors

☐ No medical benefits provided

B. Employer Paid Vacation? ☐ Yes ☐ No C. Employer paid sick leave ☐ Yes ☐ No

Employee Management:

A. Pre-hire Screening: ☐ Yes ☐ No B. Pre-Employment drug testing: ☐ Yes ☐ No

Application ☐ Yes ☐ No C. Post Accident drug testing: ☐ Yes ☐ No

Employee Management:

A. Union ☐ Yes ☐ No

B. Number of W-2's filed for last reporting period: _____ Starting wage/hr: $_____ Average wage/hr: $_____

# of permanent employees: _____ # of Full Time: _____ # of Part Time: _____

# of temporary or seasonal employees: _____ Average # of years with company:_____

# of employees per class:

Classification Code: 8810 #P/T _____ #F/T_____ Annual Payroll $ _____

Classification Code: 8740 #P/T _____ #F/T_____ Annual Payroll $ _____

Classification Code: 9011 #P/T _____ #F/T_____ Annual Payroll $ _____

Classification Code: 9015 #P/T _____ #F/T_____ Annual Payroll $ _____

C. Interchange of labor? (If yes, existence of physical separations?) ☐ Yes ☐ No

D. Percent of payroll for "off premises" operations: _____%

E. Number of company autos: _____ Number of Drivers: _____ MVR's Checked: ☐ Yes ☐ No If yes, how often? _____

F. Number of company trucks: _____ Number of Drivers: _____ Radius of operations: _____

G. Do Employees drive their personal autos on Company Business: ☐ Yes ☐ No K. Early return to work program: ☐ Yes ☐ No

H. Are employees allowed to use motorcycles on company business: ☐ Yes ☐ No L. Is the risk a restaurant: ☐ Yes ☐ No

I. Hours of Operation: _____ M. Do they operate a micro-brewery: ☐ Yes ☐ No

J. Any weekend, night shifts or graveyard shifts? ☐ Yes ☐ No

Employee Safety Program:

A. New employee orientation program: ☐ Yes ☐ No H. Documented physical inspection of premises: ☐ Yes ☐ No

B. Formal written safety program: ☐ Yes ☐ No I. Maximum weight lifted manually: _____Lbs.

C. Documented safety meetings w/ all employees: ☐ Yes ☐ No J. Machine safety guard in place: ☐ Yes ☐ No

D. Safety incentive plan: ☐ Yes ☐ No K. Lockout/Tag-out program in place: ☐ Yes ☐ No

E. Written supervisor accountability plan: ☐ Yes ☐ No L. Personal protective equipment provided: ☐ Yes ☐ No

F. Full time safety director/risk manager: ☐ Yes ☐ No M. Documented accident investigation: ☐ Yes ☐ No

G. Employee training program for all employees: ☐ Yes ☐ No Formal disciplinary procedure in place: ☐ Yes ☐ No

Employee Payroll Trends:
A. Future staff increases: ☐ Yes ☐ No Future staff decreases: ☐ Yes ☐ No
B. Future layoffs foreseen: ☐ Yes ☐ No

Management:

A. Owners: Active: ☐ Yes ☐ No Absentee Management: ☐ Yes ☐ No Trade Associations: _____
B. Group transportation provided: ☐ Yes ☐ No
C. Ration of supervisors to employees: _____:_____ Average # of years experience: _____ Number of years w/ company: _____

Claims: Please forward the following years loss information to us. Valuation date should be within 90-days of the policy inception date.

☐ 2013-2014, Carrier: _____ Payroll: $_____ Premium: $_____
☐ 2012-2013, Carrier: _____ Payroll: $_____ Premium: $_____
☐ 2011-2012, Carrier: _____ Payroll: $_____ Premium: $_____
☐ 2010-2011, Carrier: _____ Payroll: $_____ Premium: $_____

For all claims over $25,000, please advise of the following: What the injury?, How did it occur?, What corrective action as the insured taken to prevent recurrence?
_____
_____
_____

Type of Property Management:

Apartments ☐ Yes ☐ No Community Association: ☐ Yes ☐ No RV Park: ☐ Yes ☐ No
Single Family Homes ☐ Yes ☐ No Commercial ☐ Yes ☐ No 55+ Communities: ☐ Yes ☐ No
Other:_____ ☐ Yes ☐ No

A. Is housing provided? ☐ Yes ☐ No
B. Are employees involved in property maintenance? ☐ Yes ☐ No
C. Security Guards employed? ☐ Yes ☐ No

Completed By:_____, **Title:** _____ **Date:**_____

Please submit completed applications to submissions@cidinsurance.com
Attn: Caesar Serrano
or fax to (619) 593-2008
Any questions, please call (619) 593-2008