# WORKERS COMPENSATION INSURANCE PLAN
## ASSIGNED RISK SECTION

DATE (MM/DD/YYYY)

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**

## 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.)**

**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-GROUP | | |
| ☐ SELF INSURED-INDEP ☐ # 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). | | |
| 3. YEAR APPLICANT'S BUSINESS BEGAN: | | |

| EXPLAIN ALL "YES" RESPONSES IN THE REMARKS SECTION | YES | NO |
|---|---|---|
| 4. HAS THERE BEEN A NAME CHANGE, CONSOLIDATION, MERGER OR OWNERSHIP CHANGE DURING THE PAST FIVE YEARS? IF YES, GIVE PREVIOUS NAME AND DATE OF CHANGE. CONTACT THE PLAN ADMINISTRATOR ABOUT AN ERM-14. | | |
| 5. IS APPLICANT RELATED THROUGH COMMON MANAGEMENT OR OWNERSHIP TO ANY ENTITY NOT LISTED HERE, WHETHER COVERAGE IS REQUIRED OR NOT? IF YES, GIVE DETAILED EXPLANATION. | | |
| 6. DO YOU LEASE WORKERS FROM A LABOR CONTRACTOR? IF YES, REFER TO WCIP INSTRUCTIONS. | | |
| 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 LABOR SERVICES TO OTHER EMPLOYERS? | | |
| 10. DO YOU HAVE A FRANCHISE OR LICENSING AGREEMENT? IF YES, PROVIDE DETAILS OF THE AGREEMENT. | | |
| 11. DO TRUCKING CLASSIFICATIONS APPLY? IF YES, COMPLETE QUESTIONS 12-14. | | |

12. 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 | | | | | |
| 2 | | | | | |
| 3 | | | | | |

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

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

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

## INSURANCE COMPANIES WHO HAVE OFFERED/REFUSED INSURANCE

| | YES | NO |
|---|---|---|
| 1. 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 IN THE REMARKS SECTION. | | |

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

IN ACCORDANCE WITH PLAN RULES, THE APPLICANT OR ITS REPRESENTATIVE SHALL MAINTAIN ON RECORD FOR THIS POLICY PERIOD THE CARRIER NAME, CONTACT PERSON, ADDRESS, PHONE NUMBER AND DATE OF CONTACT OF THOSE CARRIERS REFUSING COVERAGE AND MAKE SUCH INFORMATION AVAILABLE TO THE PLAN ADMINISTRATOR OR ASSIGNED RISK CARRIER UPON REQUEST.

## REMARKS

## PREMIUM PAYMENT (Refer to WCIP instruction sheet for state requirements)

PAYMENT METHOD - SELECT ONE:

IS THE PREMIUM FINANCED? ☐ YES ☐ NO

☐ 1. ELECTRONIC FUNDS TRANSFER

**BANK/ABA #** | **ACCOUNT #** | **PREMIUM PAYMENT AMOUNT** $ .00

☐ 2. MAIL-IN CHECK

**CHECK #** | **PREMIUM PAYMENT AMOUNT** $ .00

**For submission method 1:**

1. Does the payor require a physical record of this transaction? ☐ YES ☐ NO
2. To ensure accuracy, a voided check or deposit slip (of the payor) should be faxed to NCCI, Inc. upon return of the signed ACORD applications.
3. The undersigned Producer or Applicant certifies that by signing this application he/she authorizes NCCI, Inc. to deduct or has obtained financial information and authorization from the payor to direct NCCI, Inc. to deduct the Premium Payment Amount, and any other monies required to bind coverage, from the bank and the account number as indicated above for purposes of securing workers compensation insurance pursuant to this application.

## APPLICANT'S STATEMENT

The undersigned Applicant hereby certifies that he/she has read and understands the statements in this application. As further consideration of coverage being afforded under the WCIP, the Applicant also certifies that any and/or all responses provided in or to this application are true and accurate and further understands and agrees that:

- since he/she has been unable to secure workers compensation coverage through any other insurance carrier or provider, this coverage is being afforded through a Workers Compensation Insurance Plan (WCIP or Plan), and that the applicable rates and rating programs charged may be higher than those in the voluntary market. In addition, the following statement is only applicable in jurisdictions where the NCCI, Inc. Loss Sensitive Rating Plan has been approved for use:

  By signing below, I, the Applicant, acknowledge that the NCCI, Inc. Loss Sensitive Rating Plan has been explained to me or that an explanatory notice or brochure has been provided to me and I agree that I shall be bound by the terms of such plan if my estimated annual premium or preliminary physical audit premium meets or exceeds the premium eligibility requirement.

- coverage is NOT bound until the signed application is received with the appropriate 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 individual state WCIP's for applicable binding rules.

- a Voluntary Coverage Assistance Program (NCCI's VCAP® Service) is incorporated into and made a part of the WCIP, in approved jurisdictions, which serves as an additional mechanism to assist producers and employers in finding workers compensation coverage in the voluntary market. VCAP® Service will apply to all employers seeking coverage in the Workers Compensation Insurance Plan and will operate as a supplemental program to NCCI's Residual Market Application Processing System (RMAPS® Service). All applications (electronic, phone-in, or mail-in) submitted to the Plan Administrator will be reviewed to determine if they meet any of the preselected criteria specified by a participating voluntary carrier. If the Applicant meets the criteria of a voluntary carrier and a reasonable offer of voluntary coverage is provided, the Applicant must accept such voluntary offer and further will be deemed ineligible for coverage in the assigned risk Plan. If an application does not meet any voluntary carrier criteria, the application will continue through RMAPS® Service.

If deemed eligible under the WCIP and as further consideration of policy issuance under the WCIP, the 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.
- 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.
- To comply with all reasonable recommendations made by the insurance company relating to the welfare, health, and safety of employees.
- To take no action in any form to evade the application of an experience rating modification determined in accordance with the experience rating rules, as determined by NCCI, Inc.
- 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.

The undersigned Applicant also certifies that he/she has had no difficulties 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:

_____

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.

| APPLICANT'S NAME AND TITLE (PRINT OR TYPE) | DATE | SIGNATURE (MUST BE AN OWNER OR AN OFFICER) |
|---|---|---|
| | | |

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

## 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 ACORD 133 IS TRUE AND ACCURATE TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF.

| AGENCY FEIN | AGENCY PHONE NUMBER (A/C, No, Ext) | AGENCY FAX NUMBER (A/C, No) |
|---|---|---|
| | | |

| RESIDENT LICENSE NUMBER | EXPIRATION DATE | NON-RESIDENT LICENSE NUMBER | EXPIRATION DATE |
|---|---|---|---|
| | | | |

| PRODUCER NAME (PRINT OR TYPE) | DATE | PRODUCER SIGNATURE |
|---|---|---|
| | | |
| E-MAIL ADDRESS: | | |

## NEBRASKA SAFETY COMMITTEE DECLARATION

The undersigned applicant hereby certifies that he/she has in place, in accordance with Nebraska law, an established safety committee which has adopted an effective written injury prevention program. Failure to comply with this law deems the applicant ineligible for workers' compensation and employers' liability insurance and may result in policy cancellation and/or payment of a civil penalty as determined by the Nebraska Department of Labor.

Nebraska Department of Labor phone number: (402) 595-3185

Signature: _____

Title: _____

Company: _____

Date: _____