American Group Insurance Service, Inc
972 701-1200
800 882-1488
972-960-6058 Fax

Fax-A-Quote

Type of Proposal Requested:
- ☐ *Occupational Accident only*
- ☐ *Occupational Accident w/Legal*
- ☐ *Employer's Excess Indemnity*

Please fax this completed form, your inforce TX insurance license and Errors & Omission dec page to **American Group Insurance Service, Inc.** Fax: (972) 960-6058

Applicant Name _____ Requested Effective Date _____

Address _____ City _____ Zip _____ 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: _____

Are Owners, Officers or Partners to be covered? ☐ Yes ☐ No. Are any affiliate companies to be covered? ☐ Yes ☐ No. If yes,

Please provide Legal Name, Address and number of employees at each location.

#of Full time W-2's	1099	# of Part-time W-2's	1099	Classification Code	Annual Payroll by Class (including Tips)	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)*

Excess Limits: _____ *($1,000,000 to $5,000,000 limits available)*

Benefit Period: _____52 wks _____104 wks _____156 wks Weekly Income (75% up to $600) _____ Waiting Period: _____days

Please submit 3 years (hard copy) currently valued loss history; Valuation Date of loss information: _____

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

1.	Has the applicant (or affiliate) been in the Texas Workers' Compensation System in the last 3 Years? If yes, have they had an experience modification factor of 200% or more?	☐ Yes ☐ No ☐ 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: _____ Applicant Signature: _____

Applicant Name: _____

Federal Employer Tax ID Number or Social Security Number: _____

☐ I verify that (I) the applicant named above has had no known losses in the previous (3) years.

☐ I verify that (I) the applicant named above has had the following employee occupational losses as listed:

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

Signature of Applicant: _____

Title: _____

Date: _____