SIS

NEW BUSINESS TRANSMITTAL CHECKLIST

1. _____ Application for Employer's Indemnity Coverage (2 pages)
2. _____ Policyholder Disclosure and Acknowledgement Certification
3. _____ Completed Census Form with Monthly Salaries **OR** Copy of Employer's Most Recent Quarterly TEC Report
4. _____ Copy of ERISA Plan Document, or ERISA Plan Worksheet if ERISA plan currently not in force (1 page)
5. _____ Copy of Formal Quote
6. _____ Three years hard copy loss runs, if not submitted at time of quote, or if loss runs are not available, a written statement from the Employer listing claims, dates and claim amounts
7. _____ First Month's Premium (check payable to Special Insurance Services, Inc.)
   Check #: _____ *Check Amount:* _____
8. _____ Requested Effective Date: _____
9. _____ Single Case Commission Agreement
10. _____ Agent Data:
    Name: _____
    Phone #: _____ *Fax #:* _____
    Email Address: _____
11. _____ Agent Licensing Information (if not previously submitted & on file with SIS)
    _____ *Agent Appointment Data Sheet*
    _____ *Completed W-9*
    _____ *Copy of Current Group I or Local Recording Agent License*
    _____ *Copy of Current E&O Policy Declarations Page*

The American Group
Insurance Brokerage Service, Inc.
The Power to Succeed
12700 PARK CENTRAL DR., SUITE 460
DALLAS, TEXAS 75251
1-800-492-6345 • FAX 972-960-6058

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INFORMATION SHEET FOR EMPLOYER'S INDEMNITY COVERAGE

The employer named below is hereby making a Request for Coverage, as specified herein, to become effective on _____, at 12:01 a.m. Central Standard Time at the address described below.

1. Legal Name of Employer: _____
   dba _____
2. Federal Tax ID Number: _____
3. Contact Person: _____ Title: _____
4. Mailing Address: _____
   _____
5. Street Address: _____
   _____
6. County: _____
7. Phone Number: _____
   Fax Number: _____
   Email address: _____
8. Nature of Business: _____ SIC Code: _____
9. Is employer a: Corporation Partnership Sole Proprietorship Other: _____
10. Are owners/partners to be covered? Yes No
11. Please list all owner's/partner's names: _____
12. Are any affiliated/subsidiary companies to be covered? Yes No
    (If yes, please provide legal name, address, Federal Tax ID #, and number of employees at each location on a separate piece of paper.)
13. Does the employer currently have an ERISA plan? Yes No
    Does the employer wish to continue using their current plan or have a new plan created? ☐ Use old plan ☐ Want new plan
    (If "use old plan", please provide a copy of the full plan document and the Summary Plan Description (SPD.) If "want new plan, please complete ERISA Plan Document Worksheet.))
14. Does the employer have any employees who are subject to the U.S. Longshore & Harbor Workers' Act, the Jones Act, and/or the Federal Employer's Liability Act? Yes No
    (If yes, please state which Acts apply.)
15. Does the employer have a written Safety/Loss Control Program? Yes No
    (If yes, please complete the following in detail. If 250 lives or more, please attach a copy of the program.)

    Name _____
    Address: _____
    _____
    Phone: _____ Fax: _____

    Implementation Date: _____ Date Last Updated: _____

16. Does the employer manufacture, store, distribute, sell, handle or transport any of the following:

a.	Chemicals	Yes	No	e.	Fuel Oils	Yes	No
b.	Pharmaceuticals/Drugs	Yes	No	f.	Hazardous Wastes	Yes	No
c.	Explosives	Yes	No	g.	Nuclear Materials	Yes	No
d.	Gasoline	Yes	No	h.	Asbestos Materials	Yes	No

17. Does the employer now (or have future plans to) own, lease or charter any type of aircraft? Yes No
(If yes, and coverage is desired for employees while flying in, or operating such aircraft, please provide pilot history questionnaires and aircraft questionnaires for all aircraft and pilots. Also, provide a written statement as to what each aircraft is used for specifically, i.e, business travel, crop dusting, pipeline inspection, etc.) **Coverage does not automatically include such exposure, unless this additional coverage was requested at the time of quote.**

18. Is there any automobile exposure? Yes No
(If yes, please provide the number of automobiles/truck owned, operated, or leased by type of vehicle and radius in which they travel. Also, please state corporate rule, if any, for the number of employees allowed to travel together at any one time.)

REQUESTED COVERAGE LIMITS

The employer hereby requests occupational only coverage for the following limits (copy of formal quote also attached):

Combined Single Limit per Person per Occurrence: $ _____
Aggregate per Occurrence: $ _____
Policy Aggregate Limit: $ _____
Deductible per Person per Occurrence: $ _____
Benefit Period: _____ weeks

Occupational Disease/Cumulative Trauma, if quoted: Yes No

Waiver of Subrogation, if quoted: Yes No

The Policy forms will be delivered to the group electronically unless you request in writing to receive a paper copy.

This form does not bind any agent or insurance company to coverage. This is a quotation/policy request form and will not effect any insurance until approved by the Company or its representatives.

The employer represents that, to the best of his or her knowledge and belief, all of the statements made in this Request for Coverage are true and complete.

_____ _____ _____
Employer's Signature (must be an Officer) Title Date

_____
Please print/type above name

The undersigned Agent warrants he/she has not represented the above coverage, as anything other than an employer's indemnity reimbursement policy for on-the-job employee related injuries.

Agent's Signature: _____ Date: _____

Agent/Agency Printed Name _____
Address _____
_____

Phone # _____ Fax # _____

EMPLOYEE NAME	M/F	S.S. #	DETAILED JOB DESCRIPTION (JOB TITLES NOT ACCEPTABLE)	DATE OF HIRE	DATE OF BIRTH	MONTHLY SALARY	CLASS CODE

SIS

SPECIAL INSURANCE SERVICES, INC.
(Hereinafter called the Company)

SINGLE CASE AGREEMENT

This section must be completed by Agent/General Agent

Agent/General Agent	Agent Number	Commission Percent*
_____	_____	_____ % (New & Renewal)
_____	_____	_____ % (New & Renewal)
_____	_____	_____ % (New & Renewal)

*This should be the percentage of premium that the agent/general agent will receive as commission. Do not enter "100%" in this space.

ACCOUNT NAME: _____

OF ELIGIBLE PERSONS: _____

PLEASE READ THE REVERSE SIDE OF THIS FORM AND SIGN BELOW

(No reproductions of this form will be accepted.)

AGREED: Special Insurance Services, Inc.

Signed: _____ Dated: _____

AGREED:

Agent: _____

Signed: _____ Dated: _____

Agent: _____

Signed: _____ Dated: _____

Agent: _____

Signed: _____ Dated: _____

Instructions:
The Writing Agent must complete this Agreement (both front and back) and submit it, along with the new business information, to the General Agent. The General Agent will complete the Agreement and forward it to Special Insurance Services, Inc. No agent will be paid commission until he/she is appointed by the underwriting carrier.

1. The Company agrees to pay you as full remuneration for services rendered for the production of insurance premiums, a commission as listed herein, on the premiums paid to the Company and received by the Company, and earned by the Company.

2. The commission provided herein shall not be payable after (a) the date on which you are no longer recognized by the employer as its Agent or Broker for this insurance; (b) the Department of Insurance has issued rules or adopted regulations affecting the commissions herein or necessitating the revision of such insurance (in the event of such contingency, this Agreement shall be subject to re-negotiation); (c) your ceasing to be a licensed Agent or Broker for any reason; (d) your ceasing to be an appointed Agent of the Company; or (e) your permanent or temporary loss of license for any reason.

3. The Agent/Broker shall receive compensation as specified for as long as the Company receives compensation at the same level as of the date of the execution of this Agreement, or until commission for all such policies is reduced by the Company. In the event of a reduction in the Company's income from levels applicable on the date of this contract, both parties agree that adjustments will be made accordingly.

4. This contract can be terminated by either party sending not less than 30 days written notice of such termination.

5. PREMIUMS AND ACCOUNTING

   5.1 All premiums are to be paid directly to the Company. The Agent has no authority to alter, modify, waive or change any of the terms, rates or conditions of the Company's Master Policy or certificates, to collect renewal premium, to extend time for payment of premium, or to endorse checks payable to the Company.

   5.2 The right of the Agent or any other person to receive commissions shall, at all times, be subordinate to the right of the Company to offset or apply commissions against any indebtedness of the Agent to the Company. This right of offset shall include, but not be limited to, application against any liability incurred by the Company to any person by reason of the negligent or unauthorized acts committed by the Agent or any of his sub-agents or brokers. In the event commissions due hereunder are not sufficient to satisfy the debt, the Company may require immediate repayment of the debt from the Agent. An extension of time for repayment or modification of the amount due shall not waive the Company's rights hereunder.

   5.3 All accounting and records of the Agent pertaining to insurance written through the Company shall be subject to inspection and audit by the Company at any reasonable time.

6. GENERAL PROVISIONS

   6.1 The Company shall not be responsible for any expenses incurred by the Agent whether on the Agent's or Company's behalf. The Company shall administer the program and pay for all application forms, certificates, renewal billings and reporting forms.

   6.2 Should the Company, for any reason, refund any premium on any policy or insured enrolled by any application procured by the Agent, his sub-agent or broker, the Agent shall be liable and shall make repayment of any commission paid to the Agent for the policy or application.

   6.3 The assignment of commission or any other funds that may be due the Agent under this Agreement is prohibited and shall not be valid unless authorized in advance in writing by the Company. Any such authorized assignment shall at all times be subject to any and all indebtedness of the Agent to the Company.

   6.4 All notices, requests, communications and demands under this Agreement shall be in writing and shall be duly given if delivered in person or sent by registered mail, postage prepaid, to the party entitled to notice at the address which appears in the records of the Company.

Writing Agent's Initials: _____ Date: _____

POLICYHOLDER DISCLOSURE & ACKNOWLEDGEMENT CERTIFICATION

This will acknowledge, in solicitation of my business insurance, the Agent named below (herein referred to as "Agent"), explained to me the following facts about the Texas Workers' Compensation Act (the "Act"). The following facts were discussed, and as an employer I am aware of their importance. To my knowledge, no statements contrary to the following statements were made by the Agent to anyone employed by, or representing, the Named Insured.

1. This is not Workers' Compensation Insurance.
2. It is my responsibility, should I elect not to purchase Workers' Compensation Insurance, to notify the Division of Workers' Compensation of the Texas Department of Insurance ("DWC") at the time of such election by filing the appropriate form (currently the DWC Form 5). I must also annually file the appropriate form (currently DWC Form 5) with the DWC on the anniversary date of the original filing or if I have canceled my workers' compensation policy, on the anniversary of the cancellation date of the workers' compensation policy. I am aware of the penalty for failure to properly file can be as much as $500 per day. I also must notify my workers' compensation carrier, in the manner provided by the law, at the time of my election. All notices and elections must be made by certified mail, return receipt requested.
3. I have been advised that if I become "non-subscriber" under the Act, I should seek the advice of competent legal counsel in meeting the provisions of the Act. Agent has advised me to seek legal advice for the current law as it applies to my situation.
4. I am aware as a "non-subscriber", should I purchase an "alternative" insurance product that provides Injury medical benefits for my employees, I come under the Employee Retirement Income Retirement Security Act of 1974 (ERISA). It is in my best interest to have a written employee Injury benefit plan, and to file this plan under ERISA with the U.S. Department of Labor. Such insurance and plan do not preempt a personal Injury negligence lawsuit. Coverage under my ERISA plan and insurance policy may differ and I acknowledge that fact.
5. I am aware that changes in any ERISA plan attached to the application for the insurance contract do not change the reimbursement amount or terms of the benefits of the insurance policy issued, unless such changes are approved in writing by the insurance carrier.
6. Special Insurance Services, Inc. (SIS) may administer the claims on behalf of the Company. Even when SIS has also been selected as the Third Party Administrator for our ERISA plan, there may be instances where benefits are payable under our ERISA plan and are not reimbursable/payable under the insurance contract issued by the Company.
7. I understand an approved safety program could help reduce the frequency and severity of on-the-job injuries and could also help us meet our responsibility to provide a "reasonably safe place to work" for our employees.

The undersigned Agent has shown me an alternative work place Injury insurance plan. I acknowledge the option I have selected is solely my choice and the alternative plan I have chosen was not represented by Agent to any person as being a substitute for statutory Workers' Compensation Insurance. Agent did not induce me, or any representative of my company, to reject Workers' Compensation.

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

I have read the above and acknowledge that the Agent has discussed each of these items with me.

Signed this _____ day of _____, 20 _____ .

Applicant Signature (Must be Officer/Owner)	Firm Name (please print)
Agent Signature	Witness Signature

ERISA PLAN WORKSHEET

Company's Legal Name: _____

Federal Tax ID Number: _____

President of Company: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____

Contact Person: _____

Number of Covered Employees: _____

Do you currently have an ERISA Plan in-force: ❑ Yes ❑ No
If "Yes", what is the Plan Number: _____

Name of Person to be named ERISA Plan Administrator: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____

Name of Insurance Agent: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____

Effective Date of ERISA Plan: _____