EMPLOYERS®

America's small business insurance specialist.®

## HOW TO COMPLETE THE APPLICATION

- **All** the blank areas of the application must be completed.
- The completed application must be **signed by the insured/applicant.**
- Please **read** through these instructions for help in completing the application.
- **For agent:** If this is your first submission, please send a **copy** of your Fire & Casualty license, **or** I.E.A. Certificate **and** your Life Agent license, with your first submission.

## Page One of Application:

- Please provide an Anthem Blue Cross Small Group policy number or indicate if the applicant is currently applying for a Small Group policy.
- **BROKER INFORMATION** – Application **must** have complete broker/agent information and application **must** be signed by **insured/applicant**.
- **COMPANY INFORMATION** – Provide the **full name** and mailing address of the applicant, the **number of years** in business and **indicate** whether the applicant is an Individual, Partnership or Corporation. Provide the **Federal Employer ID number** for the applicant. The NCCI ID number and other Rating Bureau ID numbers are not necessary.
- **LOCATIONS** – Provide **all physical** locations for the applicant.
- **POLICY INFORMATION** – Provide the **proposed effective date** and **expiration date.** Show **CA** for California in Part 1 (States).
- **RATING INFORMATION** – Show **CA** for California. Provide the respective **class codes*** of the payroll, **classification description,* number of employees** in that class **and total payroll** in that class. If available, please provide the applicant's Experience Modification.

*A copy of the client's Declaration Page of their current coverage will assist you in determining classifications.

## Page Two of Application:

- **INDIVIDUALS INCLUDED/EXCLUDED** – List **all** OFFICERS or PARTNERS to be included **or** excluded from coverage, **including** title and ownership percentage, totaling 100%.
- **PRIOR CARRIER INFORMATION** – Provide **currently valued loss runs** from the prior carrier for the last 3 years; this information may be obtained from the applicant who would get them from their prior carrier. (**Note:** Loss runs are not required if annual premium is less than $15,000.)
- **NATURE OF BUSINESS** – Provide a **complete description** of the applicant's operations (attach a business brochure, if available).
- **GENERAL INFORMATION** – Answer **"yes"** or **"no"** to **all** questions. Explain all "yes" answers in the "Remarks" section below. Provide a **contact** person's name and telephone number or indicate if the applicant is currently applying for a Small Group Policy.

**Sign and Date the Application**
**Note:** Please also complete the worker's compensation supplemental application

**MAIL OR FAX THE COMPLETED APPLICATION TO EMPLOYERS®:**

P. O. Box 9057 · Oxnard, CA 93031 · 800/520-1683 · Fax 805/499-7214

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# WORKERS' COMPENSATION APPLICATION

*Please type or print* **PLEASE FAX or MAIL COMPLETED APPLICATION**

| Name of Company<br>EMPLOYERS COMPENSATION INSURANCE COMPANY | Group Health No. | Date (MM/DD/YY) |
|---|---|---|

**Will this Workers' Compensation Application be integrated with an Anthem Blue Cross Small Group Health Plan?** ☐ Yes ☐ No *If yes, please continue.*

## BROKER INFORMATION

| Writing Broker's Name | | Broker License No. |
|---|---|---|
| Broker Address | General Agent License No. | Broker Employer I.D. No. |
| City/State/ZIP Code | Phone No. | Fax No. |

## COMPANY INFORMATION

| Name of Company and D.B.A. | Years in Business |
|---|---|

☐ Individual ☐ Partnership ☐ Corporation ☐ Subchapter "S" Corp ☐ Other (specify):

| Mailing Address | Federal Employer I.D. No. |
|---|---|
| City / State / ZIP Code | Other Rating Bureau I.D. No. |

## LOCATIONS

| # | Address | City/County/State/ZIP Code |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |

## POLICY INFORMATION

| Proposed Effective Date (MM/DD/YY) | Proposed Expiration Date (MM/DD/YY) | Normal Anniversary Date (MM/DD/YY) |
|---|---|---|

**Part I (State)**

**Provide the level of contribution by employer towards payment of health benefits on behalf of the employer**

## RATING INFORMATION ( MANDATORY )

| State | LOC | Class Code | Categories/Duties/Classifications | Number of Employees Full-Time | Number of Employees Part-Time | Estimated Annual Payroll |
|---|---|---|---|---|---|---|
| | | | | | | |
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**Specify Additional Coverages/Endorsements** *(All exposures checked above should be explained)*

*(Continued on Page Two)*

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# INTEGRATED MEDICOMP WORKERS' COMPENSATION APPLICATION *(Continued)*

## INDIVIDUALS INCLUDED/EXCLUDED

Partners, officers, relatives to be included or excluded (Remuneration to be included must be part of Rating Information section)

| # | Name | Date of Birth | Title/Relationship | Ownership % | Duties | Include/Exclude | Class Code | Remuneration |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
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## PRIOR CARRIER INFORMATION/LOSS HISTORY

**Provide information for the past five (5) years and use the Remarks section for loss details. (Must have a minimum of three (3) years loss runs attached).**

| Year | Carrier | Policy No. | Annual Premium | Mod. | No. Claims | Amount Paid | Reserve |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
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## NATURE OF BUSINESS/DESCRIPTION OF OPERATION ( MANDATORY )

**Provide comments and descriptions of business, operations and products. Manufacturing: raw materials, processes, product, and equipment. Contractor: type of work, subcontracts. Mercantile: merchandise, customers, and deliveries. Service: type, location. Farm: acreage, animals, machinery, and subcontracts.**

## GENERAL INFORMATION

| Please explain all "Yes" responses in the *"Remarks"* section below. | Yes | No |
|---|---|---|
| 1. Does applicant own, operate or lease aircraft/watercraft? | ☐ | ☐ |
| 2. Does operation involve storing, treating, discharging, applying, disposing or transporting of hazardous material? (e.g., landfills, asbestos, wastes, fuel tanks) | ☐ | ☐ |
| 3. Any work performed underground or above 15 feet? | ☐ | ☐ |
| 4. Any work performed on barges, vessels, docks, or bridges over water? | ☐ | ☐ |
| 5. Is applicant engaged in any other type of business? | ☐ | ☐ |
| 6. Are subcontractors used? | ☐ | ☐ |
| 7. Any work sublet without certificate of insurance? | ☐ | ☐ |
| 8. Is a formal safety program in operation? | ☐ | ☐ |
| 9. Any group transportation provided? | ☐ | ☐ |

| Please explain all "Yes" responses in the *"Remarks"* section below. | Yes | No |
|---|---|---|
| 10. Any employee under 16 or over 50 years of age? | ☐ | ☐ |
| 11. Any employees over 60 years of age? | ☐ | ☐ |
| 12. Any part-time or seasonal employees? | ☐ | ☐ |
| 13. Is there any volunteer or donated labor? | ☐ | ☐ |
| 14. Any employees with physical handicaps? | ☐ | ☐ |
| 15. Do employees travel out of state? | ☐ | ☐ |
| 16. Are athletic teams sponsored? | ☐ | ☐ |
| 17. Are pre-employment physicals required? | ☐ | ☐ |
| 18. Any other insurance with this insurer? | ☐ | ☐ |
| 19. Any prior coverage declined/cancelled/nonrenewed (last 3 years)? | ☐ | ☐ |

| Inspection Contact | Phone No. | Account Records Contact | Phone No. |
|---|---|---|---|
| | | | |

**Remarks**

| Signature of Insured | Date |
|---|---|
| | |

Integrated MediComp Workers' Compensation coverage offered by Anthem Blue Cross and Employers Compensation Insurance Company.