SELF-INSURANCE APPLICATION FOR BUFFER LAYER SPECIFIC EXCESS COVERAGE

☐ New Application Effective Date: _____

☐ Renewal of Policy Number: _____ To Be Quoted By: _____

1. Name of Applicant (as shown on self-insurance permit):

_____

2. Address: _____

City: _____ ST: _____ Zip: _____

3. Applicant Phone Number: _____

4. Federal Employers Identification Number: _____

5. Describe operations to be covered; subsidiaries to be covered if any. (Attach copy of current and comprehensive engineering inspection reports, annual report, or 10k report and products brochure.)

_____

_____

_____

6. Describe any substantial or unusual changes in operations that are planned or have taken place in the past five years:

_____

_____

_____

7. Date qualified as a self-insured: _____

8. States to be self-insured: _____

9. Are there other states or jurisdictions included for self-insurance that would not be covered by the insurance requested by this application? ☐ Yes ☐ No

If yes, list: _____

10. Do any employees receive supplemental benefits in addition to workers' compensation benefits? ☐ Yes ☐ No

11. Provide details of any OSHA or State OSHA violation within the past 5 years: _____

_____

12. Does the applicant have any employees who may be subject to the Longshoremen and Harbor Workers Act, Jones Act or Federal Employee's Liability Act? (Unless endorsed, our policy does NOT include federal acts coverage.) ☐ Yes ☐ No

If yes, describe: _____

13. Do the operations of the applicant include volunteer or donated labor? ☐ Yes ☐ No

If yes, describe: _____

14. Does applicant have any foreign operations or employees who travel to foreign countries? ☐ Yes ☐ No

If yes, describe: _____

15. Is applicant engaged in the manufacture, production, refining, storage, distribution, or transportation of gases, gasoline or flammables? ☐ Yes ☐ No

If yes, describe: _____

16. Are there any occupational disease exposures involved in the applicant's operations? (asbestos; silica; dusts; toxic, injurious or hazardous chemicals; caustics, fumes, radiation, communicable diseases and any other O.D. exposures) If yes, describe steps taken to control: ☐ Yes ☐ No

17. Does applicant perform any underground, subaqueous, or tunneling operations? ☐ Yes ☐ No
If yes, describe: _____

18. Do the operations of the applicant include wrecking or demolition of structures? ☐ Yes ☐ No
If yes, describe: _____

19. Do the operations of the applicant involve exposure to heights? ☐ Yes ☐ No
If yes, describe: _____

20. Does applicant now (or have future plans to) own, lease or charter watercraft? ☐ Yes ☐ No
If yes, describe watercraft, use, number of crew members, passenger capacity and whether craft is owned, leased, or chartered. _____

21. Does applicant own, lease, or charter aircraft? *(If yes, Aircraft Questionnaire must be completed.)* ☐ Yes ☐ No

22. Complete the following information on owned or leased vehicles:
   a. Number of: Passenger cars _____ Vans trucks _____ Tractors _____
   Trailers _____
   b. Number of commercial vehicles owned by: applicant _____ owner-operator _____
   c. Is applicant responsible for W.C. coverage on owner-operators? ☐ Yes ☐ No
   If no, does applicant obtain certificate of W.C. insurance from such operators? ☐ Yes ☐ No
   d. With respect to commercial vehicles:
      1. States in which vehicles operate: _____
      2. Average number of persons in each unit: _____
      3. Does applicant transport chemicals, hazardous materials, explosives, explosive material, flammable material, or any petroleum products? ☐ Yes ☐ No
      If yes, provide full details: _____

23. Does applicant provide any transportation for employees to or from the workplace? ☐ Yes ☐ No
If yes, describe the type of conveyance, frequency of trips and number of employees (total number and number per conveyance involved): _____

24. Policy Coverages and Limits.

Current Carrier: _____

Present Program:

SPECIFIC EXCESS LIMIT	EMPLOYERS LIABILITY LIMIT	SELF-INSURED RETENTION	RATE

Coverage Desired:

ATTACHMENT POINT	LIMIT	O.D.	C.T.	E.L.
		No	No	No

25. Payroll and Manual Premium by Classification Code

a. Projected payroll. Provide the following information regarding each state or jurisdiction:
(*If more space is needed, use a separate page.)*

			POLICY PERIOD:					
STATE	W.C. CODE	CLASSIFICATION	PAYROLL	MANUAL RATE	MANUAL PREM	1st Prior Payroll	2nd Prior Payroll	3rd Prior Payroll
				Exp Mod				
		Totals:						

b. Is there any significant change to the payroll distribution by classification code in the last five years? ☐ Yes ☐ No

c. If yes, describe reason for change(s): _____

26. Loss Experience and Historical Activity.

a.

STATE	POLICY PERIOD	PAID	RESERVED	RECOVERED	TOTAL INCURRED	VALUATION DATE ***

* Electronic file detailing the insured's loss experience by policy period. Data elements should include all claims, open/closed status, payment activity including paid/reserved/total incurred amounts split by medical and indemnity, and a state or location code with a related definition for that code.

** Include allocated claims expenses as part of indemnity

*** Valuation date must be within the past 3 months

b.

STATE	POLICY PERIOD	OPEN	CLOSED	TOTAL CLAIMS	DENIED	VALUATION DATE

* CNPs are defined as claims reported and closed without any payment being made.

c. Are CNP claims included in the totals for open and closed claims? ☐ Yes ☐ No ☐ Don't Know

d. If yes, indicate the approximate percentage of total claims that are CNPs: _____ % ☐ Don't Know

27. Individual claims in excess of $ 50,000 incurred(past 5 years)

STATE	DATE OF LOSS	DESCRIPTION OF ACCIDENT	TOTAL PAID	TOTAL RESERVE	TOTAL INCURRED	NO. OF EMPLOYEES

28. Total number of employees: _____

29. Concentration of Risk.

Give the following information regarding each location. *(If more space is needed, use a separate page.)*

LOCATION / ADDRESS	STATE	ZIP CODE	TOTAL NUMBER EMPLOYEES IN ALL SHIFTS	TOTAL NUMBER EMPLOYEES IN MAX SHIFT	NUMBER OF STORIES IN BLDG

30. Loss Prevention.

a. Loss Prevention Service Company Information:

1. Name of service company _____

2. Address of service company: _____

City: _____ ST: _____ Zip Code: _____

b. Do you have dedicated safety professionals on staff who are not human resources personnel? ☐ Yes ☐ No

c. Do you have safety committees? ☐ Yes ☐ No

d. If yes, do they have management participation? ☐ Yes ☐ No

e. Do you provide new hire safety training? ☐ Yes ☐ No

f. Do you provide job specific safety training thereafter? ☐ Yes ☐ No

g. Do you have a cost allocation system in place which links workers' compensation costs to the department or facility? ☐ Yes ☐ No

h. Do you have any incentive plans in place linking individual and department workplace safety to a rewards system? Annual Driver Safety Bonus ☐ Yes ☐ No

31. Claims Handling. *(If no service company, Self-Administration Questionnaire must be completed.)*

a. Service Company Information:

1. Name of service company _____

2. Address of service company _____

City: _____ ST: _____ Zip Code: _____

3. Phone number: _____

4. Contact name for this account: _____

b. Are claims handled to conclusion? If no, give details. ☐ Yes ☐ No

_____

c. What is normal length of service contract? _____

d. Does applicant agree to let the excess carrier know about any changes in the service company or in the kind or amount of services to be performed by the service company? ☐ Yes ☐ No

e. Do you have an alternative duty return to work program in place for all departments? ☐ Yes ☐ No

f. Do you provide in-house medical attention for first aid injuries? ☐ Yes ☐ No

g. If so, who provides the treatment? _____

h. Do you have a process in place in which all injuries are internally investigated and reported to your claim servicing company within 24 hours? ☐ Yes ☐ No

i. Do you conduct regular or quarterly claim reviews with your claim servicing company? ☐ Yes ☐ No

j. Check the following managed care programs that apply to your program:

☐ PPO ☐ contracted pricing ☐ other _____

☐ fee scheduling ☐ nurse case management

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement is guilty of insurance fraud.

Date | Applicant's Signature | Title

Print Applicant's Name | Print Applicant's Title

This application is for an insurance contract with Great American E & S Insurance Company, an insurer not licensed to transact insurance in this state. Insurance contracts arising from this application are issued and delivered as surplus line coverage, and may not be available in all jurisdictions. This application is not directed to or intended for use by any person or entity in any jurisdiction in which the solicitation, offer, sale or purchase of surplus lines insurance would be unlawful under the insurance laws and regulations of such jurisdiction.