



WORKERS' COMPENSATION APPLICATION

Please type or print

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Name of Company	Group Health No.	Date (MM/DD/YY)
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Will this Workers' Compensation Application be integrated with a Blue Cross of California 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
<input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Subchapter "S" Corp <input type="checkbox"/> 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)
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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		Estimated Annual Payroll
				Full-Time	Part-Time	

Specify Additional Coverages/Endorsements (All exposures checked above should be explained)

(Continued on Page Two)

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
						N/A		
						N/A		
						N/A		
						N/A		
						N/A		

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

NATURE OF BUSINESS/DESCRIPTION OF OPERATION (MANDATORY)

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

GENERAL INFORMATION

Please explain all "Yes" responses in the "Remarks" section below.			Yes	No	Please explain all "Yes" responses in the "Remarks" section below.			Yes	No
1. Does applicant own, operate or lease aircraft/watercraft?	<input type="checkbox"/>	<input type="checkbox"/>			10. Any employee under 16 or over 50 years of age?	<input type="checkbox"/>	<input type="checkbox"/>		
2. Does operation involve storing, treating, discharging, applying, disposing or transporting of hazardous material? (e.g., landfills, asbestos, wastes, fuel tanks)	<input type="checkbox"/>	<input type="checkbox"/>			11. Any employees over 60 years of age?	<input type="checkbox"/>	<input type="checkbox"/>		
3. Any work performed underground or above 15 feet?	<input type="checkbox"/>	<input type="checkbox"/>			12. Any part-time or seasonal employees?	<input type="checkbox"/>	<input type="checkbox"/>		
4. Any work performed on barges, vessels, docks, bridges over water?	<input type="checkbox"/>	<input type="checkbox"/>			13. Is there any volunteer or donated labor?	<input type="checkbox"/>	<input type="checkbox"/>		
5. Is applicant engaged in any other type of business?	<input type="checkbox"/>	<input type="checkbox"/>			14. Any employees with physical handicaps?	<input type="checkbox"/>	<input type="checkbox"/>		
6. Are sub-contractors used?	<input type="checkbox"/>	<input type="checkbox"/>			15. Do employees travel out of state?	<input type="checkbox"/>	<input type="checkbox"/>		
7. Any work sublet without certificate of insurance?	<input type="checkbox"/>	<input type="checkbox"/>			16. Are athletic teams sponsored?	<input type="checkbox"/>	<input type="checkbox"/>		
8. Is a formal safety program in operation?	<input type="checkbox"/>	<input type="checkbox"/>			17. Are pre-employment physicals required?	<input type="checkbox"/>	<input type="checkbox"/>		
9. Any group transportation provided?	<input type="checkbox"/>	<input type="checkbox"/>			18. Any other insurance with this insurer?	<input type="checkbox"/>	<input type="checkbox"/>		
					19. Any prior coverage declined/cancelled/non-renewed (last 3 yrs)?	<input type="checkbox"/>	<input type="checkbox"/>		

Inspection Contact	Phone No.	Account Records Contact	Phone No.
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Remarks

Signature of Producer (MANDATORY)	Date
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Integrated MediComp Workers' Compensation coverage offered by Blue Cross of California and Fremont Employers Insurance Company. Workers' Compensation insurance policies to be issued by Harbor Specialty Insurance Company or Million Insurance Agency.

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66 Bovert Rd suite 325 P.O.BOX 5580 San Mateo,CA 94402 FAX 650-350-2900