



# WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY)  
10/26/2009

AGENCY <b>Richard W Endlar Ins Agcy Inc</b> 145 Rosemary Street, Bldg K Needham MA 02494-3238		COMPANY <b>Norfolk &amp; Dedham Group</b>		UNDERWRITER <b>Manager#</b>	
PHONE (A/C, No, Ext): <b>781-455-6664</b>		APPLICANT NAME		E-MAIL ADDRESS	
FAX (A/C, No): <b>781-453-0204</b>		MAILING ADDRESS (including ZIP + 4)		CORPORATION	
E-MAIL ADDRESS:		YRS IN BUS		PARTNERSHIP	
CODE: SUB CODE:		SIC		SUBCHAPTER 'S' CORP	
AGENCY CUSTOMER ID <b>TESTC-1</b>		CREDIT BUREAU NAME: <b>N</b>		ID NUMBER:	
		FEDERAL EMPLOYER ID NUMBER		OTHER RATING BUREAU ID OR STATE EMPLOYER REGISTRATION NUMBER	
		NCCI ID NUMBER		<input checked="" type="checkbox"/> Trust	

**STATUS OF SUBMISSION****BILLING/AUDIT INFORMATION**

<input checked="" type="checkbox"/> QUOTE	<input type="checkbox"/> ISSUE POLICY	BILLING PLAN		PAYMENT PLAN		AUDIT	
<input checked="" type="checkbox"/> BOUND (Give date and/or attach copy)		<input type="checkbox"/> AGENCY BILL	<input checked="" type="checkbox"/> ANNUAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> AT EXPIRATION	<input type="checkbox"/> MONTHLY
<input type="checkbox"/> ASSIGNED RISK (Attach ACORD 133)		<input checked="" type="checkbox"/> DIRECT BILL	<input type="checkbox"/> SEMI-ANNUAL	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> Group
			<input type="checkbox"/> QUARTERLY	% DOWN:		<input type="checkbox"/> QUARTERLY	

**LOCATIONS**

LOC #	STREET, CITY, COUNTY, STATE, ZIP CODE

**POLICY INFORMATION**

PROPOSED EFF DATE		PROPOSED EXP DATE		NORMAL ANNIVERSARY RATING DATE		PARTICIPATING <input checked="" type="checkbox"/>		RETRO PLAN	
PART 1 - WORKERS COMPENSATION (States) <b>MA</b>		PART 2 - EMPLOYER'S LIABILITY		PART 3 - OTHER STATES INS		DEDUCTIBLES		AMOUNT%	
		\$ 500.000 EACH ACCIDENT				MEDICAL			
		\$ 500.000 DISEASE-POLICY LIMIT				INDEMNITY			
		\$ 500.000 DISEASE-EACH EMPLOYEE						OTHER COVERAGES	
DIVIDEND PLAN/SAFETY GROUP		ADDITIONAL COMPANY INFORMATION		"If any" workers compensation. No known payroll				U.S.L. & H. VOLUNTARY COMP FOREIGN COV	

**RATING INFORMATION**

STATE	LOC #	CLASS CODE	DESCR CODE	CATEGORIES, DUTIES, CLASSIFICATIONS	# EMPLOYEES		ESTIMATED ANNUAL REMUNERATION	RATE	ESTIMATED ANNUAL PREMIUM
					FULL TIME	PART TIME			
MA		9015		Bldgs- ops by owner				2.94	0

STATE:	FACTOR	FACTORED PREMIUM	FACTOR	FACTORED PREMIUM	SPECIFY ADDITIONAL COVERAGES / ENDORSEMENTS
TOTAL		\$	EXPENSE CONSTANT	N/A \$ 159	
INCREASED LIMITS		\$ 50	TAXES / ASSESSMENTS	N/A \$	
DEDUCTIBLE	N/A	\$	DIA	6.3% \$ 0	
Policy Min Diff		\$ 103	ESTIMATED ANNUAL PREMIUM	N/A \$	
EXPERIENCE OR MERIT MODIFICATION	N/A	\$			
LOSS CONSTANT	N/A	\$ 20			
ASSIGNED RISK SURCHARGE		\$			
ARAP		\$			
SCHEDULE RATING		\$			
CCPAP		\$	TOTAL EST ANNUAL PREMIUM	N/A \$	
STANDARD PREMIUM		\$	MINIMUM PREMIUM	\$	
PREMIUM DISCOUNT		\$	DEPOSIT PREMIUM	\$ 332	

**INDIVIDUALS INCLUDED/EXCLUDED**

PARTNERS, OFFICERS, RELATIVES TO BE INCLUDED OR EXCLUDED. (Remuneration to be included must be part of rating information section.)

STATE	LOC #	NAME	DATE OF BIRTH	TITLE/RELATIONSHIP	OWNER-SHIP %	DUTIES	INC/EXC	CLASS CODE	REMUNERATION

**PRIOR CARRIER INFORMATION/LOSS HISTORY**

PROVIDE INFORMATION FOR THE PAST 5 YEARS AND USE THE REMARKS SECTION FOR LOSS DETAILS

YEAR	CARRIER & POLICY NUMBER	ANNUAL PREMIUM	MOD	# CLAIMS	AMOUNT PAID	RESERVE
	CO: POL #:					
	CO: POL #:					
	CO: POL #:					
	CO: POL #:					
	CO: POL #:					

**NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS**

GIVE COMMENTS AND DESCRIPTIONS OF BUSINESS, OPERATIONS 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**

EXPLAIN ALL "YES" RESPONSES	YES	NO	EXPLAIN ALL "YES" RESPONSES	YES	NO
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT/WATERCRAFT?		<input checked="" type="checkbox"/>	18. ANY PRIOR COVERAGE DECLINED/ CANCELLED/NON-RENEWED (Last 3 years)?		<input checked="" type="checkbox"/>
2. DO/HAVE PAST, PRESENT OR DISCONTINUED OPERATIONS INVOLVE(D) STORING, TREATING, DISCHARGING, APPLYING, DISPOSING, OR TRANSPORTING OF HAZARDOUS MATERIAL? (e.g. landfills, wastes, fuel tanks, etc)		<input checked="" type="checkbox"/>	19. ARE EMPLOYEE HEALTH PLANS PROVIDED?		<input checked="" type="checkbox"/>
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?		<input checked="" type="checkbox"/>	20. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS/SUBSIDIARY?		<input checked="" type="checkbox"/>
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?		<input checked="" type="checkbox"/>	21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?		<input checked="" type="checkbox"/>
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?		<input checked="" type="checkbox"/>	22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME?		<input checked="" type="checkbox"/>
6. ARE SUB-CONTRACTORS USED? (IF YES, GIVE % OF WORK SUBCONTRACTED)	100	<input checked="" type="checkbox"/>	23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST 5 YEARS?		<input checked="" type="checkbox"/>
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INS.?		<input checked="" type="checkbox"/>	24. ANY UNDISPUTED AND UNPAID WORKERS COMPENSATION PREMIUM DUE FROM YOU OR ANY COMMONLY MANAGED OR OWNED ENTERPRISES? IF YES, EXPLAIN INCLUDING ENTITY NAME(S) AND POLICY NUMBER(S).		<input checked="" type="checkbox"/>
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?		<input checked="" type="checkbox"/>	<b>CONTACT INFORMATION</b>		
9. ANY GROUP TRANSPORTATION PROVIDED?		<input checked="" type="checkbox"/>	IN- SPECTION	PHONE:	ph#
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?		<input checked="" type="checkbox"/>		NAME:	Contact Name
11. ANY SEASONAL EMPLOYEES?		<input checked="" type="checkbox"/>		E-MAIL:	
12. IS THERE ANY VOLUNTEER OR DONATED LABOR?		<input checked="" type="checkbox"/>	ACCTNG RECORD	PHONE:	
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?		<input checked="" type="checkbox"/>		NAME:	
14. DO EMPLOYEES TRAVEL OUT OF STATE?		<input checked="" type="checkbox"/>		E-MAIL:	
15. ARE ATHLETIC TEAMS SPONSORED?		<input checked="" type="checkbox"/>	CLAIMS INFO	PHONE:	
16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?		<input checked="" type="checkbox"/>		NAME:	
17. ANY OTHER INSURANCE WITH THIS INSURER?		<input checked="" type="checkbox"/>		E-MAIL:	

APPLICABLE IN TENNESSEE: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO ANY PARTY TO A WORKERS COMPENSATION TRANSACTION FOR THE PURPOSE OF COMMITTING FRAUD. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, HI, NE, OH, OK, OR, TN or VT; in DC, LA, ME and VA, insurance benefits may also be denied)

REMARKS (Attach additional sheets if more space is required)

APPLICANT'S SIGNATURE	DATE	PRODUCER'S SIGNATURE	NATIONAL PRODUCER NUMBER
-----------------------	------	----------------------	--------------------------