ACORD

WORKERS COMPENSATION INSURANCE PLAN
ASSIGNED RISK SECTION

DATE (MM/DD/YY)

THIS FORM ALONG WITH AN ACORD 130 WORKERS COMPENSATION APPLICATION CONSTITUTE AN APPLICATION FOR WORKERS COMPENSATION INSURANCE PLAN (ASSIGNED RISK) COVERAGE. THIS FORM MUST BE ATTACHED TO AN ACORD 130 FOR SUBMISSION. PLEASE REFER TO THE STATE SPECIFIC INSTRUCTIONS PAGE FOR SPECIFIC REQUIREMENTS.

APPLICANT NAME

PROPOSED EFF DATE

SUPPLEMENTAL INFORMATION

MAIL OFFICE NAME, ADDRESS AND TELEPHONE NUMBER
(PO BOX ADDRESS ALONE IS NOT ACCEPTABLE, PLEASE PROVIDE MAILING INSTRUCTIONS IF A ROUTE ADDRESS IS SHOWN.)

EXPLAIN ALL "YES" RESPONSES IN THE REMARKS SECTION	YES	NO
4. HAS THERE BEEN A NAME CHANGE, CONSOLIDATION, MERGER OR OWNERSHIP CHANGE DURING THE PAST FIVE YEARS? IF YES, GIVE PREVIOUS NAME AND DATE OF CHANGE. CONTACT THE PLAN ADMINISTRATOR ABOUT AN ERM-14.		
5. IS APPLICANT RELATED THROUGH COMMON MANAGEMENT OR OWNERSHIP TO ANY ENTITY NOT LISTED HERE, WHETHER COVERAGE IS REQUIRED OR NOT? IF YES, GIVE DETAILED EXPLANATION.		
6. DO YOU LEASE WORKERS FROM A LABOR CONTRACTOR? IF YES, REFER TO WCIP INSTRUCTIONS.		
7. DO YOU LEASE WORKERS TO A CLIENT COMPANY? IF YES, REFER TO WCIP INSTRUCTIONS.		
8. ARE YOU SEEKING TO COVER THE LEASED WORKERS? IF YES, REFER TO WCIP INSTRUCTIONS.		
9. DO YOU PROVIDE TEMPORARY LABOR SERVICES TO OTHER EMPLOYERS?		
10. DO YOU HAVE A FRANCHISE OR LICENSING AGREEMENT? IF YES, PROVIDE DETAILS OF THE AGREEMENT.		
11. DO TRUCKING CLASSIFICATIONS APPLY? IF YES, COMPLETE QUESTIONS 12-14.		

ESTIMATE DEVELOPING HIGHEST PAYROLL:

EXPLAIN ALL "YES" RESPONSES IN THE REMARKS SECTION

	YES	NO
WAS THERE BEEN PREVIOUS WORKERS COMPENSATION COVERAGE:		
IN THIS STATE?		
IN ANY OTHER STATE?		

IF NO TO BOTH QUESTIONS, WAS THIS DUE TO:

☐ NEW BUSINESS ☐ SELF INSURED-GROUP
☐ SELF INSURED-INDEP ☐ # EMPLOYEES

IS THERE ANY UNPAID WORKERS COMPENSATION PREMIUM DUE OR IN DISPUTE FROM YOU OR ANY COMMONLY MANAGED OR OWNED ENTERPRISES? IF YES, EXPLAIN INCLUDING ENTITY NAME(S) AND POLICY NUMBER(S).		

YEAR APPLICANT'S BUSINESS BEGAN:

DO YOU OR YOUR EMPLOYEES REGULARLY OPERATE FROM A BASE TERMINAL(S) WHICH IS (ARE) USED TO LOAD, UNLOAD, STORE OR TRANSFER FREIGHT? IF YES, PLEASE PROVIDE A LIST OF TERMINAL ADDRESSES:

	STREET	CITY	COUNTY	ST	ZIP CODE
1					
2					
3					

CAN EACH DRIVER'S STATE OF MAJORITY DRIVING TIME BE ESTABLISHED THROUGH VERIFIABLE RECORDS OR LOGS?

PLEASE PROVIDE A LIST OF ALL DRIVERS/HELPERS AND THEIR STATE OF RESIDENCE:

	DRIVER NAME	TERMINAL # (SEE ABOVE)	MAJORITY DRIVING STATE	RESIDENCE STATE
1				
2				
3				

INSURANCE COMPANIES WHO HAVE OFFERED/REFUSED INSURANCE

	YES	NO
HAVE YOU RECEIVED ANY OFFERS OF VOLUNTARY COVERAGE? (INCLUDE MULTI-LINE OR RETROSPECTIVE RATING PLAN, IF APPLICABLE) IF YES, PROVIDE FULL DETAILS INCLUDING PLAN TERMS IN THE REMARKS SECTION.		

INDICATE THE NUMBER OF INSURANCE COMPANIES WHICH HAVE REFUSED THE APPLICANT COVERAGE IN THE LAST 60 DAYS (OR IN ACCORDANCE WITH STATE SPECIFIC GUIDELINES): ☐

IN ACCORDANCE WITH PLAN RULES, THE APPLICANT OR ITS REPRESENTATIVE SHALL MAINTAIN ON RECORD FOR THIS POLICY PERIOD THE CARRIER NAME, CONTACT PERSON, ADDRESS, PHONE NUMBER AND DATE OF CONTACT OF THOSE CARRIERS REFUSING COVERAGE AND MAKE SUCH INFORMATION AVAILABLE TO THE PLAN ADMINISTRATOR OR ASSIGNED RISK CARRIER UPON REQUEST.

REMARKS

Exhibit 2, OAR 836-043-0024 (Page 1)

MIUM PAYMENT (Refer to WCIP instruction t for state requirements)

MENT METHOD - SELECT ONE: IS TH... PREMIUM FINANCED? ☐ YES ☐ NO

1. VERBAL CHECK

ROMBA # | ACCOUNT # | CHECK # | PREMIUM PAYMENT AMOUNT $ .00

2. ELECTRONIC FUNDS TRANSFER

ROMBA # | ACCOUNT # | PREMIUM PAYMENT AMOUNT $ .00

3. MAIL-IN CHECK

BOX # | PREMIUM PAYMENT AMOUNT $ .00

r submission methods 1 and 2:

Does the payor require a physical record of this transaction? ☐ YES ☐ NO

To ensure accuracy, a voided check or deposit slip (of the payor) should be faxed to NCCI, Inc. upon return of the signed ACORD applications.

The undersigned Producer or Applicant certifies that by signing this application he/she authorizes NCCI, Inc. to deduct or has obtained financial information and authorization from the payor to direct NCCI, Inc. to deduct the Premium Payment Amount, and any other monies required to bind coverage, from the bank and the account number as indicated above for purposes of securing workers compensation insurance pursuant to this application.

LICANT'S STATEMENT

The undersigned applicant hereby certifies that he/she has read and understands the statements in this application. As further consideration of policy issuance, the applicant also certifies that the responses provided in this application are true and furthermore agrees:

To maintain a complete record of all payroll transactions in such form as the insurance company may reasonably require and that such record will be available to the company at the designated address.

To comply substantially with all laws, orders, rules, and regulations in force and effect made by the public authorities relating to the welfare, health, and safety of employees.

To comply with all reasonable recommendations made by the insurance company relating to the welfare, health, and safety of employees.

To take no action in any form to evade the application of experience modification determined in accordance with the experience rating rules, as determined by the Plan Administrator.

The undersigned applicant also certifies he/she has had no difficulties with any producer or company in regard to: (a) payroll records; (b) the amount of premium charged; (c) the payment of premium; (d) the carrying out of any recommendation made for the purpose of safeguarding employees; (e) the handling of any claim or accident report except the following: _____

Violation of any of these agreements may result in cancelation of a policy of insurance issued under a Workers Compensation Insurance Plan.

The undersigned applicant understands also that coverage is NOT bound until the signed application is received with appropriate premium and eligibility is determined by the administrator. Provided that applicant is determined to be eligible and in good faith entitled to WCIP insurance, based upon the information provided herein or otherwise available, coverage will be bound in accordance with plan rules. See individual state plans for applicable binding rules.

The undersigned applicant understands further that since he/she has been unable to secure workers compensation coverage through any other insurance provider, this coverage is being afforded through a Workers Compensation Insurance Plan, and that the rates charged may be higher than those in the voluntary market.

The following statement is only applicable in jurisdictions where the NCCI, Inc. Loss Sensitive Rating Plan has been approved for use:

By signing below I acknowledge that the NCCI, Inc. Loss Sensitive Rating Plan has been explained to me or that an explanatory notice or brochure has been provided to me and I agree that I shall be bound by the terms of such plan if my estimated annual premium or preliminary physical audit premium meets or exceeds the premium eligibility requirement.

ICANT'S NAME AND TITLE (PRINT OR TYPE)	DATE	SIGNATURE (MUST BE AN OWNER OR AN OFFICER)

REMINDER: BOTH THE ACORD 130 AND 133 APPLICATIONS MUST BE SIGNED BY THE APPLICANT AND DESIGNATED PRODUCER.

DUCER'S CERTIFICATION

PRODUCER ALSO CERTIFIES THAT HE/SHE HAS BEEN AUTHORIZED TO SUBMIT THE APPLICATION ON BEHALF OF THE APPLICANT AND THAT INFORMATION PROVIDED ON THE ACORD 130 AND ACORD 133 IS TRUE AND ACCURATE TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF.

ICY FEIN	AGENCY PHONE NUMBER (A/C, No, Ext)	AGENCY FAX NUMBER (A/C, No)

DENT LICENSE NUMBER	EXPIRATION DATE	NON-RESIDENT LICENSE NUMBER	EXPIRATION DAT

DUCER NAME (PRINT OR TYPE)	DATE	PRODUCER SIGNATURE

Exhibit 2, OAR 836-043-0024
(Page 2)