

<b>Do you have? Please check below:</b> <input type="checkbox"/> Life & Health License <input type="checkbox"/> Property & Casualty License <input type="checkbox"/> E&O Coverage	<b>THE COMP SOLUTIONS NETWORK, INC</b> <b>“FAX-A-QUOTE”</b> <b>For Occupational Accident Programs</b> <b>(Non-Subscriber Programs)</b> <b>(713) 690-3500 (800) 256-8035 FAX (713) 690-8484</b>	<b>Type of Proposals Requested:</b> <input type="checkbox"/> Occupational Accident <i>No Legal</i> <input type="checkbox"/> Occupational Accident <i>With Legal Included</i>
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**Applicant Information: (Please Print)**
**Requested Effective Date:** \_\_\_\_\_

Business Name and dba:				
Physical Address:		City:	State:	Zip:
Mailing Address:		City:	State:	Zip:
<input type="checkbox"/> Corporation	<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> Partnership	<input type="checkbox"/> LLC	
Yrs. in Business:		Website:		
Phone:	Fax:	Hrs. of Operations:		
Federal Tax ID Number:	* No. Of Locations:	Email:		
Contact Person:	Title:	Details of Operations:		
Has Worker's Comp or Occupational Accident coverage ever been canceled, refused or non-renewed? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If Yes, please explain:				

**\*If multiple locations, please indicate if the business name(s) are different, along with the Tax ID #'s. List on separate sheet.**

**Rating Information:**

# of Full-Time EES 1099		# of Part-Time EES 1099		Classification Code	Annual Payroll	Classification or Description

Officers/Owners: Included \_\_\_\_\_ Excluded \_\_\_\_\_

Loss Information for Prior 3 yrs (All losses must be first dollar losses) Valuation Date: \_\_\_\_\_

Period	Carrier	Medical Pd.	Indemnity Pd.	Reserved	Total Inc.	# of Losses	Premium

**\* Give detailed description of each loss in excess of \$5,000 on separate sheet.**

**Safety Exposure:**

	Y	N		Y	N
Does entity have a formal maintenance/Safety Program?			Is there an appointed Safety Director?		
When was it last updated: _____			Safety Director's Name: _____		
Written Safety Manual?			Safety Committee?		
Safety Incentive Program?			Alcohol/Drug Testing Program?		
Safety Meetings Held? Meeting Frequency: _____			Periodic Self-Inspections? Inspection Frequency: _____		
Written Training Program for New Employees"			Ongoing Employee Training?		
Bodily Injury Reporting & Record Keeping?			Bodily Injury Investigation?		
Return to work program?					
Any other Safety controls in place that assist you in controlling losses? List or attach on separate page.					

## General Information:

	Y	N		Y	N
Have you had any OSHA violations in the past 5 yrs?			Is entity subject to Jones Act?		
Have you filed bankruptcy in the last 5 yrs?			Is entity subject to Federal Employer's Liability Act?		
Do you own, leased or charter aircraft or watercraft?			Is entity subject to U.S. Longshore & Harbor Act?		
Do you have any employees under 18 or over 65?			Underground/tunneling or sub-aqueous work?		
Do you use leased or temporary employees?			Are employee's healthcare plans provided?		
Heights over 15 feet? Max? _____			Are all forklifting operators certified?		
Do you use sub-contractors?			Maximum weight of material handling _____		
If in Worker's Comp, is Exp. Mod Factor 200% or more?			Does entity handle, store or transport any explosive caustic or hazardous material?		
Has applicant (or affiliate) ever had an Employer's Liability Claim?			Has the applicant (or affiliate) ever had an Occupational Disease (e.g. Black Lung, silicosis, lead poisoning, cancer, etc.) or Cumulative Trauma (e.g. carpal tunnel, stress, etc.) claim?		
Do you have underground exposure in excess of 6 feet?					
Explain all "Yes" answers:					

## Driving Exposure:

Is applicant subject to LPG or TX DOT Regulations?  Yes  No

Driving Radius: \_\_\_\_\_

Specify Commodities hauled: \_\_\_\_\_

What % of loads are manually loaded or unloaded: \_\_\_\_\_% Loaded \_\_\_\_\_% Unloaded

Are employees required to drive their own vehicles for business purpose?  Yes  No If yes, please explain: \_\_\_\_\_

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IS MVR's run at least annually on all drivers?  Yes  No

Minimum Standards for Drivers:

Minimum age: \_\_\_\_\_ Maximum Age: \_\_\_\_\_

Minimum Commercial truck driving experience: \_\_\_\_\_ years

Maximum number of accidents permitted: \_\_\_\_\_ (number) in the past \_\_\_\_\_ years.

Maximum number of violations permitted: \_\_\_\_\_ (number) in the past \_\_\_\_\_ years.

Radius of Operation	Number of Commercial Units					
	Private Passenger	Light	Medium	Heavy	X-Heavy	Tractor
0-50	_____	_____	_____	_____	_____	_____
51-200	_____	_____	_____	_____	_____	_____
Over 200	_____	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____	_____

## Convenience Store:

Hours of Operations: (Specifically) List hours for each day: \_\_\_\_\_

Has the store ever been robbed?  Yes  No If yes, give details: \_\_\_\_\_

Does the store also offer gasoline/kerosene?  Yes  No If yes, give hours of operations if different from store hrs. \_\_\_\_\_

How much cash do they keep on hand? \_\_\_\_\_

What type of security is in place? Additional Comments: \_\_\_\_\_

What type of formal training is given to the employees in case of a robbery? \_\_\_\_\_

What is the minimum number of employees working at any one time? \_\_\_\_\_

Additional Comments: \_\_\_\_\_

## Select Coverage's to be Quoted

Limits	Deductible or SIR (Self Insured Retention)	Max. Weekly Disability	Benefit Period	Waiting Period for Disability
<input type="checkbox"/> \$100,000	<input type="checkbox"/> \$250	<input type="checkbox"/> \$200	<input type="checkbox"/> 52 weeks	<input type="checkbox"/> 7 days
<input type="checkbox"/> \$200,000	<input type="checkbox"/> \$500	<input type="checkbox"/> \$300	<input type="checkbox"/> 104 weeks	<input type="checkbox"/> 14 days
<input type="checkbox"/> \$250,000	<input type="checkbox"/> \$1,000 (Minimum for Emp's Liability)	<input type="checkbox"/> \$400	<input type="checkbox"/> 156 weeks	<input type="checkbox"/> 30 days
<input type="checkbox"/> \$300,000	<input type="checkbox"/> \$ 2,500	<input type="checkbox"/> \$500	<input type="checkbox"/> 208 weeks	
<input type="checkbox"/> \$500,000	<input type="checkbox"/> \$ 5,000	<input type="checkbox"/> \$600	<input type="checkbox"/> 260 weeks	
<input type="checkbox"/> \$750,000	<input type="checkbox"/> \$ 7,500	<input type="checkbox"/> \$700		
<input type="checkbox"/> \$1,000,000	<input type="checkbox"/> \$10,000			
<input type="checkbox"/> Other: _____	<input type="checkbox"/> \$25,000			
	<input type="checkbox"/> \$50,000			
	<input type="checkbox"/> Other: _____			

Do you want more than one deductible amount quoted?  Yes  No *Please check appropriate boxes above*

Waiver of Subrogation?  Yes  No

Occupational Disease & Cumulative Trauma?  Yes  No

Any Additional Comments:

Agent and Applicant hereby acknowledge that: (a) all answers and statements contained herein, including any attached data, are true and complete; (b) Insurer will rely solely on the information provided in this Fax-A-Quote, along with any attached data, in considering whether to provide the requested insurance coverage.

**Agent Name: (Please Print )** \_\_\_\_\_ **Phone:** \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Fax: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Agent's Signature:** **X** \_\_\_\_\_ **Date:** \_\_\_\_\_

Agent's Email: \_\_\_\_\_

Agency Website: \_\_\_\_\_

Are you currently contracted with Comp Solutions?  Yes  No

Please fax completed form to Jessie Sanchez at 713-690-8484.

If you are a new agent to Comp Solutions,  
please send your in force Agent License(s),  
and your Errors & Omissions declaration page.



Please visit our website for various Forms, Applications and  
our Agent/Producer Agreement and Contracting.

Thank you!

Need help? Please contact Jessie Sanchez at

(713) 690-3500 Ext 42

Outside the Houston area 1-800-256-8035 or by email:

[jessiesanchez@compsolutionsnetwork.com](mailto:jessiesanchez@compsolutionsnetwork.com)

*“Your Success is Our Success”*

[www.compsolutionsnetwork.com](http://www.compsolutionsnetwork.com)