THE COMP SOLUTIONS NETWORK, INC

WHOLESALE & SURPLUS LINES BROKERAGE * WORKERS' COMP & OCCUPATIONAL ACCIDENT

One Beacon Occupational Accident Program

New Business Checklist

1. OneBeacon Application (3 pages).
2. ERISA Plan worksheet.
3. Quote Acceptance (signed copy of the quote).
4. Check for the 1st months premium made payable to OneBeacon.
5. Please complete bottom portion of the Emergency Contact for the Travel Assistance Program

Please send all original paperwork to:

The Comp Solutions Network, Inc
Attn: Jessie Sanchez
7826 Hillmont Street
Houston Texas 77040

Need Help? Have questions?

Please call Jessie Sanchez
713-690-3500 ext 46

jessiesanchez@compsolutionsnetwork.com

Thank You!

Homeland Insurance Company of New York ("Company")
1000 Woodbury Road
Woodbury, NY 11797

Application for
Occupational Injury/Employer's Liability Coverage

Proposed Effective Date: ______________________

Applicant's Name: ______________________
Physical Street Address: ______________________
City: ______________________ State: ______________ Zip: ____________
Description of entity's operation: ______________________
Contact Person: ______________________ Title: ______________________
Telephone Number: ______________________ Fax Number: ______________________
dba: ______________________ Federal Tax ID Number: ______________________

Please answer the following questions:

- Number of years in business: ____________ Corporation ☐ Partnership ☐ Sole Proprietor ☐ LLC ☐ Other ☐
- Has entity rejected WC? Yes ☐ No ☐ Date of rejection of the act: ______________________
- Has Worker's Compensation or Occupational coverage ever been cancelled, refused or non-renewed? Yes ☐ No ☐
  If yes, please explain: ______________________
- Does entity have any employees who are subject to the following:
  a) Federal Employers Liability Act? Yes ☐ No ☐
  b) U.S. Longshore & Harbor Worker's Act? Yes ☐ No ☐
  c) Underground/tunneling or sub-aqueous work? Yes ☐ No ☐
  d) Jones Act? Yes ☐ No ☐
  e) Exposed to Heights Over 15 feet? Yes ☐ No ☐
- Do the drivers load or unload? Yes ☐ No ☐ Commodities Transported: ______________________
- Is entity subject to LPG or Texas DOT requirements? Yes ☐ No ☐ Radius of Operations: ______________________
- Does the entity handle, store or transport any explosives caustic or hazardous material? Yes ☐ No ☐
- Does the applicant have a written Safety/Loss Control Program? Yes ☐ No ☐ **If Yes, provide the following**:
  Who developed the program? Name: ______________________
  Address: ______________________ City: ______________________
  State: ____________ Zip: ____________ Phone: ______________________ Fax: ______________________

Please provide the following information concerning the current loss prevention practices:

A. Safety:

Does the safety/loss control program include:

1. A written safety manual? Yes ☐ No ☐
2. Safety Director? Yes ☐ No ☐
3. Safety incentive Program? Yes ☐ No ☐
4. Alcohol/drug testing program? Yes ☐ No ☐
5. Safety Committee? Yes ☐ No ☐
6. Safety meetings? Yes ☐ No ☐
7. Meeting Frequency: ______________________
8. Periodic self-inspections? Yes ☐ No ☐
9. Inspection Frequency: ______________________

B. Training:

Does the training program include:

1. Written training program for new employees? Yes ☐ No ☐
2. Training Director? Yes ☐ No ☐
3. Ongoing employee training? Yes ☐ No ☐

C. Other Procedures:

Does the program include:

1. Bodily Injury reporting and record keeping? Yes ☐ No ☐
2. Bodily Injury investigation? Yes ☐ No ☐

- Has entity had or been threatened with an Employer's Liability Loss/Claim? Yes ☐ No ☐

  Please provide loss history and Occupational Accident/WC Premium for the prior 3 years below.
  (all losses must be first dollar losses)

Period	Medical	Indemnity	Reserved	Fatality	#of Losses	Premium

Please list all applicable classifications for the applicant: P/T employees are defined as working less than 30 hours/week.

Class Code	Description	F/T	P/T	Monthly Payroll	Annual Payroll

INSURANCE PLAN DESIGN

COVERAGES:

- Occupational Injury Coverage
- Occupational Disease Coverage
- Cumulative Trauma Coverage
- Limited Employer's Liability Coverage

Claims Payment Method: Check one box: "Pay on Behalf of" ☐ or "Reimbursement" ☐

PLEASE SELECT DESIRED COVERAGE LEVELS:

- Combined Single Limit (per any one Person):
  $250,000 ☐ $500,000 ☐ $1,000,000 ☐ $2,000,000 ☐ $5,000,000 ☐
- Combined Single Limit (per any one Occurrence):
  10 times the above Combined Single Limit up to maximum of $20,000,000
- Deductible (per any one person, any one Occurrence):
  $1,000 ☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ $100,000 ☐ Other $_________
- Combined Benefit Period:
  110 weeks ☐ 156 weeks ☐
- Weekly Indemnity:
  75% of weekly earnings to a maximum of $600
- Elimination Period:
  7 days ☐ 14 days ☐
- Annual Policy Aggregate: $25,000,000
- Combined Benefit Amount: as per Plan Document

It is recommended that entity consult with its legal advisors to ensure that it fully understand the coverage provided.

The undersigned understands that the insurance coverage being offered is conditioned upon the undersigned's employees' consent to enter into arbitration governed by the Federal Arbitration Act between the undersigned and its respective employees. Company reserves the right to void coverage if an employee fails to consent to binding arbitration.

The coverage applied for shall not be effective until the request for policy is approved and accepted by Company, and a policy is issued. No agent has the authority to bind coverage.

The undersigned entity understands that he or she may be subject to an on-site loss control/safety inspection by a certified safety consultant, as a contingency for coverage acceptance. The entity also understands and agrees that he or she will be required to comply with any/all loss control/safety recommendations as a contingency for continuation of coverage.

Non-subscribers legal compliance is the sole responsibility of entity. Entity should seek tax and/or legal counsel with respect to satisfaction of all state and federal legal requirements relating to its status as a non-subscriber and other matters relating to the coverage applied for. Entity may obtain current instructions and forms relating to Texas reporting and disclosure requirements (including, but not limited to, the annually required DWC-5) by calling Texas Compensation Commission at (512) 448-7900.

Brentwood Services Administrators, Inc. will administer claims under the insurance Policy on behalf of Company, which may include providing the Named Insured with confirmations regarding amounts that will be reimbursed or paid on behalf of the Named Insured under the Policy.

The entity acknowledges that agent has explained and entity understands that the insurance Policy provides indemnification to the Named Insured to reimburse or pay on behalf of the Named Insured for certain types of loss that result from bodily injury to covered employees.

The undersigned entity understands that by purchasing the insurance coverage, the entity is establishing an occupational injury plan of insurance which is subject to the Employee Retirement Income Security Act (ERISA). The entity understands and acknowledges that legal compliance is the sole responsibility of the entity.

Acceptance of coverage is contingent upon verification of the following: (1) Company's ERISA plan document; and (2) binding arbitration procedures.

Signature of Authorized Person for Proposed Insured: ____Date: _______________

Print Name: ____ Title: __________________________________

Signature of Writing Agent:____ Date: ____________________

Print Name: ____ Title: __________________________________

Signature of AIM Representative: ____ Date: ____________________

Print Name: ____ Title: __________________________________

THIS INSURANCE CONTRACT IS WITH AN INSURER NOT LICENSED TO TRANSACT INSURANCE IN THIS STATE AND IS ISSUED AND DELIVERED AS A SURPLUS LINES COVERAGE PURSUANT TO THE TEXAS INSURANCE STATUTES. THE STATE BOARD OF INSURANCE DOES NOT AUDIT THE FINANCES OR REVIEW THE SOLVENCY OF THE SURPLUS LINES INSURER PROVIDING THIS COVERAGE, AND THE INSURER IS NOT A MEMBER OF THE PROPERTY AND CASUALTY INSURANCE GUARANTY ASSOCIATION CREATED UNDER THE INSURANCE CODE, ARTICLE 21.28C. THE INSURANCE CODE, ARTICLE i. 14-2, REQUIRES PAYMENT OF 4.85 PERCENT TAX ON GROSS PREMIUM.

THIS IS NOT A POLICY OF WORKERS' COMENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

FOR HOME OFFICE USE ONLY

APPROVED: YES______ NO_______ DATE: _________________________

ERISA PLAN WORKSHEET

Company's Legal Name: ____

President of Company: ____

Physical Address: ____

____

Mailing Address: ____

____

Telephone #: ______________________________Fax#:_________________________________

Federal Tax ID# : ___________________________

Contact Person & Title (The ERISA Plan Administrator):

____

Number of Employees: ______________________

Plan Effective Date: _________________________

Insurance Agent Information:

Agent Name: ____

Physical Address: ____

____

Telephone #: ______________________________Fax#:_________________________________

The Plan Identification number will be "______ " unless you have another employee welfare plan, such as a group health plan, which is designated "______." If you have another welfare benefit plan, please indicate what the Plan Identification Number is here. ______________________________

EMERGENCY CONTACT INFORMATION FOR TRAVEL ASSISTANCE

TEXAS NON-SUBSCRIBER INSURANCE

To completed by Home Office

Policy Number: Policy Effective Date:

POLICYHOLDER INFORMATION

Name:

Address:

City: State: TX Zip Code:

Subsidiaries to be covered:

The following is to be completed by the proposed insured:

- **CORPORATE CONTACT INFORMATION FOR TRAVEL ASSISTANCE**

(This information is to be used only for notification when travel assistance medical services are utilized and for driver and/or family member eligibility verification. Information should provide access to contacts on a 24-hour emergency basis only.) **Please Print**

Employer's Name: ____

Primary Contact Name:
Title:
E-Mail Address:
Business Telephone:
Home Telephone:
Cell Phone:
Address (if different from above):

Secondary Contact Name:
Title:
E-Mail Address:
Business Telephone:
Home Telephone:
Cell Phone:
Address (if different from above):