REQUEST TO BIND

AND CERTIFICATION

According to the policy provisions, Service Lloyds, or its representative, may audit your payroll records at any time during normal business hours and up to three (3) years after the policy has expired. If it is determined that premiums have been overpaid, then the company will refund that portion of the premium. If found that the premiums have been underpaid, the company shall be entitled to collect that amount.

A. The applicant, by signing below, requests coverage based on the quote provided. The applicant agrees to all terms and conditions outlined in the policy. The applicant further agrees and understands that the request for coverage and payment of premium does not constitute coverage unless accepted by the company and a binder confirmation issued, which will then become effective on the date stated on the binder.

B. The policy, if issued, will be subject to the following requirements, including loss control, and implementation of the ERISA document with the Summary Plan Description (SPD) being distributed to all employees within 10 days of receipt, and to all new hires by first day of employment.

D. The applicant agrees, upon being issued a binder/policy for coverage, to promptly notify Service Lloyds Insurance Company of any changes in operation, ownership, or management of insured, including newly acquired entities or merger/consolidation of businesses.

E. The undersigned insured and agent understands that this policy is subject to coverage limitations, terms, conditions, and exclusions as shown in the policy and that no payment or coverage's will be afforded under the policy if the policy limit or benefit period has been exhausted.

F. The applicant understands and agrees that Service Lloyds will use the faxed copy of the check for automatic check handling and draft the applicants account to put coverage in place. Check must be made payable to Service Lloyds.

G. The applicant attests by signing below that no material misrepresentation has been made on any pages or attachments for a request to quote, the application, including attachments, or certification and request to bind.

Applicant's Signature: ________________________________ Title: ____________ Date: ______________
(officer, if corp.; or owner if partnership or individual)

The undersigned agent warrants he/she has not represented the above coverage as anything other than occupational accident insurance, an alternative to workers' compensation, for on-the-job injuries to employees, subject to policy limitations/exclusions.

Agent's Signature: ____

Print Agency and Agent Name: ____

Address: ________________________ City ________________ State ________ Zip ____________

Phone Number ______________ Fax ________________ E-mail ________________________

Revised 8/7/06

POLICYHOLDER DISCLOSURE NOTICE OF TERRORISM INSURANCE COVERAGE

Coverage for acts of terrorism will be included in your current policy, unless rejected. You should know that, effective November 26, 2002, under your existing coverage, any losses caused by certified acts of terrorism would be partially reimbursed by the United States under a formula established by federal law. Under this formula, the United States pays 90% of covered terrorism losses exceeding the statutorily established deductible paid by the insurance company providing the coverage. The portion of your annual premium that is attributable to coverage for acts of terrorism is: $50 for 0-50 employees; $100 for 51-100 employees, $250 for 101-150 employees, $275 for 151-200 employees, and $300 for over 200 employees.

I ACKNOWLEDGE THAT I HAVE BEEN NOTIFIED THAT UNDER THE TERRORISM RISK INSURANCE ACT OF 2002, ANY LOSSES CAUSED BY CERTIFIED ACTS OF TERRORISM UNDER MY POLICY COVERAGE WILL BE PARTIALLY REIMBURSED BY THE UNITED STATES AND I HAVE BEEN NOTIFIED OF THE AMOUNT OF MY PREMIUM ATTRIBUTABLE TO SUCH COVERAGE.

I ACCEPT this coverage ☐

I REJECT this coverage and no premium will be charged ☐

Policyholder/Applicant's Signature

____

Name (print)

Date____________________

Name of Insurer: SERVICE LLOYDS INSURANCE COMPANY

Nonsubscription Application
Attn: James Sides Fax # 512-485-2726

Applicant Name ____ Requested Effective Date: ________________

Address____ City: ____________ State: _____Zip:_______

Complete description of operations:

Number of years in business:___________Phone #______________________ Tax ID# ________________________

Business Type: ______Corporation _______ Partnership ________Individal ________Other: ______________________

For Corporations/LLC's include all executive officers named in corporate charter or by-laws; Partnerships include all partners & spouses, Sole Proprietors/Individuals include owner and spouse, Limited Partnerships include general and limited partners

Names	% Ownership	Class Code	Payroll (limitations may apply)	Included / Excluded

Is applicant subject to *LPG* or TXDOT Regulations? ______Yes_____No. Within what radius does applicant haul:___________

Does applicant handle, store, or engage in transport of hazardous materials (including but not limited to explosive, caustic, poisonous or flammable materials)? _____ Yes _____ No. If Yes, please explain: ____

Please specify commodities hauled:_____________________ What percent of loads are manually loaded or unloaded? _________

Does applicant perform any work at heights above 2 stories? ___ Yes ___No. If Yes, please explain what type work and how high_______

# of Full-Time	# of Part-Time	Classification Code	Annual Payroll by Class	Classification or Description

Waiver of Subrogation. ______Yes ______No Blanket _______ Specific ________(give name & address) ____________________

Are 1099 workers' to be covered under the policy? ____Yes ____No If yes, list the name(s) of those workers' as they must be endorsed onto the policy to afford coverage____.

CIRCLE BENEFIT LEVELS REQUESTED:

Per Accident: $1,000,000, $2,000,000 $3,000,000 Per Employee: $1,000,000, $2,000,000, $3,000,000 Aggregate: $3,000,000, $5,000,000

Deductible: $1,000, $2,500, $5,000, $10,000, negotiated (for accounts over $100K in premium)

Note: OD/CT included. EL Included (defense cost outside policy limits). Benefit period 156 weeks. Waiting period 7 days.

GA: The Comp Solutions Network Inc

SERVICE LLOYDS
INSURANCE COMPANY

Nonsubscription Application
Attn: James Sides Fax # 512-485-2726

Please summarize losses below and submit 3 years currently valued loss runs: (valuation date of loss information within past 60 days)

Year:____________ Carrier :________________ Incurred Losses: ___________________ Description of Each Loss in ***Excess*** *of $10,000*
(Use separate sheet if necessary)

_____________ ________________ __________________

_____________ ________________ __________________

1. *Attach a copy of current experience modifier. If not experience rated, please indicate reason: _____________*
2. *Has the applicant (or affiliate) ever had an Employer's Liability claim? _____ Yes ____ No*
3. *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? ___ Yes _____ No*
4. *Any bankruptcies in past 5 years? ______Yes ______No*

If the answer to #2 or #3 is YES, please give a complete descriptions, dates, and amounts of claims on a separate sheet.

Safety Information: (A Written/Active Safety Program is mandatory)

1. *Does applicant have a written safety/loss control program currently being enforced? ___Yes ___No*

   If yes, attach a copy of the Table of Content for the program. If No, Will a written safety program be implemented with in 30 days of binding? ___Yes ___No
2. *Does the safety program include the following:*
   - a. *Written Safety Manual _____Yes _____No*
   - b. *Safety Incentive Program _____Yes _____No*
   - c. *Safety Meetings _____Yes _____No how frequently ____*
   - d. *Safety Director _____Yes _____No Name of Director ____*
   - e. *Periodic Self-Inspections? _____Yes _____No*
   - f. *Safety Committee _____Yes _____No*
   - g. *Alcohol/drug Testing ______Yes ______No.*
   - h. *Pre-employment _____Yes _____No.*
   - I. *Post accident _____Yes _____No*
   - J. *Bodily Injury Reporting and Record Keeping _____Yes _____No Bodily Injury Investigation ____Yes ____No*
3. *Has applicant ever had any OSHA violations? _____Yes _____No*
4. *Has any OSHA recommendations not been met? _____Yes _____No*
   If yes to question 3 or 4, please explain ____

Are there any other businesses owned or operated by this entity or any of its owners/officers, which has not been included? _____Yes ____No If yes, please explain ____

Has workers' compensation coverage or occupational accident coverage ever been cancelled, refused or non-renewed? ______Yes _______No. If yes, Explain: ____

Does applicant currently have an ERISA plan? ____Yes _____No If yes, will applicant use their current plan? _____Yes ____No. If yes, provide a copy of the full plan document and the Summary Plan Description (SPD).

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 application, along with any verbal or attached data, in considering whether to provide the requested insurance coverage.

Agent: ____________________________________ *Phone ______________________________________*

Address: __________________________________ *Fax: ______________________________________*

Agent Signature: ____________________________ *Applicant Signature: ___________________________________*

Note: A quote can be provided without signature; however, if binding is requested, both the insured and agent must sign the application form, as well as the policyholder disclosure notice of terrorism insurance coverage form. The agent has no binding authority.

This is not an insurance binder. The above information is only a request to quote or bind occupational accident insurance. This is not a request for workers' compensation insurance. If the employer purchases a policy for general liability/ workers' occupational accident insurance the employer loses defenses and benefits, which would otherwise be afforded under the Workers' Compensation laws of the state of Texas. Required filings and postings must be made.