30 S 17th Street, Suite 1500, Philadelphia, PA 19103 | 302.654.1435 | www.dcrb.com

APPLICATION FOR WORKERS COMPENSATION ASSIGNED RISK PLAN

This application must be typed or printed and filed in duplicate.

Please answer all questions and requested information thoroughly. Omissions may result in delay of coverage. The undersigned employer hereby applies for workers compensation insurance in Delaware and expressly represents that such insurance is sought in good faith.

IMPORTANT: **NO** insurance is provided by this application. Coverage will be bound as of 12:01 A. M. the day following the Federal postmark time and date on the envelope in which the fully completed application is mailed (including the estimated annual or deposit premium), or the expiration of existing coverage, whichever is later. If there is no postmark, coverage will be effective 12:01 A.M. of the date of the receipt by the Bureau unless a later date is requested. Submission of an incomplete or incorrect application may delay the binding of coverage. Applications hand delivered to the Bureau will be effective as of 12:01 A.M. of the date following receipt by the Bureau unless a later date is requested.

I. General Information

Requested Effective 12:01 A.M. (Date): ______________________

1. ____
   Name of Employer

2. ______________________________ *F.E.I.N. Required by Law*
   Federal Employers Identification Number

3. ____
   Mailing Address

4. ____
   Principal Location of Business (Required)

5. ____
   Other Delaware Locations

6. ____
   Payroll Office Address

7. Legal Status: Sole Proprietor Partnership Corporation Limited Liability Title 19 - Independent Contractor
   Other (explain): ______________________________

8. Has there been a name change during the past three years? Yes No

   If "Yes", give previous name and date of change: ______________________________
   ____

9. Are there operations in states other than Delaware? Yes No

   If "Yes", complete the following: *(If self-insured or uninsured, indicate under Insurance Carrier.)*

State	Location	Insurance Carrier

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II. Insurance Record

1. Has there been previous workers compensation insurance coverage in Delaware? Yes No

   If "No", complete: New Business Self-Insured Other (explain): ______________________

   If "Yes", complete Insurance Record - Three Previous Years:

State	Insurance Company	Policy Number	Policy Period		Premiums
			From	To	

2. Total **audited** payroll for each of the above policy periods:

Policy Period		Payroll
From	To	

3. Do you owe any broker, agent, insurance company or state workers insurance fund unpaid premiums for workers compensation coverage? Yes No

   If "Yes", coverage may be denied or canceled. Explain: ______________________

4. Is applicant a parent, affiliate, or subsidiary or under common ownership or management with any other entity subject to state workers compensation laws or other applicable federal law? Yes No

   If "Yes", must **attach** information identifying the entities involved and the workers compensation insurance or self-insurance status.

III. Two Insurance Companies Who Have Refused Insurance

List below name of representative and phone numbers of two companies who have refused coverage in the past sixty days. The representative named must be a full-time employee of the insurance company. Current carrier must be one of the carriers declining coverage. The DCRB may require verification of carrier's declination.

Insurance Company	Name of Representative	Phone Number
Current Carrier:		

IV. Corporate Officer(s)

List below the name (s), title, duties and approximate annual salary of all officers or Limited Liability Company members. Officer or member salaries are subject to a minimum/maximum respectively. Note: Officers electing exclusion **must** complete and **attach** Agreement by Executive Officer(s) / LLC form.

Name	Title	Duties	Approx. Annual Salary	Excluded? Y/N

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V. Delaware Law provides that sole proprietors or partners are not included under the Act but may elect coverage. Title 19 of the Delaware Code requires independent contractors and subcontractors to be covered.
Complete: Sole Proprietors, Partners, Officers and other Coverage Endorsement (WC 00 03 10) – if applicable.

Name	Title	Duties	Approx. Annual Salary	Included? Y/N

VI. Nature of Business, Location, Classifications and Payroll in Delaware

Manufacturing Mercantile Contractor Service Farm Other: ____________

Explain nature of business / completely describe all operations at this or any other location. Give description of products and list of raw materials (Do not use manual phraseology for description).

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Calculation of Estimated Annual Premium:

Manual Classification of:	Total Payroll Basis					
Employees by Location	Class Code	No. of Employees	Total Payroll	USL&H? Y/N	Rate	Premium
Increased Limits of Liability (if applicable)						
Payroll Not included above for:						
Executive Officer(s)						
Sole Proprietor or Partner(s)						
Limited Liability Company Member(s)						

Total Premium ____________
Experience Modification (Code 9898) ____________
Standard Premium ____________
Merit Rating Adjustment (Code 988) ____________
Workplace Safety Credit (Code 9880) ____________
Construction Prem. Credit (Code 9046) ____________
Surcharge (DIP) (Code 0277) ____________
Deductible Credit (Code 9663) ____________
Less Premium Discount (Code 0063) ____________
Plus Expense Constant (Code 0900) ____________
Terrorism Risk Ins. Act (Code 9740) * ____________
Domestic Terrorism, Earthquake, Catastrophic Industrial Accidents (9741) * ____________
Total Estimated Annual Premium ____________
Percentage of Annual Estimated Premium used to determine Deposit Premium ____________
(Enclose Agent's or Employer's Certified Check in this Amount) Deposit Premium ____________

* Codes 9740 & 9741 premium charge is calculated by dividing total payroll by $100 and multiplying the result times the residual market rate for the code.

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VII. Deposit Premium

Procedures to follow in determining the proper deposit premium are printed below. Failure to follow the deposit premium rule correctly may delay the effective date of coverage. Based on the deposit premium rule, the following method of premium payment has been determined:

Annual – 100% Semi-annual – 75% Quarterly – 50% Monthly – 25%

Deposit premium is determined by taking a percentage of the annual premium. The percentage varies with the amount of the estimated annual premium. The "deposit premium" table is followed by the servicing carrier. Here is how it works:

Estimated Annual Premium	Interim Adjustment Basis	Minimum Deposit Percentage	Additional Payments During Year
Under $1,000	Annual	100% of annual	None
At least $1,000	Semi-annual	75% of annual	One
At least $5,000	Quarterly	50% of annual	Three
At least $25,000	Monthly	25% of annual	Eleven

An employer may pay the estimated annual premium as a deposit or may select any adjustment basis available. The servicing carrier, based on sound underwriting practices, has the right to make appropriate changes in the interim adjustment program which the employer has selected. The servicing carrier will give the reasons for any change. The DCRB cannot make changes to the Interim Adjustment Basis.

Deposit Premium Payment

Enclose agent or employer's certified check. Coverage will not be bound without payment of deposit premium.
Enclosed is Check No. ________ made payable to the Delaware Compensation Rating Bureau, Inc. in the amount of __________

VIII. Applicant's Statement

The undersigned employer hereby certifies that he has read and understands the statements in this application. Furthermore, in consideration of the issuance of the policy of insurance he also certifies that the statements in this application are true and agrees:

1. 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.
2. To comply substantially with all laws, order, rules and regulations in force and effect made by the public authorities relating to the welfare, health and safety of employees.
3. To comply with all reasonable recommendations made by the insurance company relating to the welfare, health and safety of employees.

The undersigned employer also certifies they have no difficulties with any broker, agent, insurance company or state workers insurance fund regarding: (a) payroll records; (b) the amount of premium charges; (c) the payment of premium; (d) the carrying out of any recommendation made for the purpose of safeguarding its employees; (e) the handling of any claim or accident report except the following:

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This insurance is being afforded through the Delaware Workers Compensation Insurance Plan and not through the private market. Violation of any of these agreements, or failure to pay valid workers compensation premium charges, may result in cancellation of any policy of insurance under the Delaware Workers Compensation Insurance Plan.

Employer Name and Title: ______________________ Date: __________
Signature*: ______________________ Phone No.: __________
** Application must be signed by an officer or owner.* Email Address (optional): __________

IX. Agency and Producer

Agency Name: ______________________ Phone No.: __________
DE Agent License No.: ______________________ Fax No.: __________
Address: ______________________ Email Address: __________
Producer Name: ______________________ Date: __________
Agent Signature: ______________________ F.E.I.N.: __________