Delaware Compensation Rating Bureau, Inc.

The Widener Building • 6th Floor
One South Penn Square
Philadelphia, PA 19107-3577
(302) 654-1435 (215) 568-2371
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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

☐☐☐☐☐☐☐☐☐ F.E.I.N. Required By Law

2. Federal Employers Identification Number

Social Security 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 ☐ 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

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", Insurance Record - Three Previous Years:

			Policy Period		
State	Insurance Company	Policy Number	From	To	Premiums

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

	Policy Period	
Payroll	To	From

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", 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 telephone 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	Telephone Number
Current Carrier:		

IV. Corporate Officer

List below name, title, duties, and approximate annual salary of officers. Officer's salary subject to a minimum/maximum of $18,200/$106,600 respectively. **Note:** Officers electing exclusion must complete and attach Agreement by Executive Officer(s) form.

Name	Title	Duties	Approx. Annual Salary

V. Delaware Law provides that sole proprietors or partners are not included under the Act but may elect coverage. Complete Sole Proprietors, Partners, Officers and other Coverage Endorsement (WC 00 03 10) - Complete, if applicable

Name	Title	Duties	Approx. Annual Salary

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).

Calculation of Estimated Annual Premium — Total Payroll Basis

Manual Classification of:					
Employees By Location	Class Code	No. of Employees	Total Payroll	Rate	Premium
Increased Limits of Liability (if applicable)					
Officers covered: Payroll not included above					

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) $250

Foreign 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 _____

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's 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 he has had no difficulties with any broker, agent, insurance company or state workers insurance fund in regard to : (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:

_____

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***** _____ Telephone No. (____) _____

***Application must be signed by an officer or owner.** E-mail address (optional) _____

IX Agency and Producer

Agency Name_____ Telephone No. (____) _____

Delaware Agent License No._____ Fax No. (____) _____

Address _____ E-mail address_____

Producer_____ _____ _____

Name **Signature** **Date**

Fed. Emp. I.D. No/Soc. Sec. No._____