Maverick General Agency, Inc.

The Agents Edge to the Occupational Injury Marketplace

Please fax this completed form to Luann Bognar at (972) 421-0805.
For assistance, please call (877) 437-1712 or via e-mail at lbognar@msltx.com

Applicant Name _____ Requested Effective Date _____

Address _____ CITY _____ ST __ ZIP _____ Nature of Business _____

Number of years in business: _____ Tax ID# _____ Date of workers' comp coverage rejection: _____

Has worker's comp or occupational accident coverage ever been canceled, refused or non-renewed? ☐Yes ☐ No

If Yes, please explain: _____

Business Type: ☐ Corporation ☐ Partnership ☐ Other: _____

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 percentage of loads are manually loaded or unloaded *(use 0% if no manual (un)loading)*? ____% Loaded _____% Unloaded

Does applicant perform any work at heights over 24 ft.? ☐ Yes ☐ No. If Yes, please explain: _____

Are Owners, Officers or Partners to be covered? ☐Yes ☐No. Are any affiliate companies to be covered? ☐ Yes ☐No. If yes, please provide Legal Name, Address and number of employees at each location.

# of Full-Time EES	1099	# of Part-Time EES	1099	Classification Code	Annual Payroll by Class (Including Tips)	Classification or Description

Total Number of Employees _____ Total Payroll $_____ Waiver of Subrogation? ☐ Yes ☐ No

Current Worker's Comp or Accident Premium: $_____ Occupational Disease & Cumulative Trauma? ☐ Yes ☐ No

Benefits to be Quoted: ***LIMITS VARY BY PRODUCT. PLEASE CALL FOR OTHER OPTIONS.***

CSL Benefit: _____ *($1,000,000 - $2,000,000)*

Deductible: _____ *($1,000 - $500,000 deductible)*

Death Benefits _____ *($50,000 to $500,000 Limits available)*

Benefit Period: ☐52 Wks ☐104 Wks ☐156 Wks Weekly Income: (75% up to $900) _____ Waiting Period: _____ days

Please submit 3 years (hard copy) current valued loss history: Valuation Date of loss information: _____

Year	Carrier	Total Losses	Description of Each Loss in Excess of $5,000 (Use separate sheet if necessary)

1. Has this applicant (or affiliate) been in the Texas Workers' Compensation System in the last 3 years? If yes, have they had an experience modification factor of 1.50% or higher?	☐ Yes ☐ No
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. Does the applicant have Employer's Excess Indemnity coverage? Carrier Name:	☐ Yes ☐ No
5. In the last 5 years, have you been issued any OSHA citations?	☐ Yes ☐ No

If the answer to #2, #3 or #5 is YES, please give a complete descriptions, dates, and amounts of claims on a separate sheet.

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; and (c) this Fax-A-Quote shall become a part of the Policy should coverage be bound.

Agent: _____ Phone: _____

Address: _____ Fax: _____

Agent Signature: _____ Applicant Signature: _____