ACORD™

NORTH CAROLINA WORKERS COMPENSATION INSURANCE PLAN
APPLICATION FOR DESIGNATION OF AN INSURANCE COMPANY

DATE (MM/DD/YY)

This application must be typed or printed and filed, in duplicate, with:

NORTH CAROLINA RATE BUREAU
P.O. BOX 176010, 5401 SIX FORKS ROAD
RALEIGH, NORTH CAROLINA 27619-6010

Failure to fully answer all questions, remit proper form or amount of deposit premium and/or include required signatures may result in a delay of coverage.

THIS APPLICATION DOES NOT PROVIDE INSURANCE.

FOR BUREAU USE ONLY

FILE NO	
EXP MOD	ARAP
EFF	EXP
CO CODE	CHECK
PREMIUM QUOTE SENT	OVERRIDE

PURSUANT TO AND IN COMPLIANCE WITH NC GS 58-36-1(5), THE UNDERSIGNED EMPLOYER HEREBY APPLIES FOR THE DESIGNATION OF AN INSURANCE COMPANY TO PROVIDE INSURANCE IN ACCORDANCE WITH THE PROVISIONS OF THE NORTH CAROLINA WORKERS COMPENSATION INSURANCE PLAN.

1. APPLICANT NAME (Enter complete legal name of employer)

TELEPHONE # (Incl Area Code):

FAX (Incl Area Code):

FEIN/SOCIAL SECURITY NUMBER

2. MAILING ADDRESS (Including ZIP Code)

3. LEGAL STATUS

☐ INDIVIDUAL ☐ CORPORATION ☐ OTHER:
☐ PARTNERSHIP ☐ LIMITED LIABILITY CO

YEARS IN BUSINESS

4. REQUESTED EFFECTIVE DATE

NOTE: NC GS 58-36-1(5) MAY DETERMINE COVERAGE EFFECTIVE DATE.

5. LOCATION OF ALL NORTH CAROLINA WORK PLACES (Show principal location first)

#	STREET, CITY, COUNTY, STATE, ZIP CODE	#	STREET, CITY, COUNTY, STATE, ZIP CODE
1		3	
2		4	

PAYROLL OFFICE ADDRESS (Street, City, State & ZIP Code)	CONTACT PERSON & TELEPHONE NUMBER (Including Area Code)

6. NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS

GIVE COMPLETE DESCRIPTION OF BUSINESS AND OPERATIONS, INCLUDING PRODUCTS MANUFACTURED, SOLD OR SERVICED.

7. GENERAL INFORMATION

	YES	NO
1. HAS THERE BEEN PREVIOUS WORKERS COMPENSATION INSURANCE COVERAGE IN THIS STATE OR ANY OTHER STATE? IF NO: ☐ NEW BUSINESS ☐ SELF INSURED ☐ OTHER:		
2. IS THERE ANY UNPAID WORKERS COMPENSATION PREMIUM DUE OR IN DISPUTE FROM YOU OR ANY COMMONLY MANAGED ENTERPRISES? IF YES, EXPLAIN, INCLUDING NAMED INSURED AND POLICY NUMBER.		
3. HAS THERE BEEN A NAME CHANGE, CONSOLIDATION, MERGER OR OWNERSHIP CHANGE DURING THE PAST FIVE YEARS? IF YES, GIVE PREVIOUS NAME AND DATE OF CHANGE. CONTACT BUREAU ABOUT AN ERM-14.		
4. ARE THERE ANY OPERATIONS IN STATES OTHER THAN NORTH CAROLINA? IF YES, LIST THE STATES:		
5. ARE YOU REQUESTING COVERAGE FOR ANY OF THOSE STATES? (EXTENSION OF COVERAGE TO OTHER STATES IS SUBJECT TO DESIGNATED CARRIER REVIEW AND APPROVAL. COVERAGE MAY NOT BE AVAILABLE IN SOME STATES.) IF YES, LIST THE STATES:		
6. DO YOU LEASE WORKERS FROM A LABOR CONTRACTOR? IF YES, ATTACH A COMPLETED CLIENT SUPPLEMENTAL EMPLOYEE LEASING APPLICATION.		
7. DO YOU LEASE WORKERS TO A CLIENT COMPANY? IF YES, ATTACH A COMPLETED LABOR CONTRACTOR SUPPLEMENTAL EMPLOYEE LEASING APPLICATION (SIDE A).		
8. ARE YOU SEEKING TO COVER THE LEASED WORKERS? IF YES, ATTACH A COMPLETED LABOR CONTRACTOR SUPPLEMENTAL EMPLOYEE LEASING APPLICATION (SIDES A & B) FOR EACH CLIENT.		
9. DO TRUCKING CLASSIFICATIONS APPLY? IF YES, ATTACH A COMPLETED TRUCKERS SUPPLEMENTAL APPLICATION.		

8. INSURANCE RECORD

PROVIDE INFORMATION FOR THREE PREVIOUS YEARS

STATE	INSURANCE COMPANY	POLICY PERIOD FROM	POLICY PERIOD TO	ANNUAL PREMIUM

9. CORPORATE OFFICERS, SOLE PROPRIETOR, PARTNERS OR MEMBERS OF A LIMITED LIABILITY COMPANY

LIST BELOW NAME AND TITLE OF ALL OFFICERS, SOLE PROPRIETOR, GENERAL PARTNERS OR MEMBERS OF A LIMITED LIABILITY COMPANY. IF COVERED, ALSO LIST DUTIES AND APPROXIMATE ANNUAL SALARY.

NAME AND TITLE	COVERAGE ELECT/REJECT		DUTIES	APPROXIMATE ANNUAL SALARY

EXECUTIVE OFFICERS OF A CORPORATION ARE AUTOMATICALLY COVERED UNDER THE ACT. ANY EXECUTIVE OFFICER MAY BE SPECIFICALLY EXCLUDED FROM COVERAGE. THE PAYROLL, SUBJECT TO INDIVIDUAL MAXIMUM OR MINIMUM LIMITATIONS AS SHOWN ON THE NORTH CAROLINA RATE PAGES FOR ALL COVERED OFFICERS, MUST BE INCLUDED IN THE PREMIUM CALCULATION SECTION.

SOLE PROPRIETORS, PARTNERS AND MEMBERS OF A LIMITED LIABILITY COMPANY ARE NOT AUTOMATICALLY COVERED UNDER THE ACT. ANY SOLE PROPRIETOR, PARTNER OR MEMBER OF A LIMITED LIABILITY COMPANY MAY ELECT TO BE COVERED. THE PAYROLL, AS SHOWN ON THE NORTH CAROLINA RATE PAGES FOR THOSE COVERED INDIVIDUALS, MUST BE INCLUDED IN PREMIUM CALCULATION SECTION.

10. CALCULATION OF NORTH CAROLINA ESTIMATED ANNUAL/DEPOSIT PREMIUM

EMPLOYEE DUTIES OR CLASSIFICATION PHRASEOLOGY	CLASS CODE	# OF EMPLOYEES	TOTAL PAYROLL	RATE	PREMIUM

DEPOSIT PREMIUM IS DETERMINED BY TAKING A PERCENTAGE OF THE ESTIMATED ANNUAL PREMIUM. THE PERCENTAGE VARIES WITH THE AMOUNT OF THE ESTIMATED ANNUAL PREMIUM. HERE IS HOW IT WORKS:

ESTIMATED ANNUAL PREMIUM	PAYMENT BASIS	MINIMUM DEPOSIT PERCENTAGE	ADDITIONAL PAYMENTS DURING YEAR
UNDER $5,000	ANNUAL	100% OF ANNUAL	NONE
AT LEAST $5,000	SEMIANNUAL	75% OF ANNUAL	ONE
AT LEAST $10,000	QUARTERLY	50% OF ANNUAL	THREE

SUCH ADDITIONAL PAYMENTS SHALL BE IN EQUAL AMOUNTS. THE SUM OF WHICH, WHEN ADDED TO THE DEPOSIT PREMIUM, SHALL EQUAL 100% OF ESTIMATED ANNUAL PREMIUM. ESTIMATED ANNUAL PREMIUM AND THE PAYMENT SCHEDULE ARE SUBJECT TO ADJUSTMENT AT INTERIM OR FINAL AUDIT, AND A RISK MAY SELECT A HIGHER DEPOSIT PREMIUM AT INCEPTION.

THIS "DEPOSIT PREMIUM" TABLE IS FOLLOWED BY THE DESIGNATED CARRIERS. THE DESIGNATED CARRIER, BASED ON SOUND UNDERWRITING PRACTICES, HAS THE RIGHT TO MAKE APPROPRIATE CHANGES IN THE PAYMENT BASIS WHICH THE EMPLOYER HAS SELECTED. THE DESIGNATED CARRIER WILL GIVE THE REASONS FOR ANY CHANGE.

PREMIUM SUB-TOTAL		
EXPERIENCE MOD		
ARAP FACTOR		
PLUS EXPENSE CONSTANT		
MINIMUM PREMIUM		
ESTIMATED ANNUAL PREMIUM		
DEPOSIT PREMIUM	%	

11. ADDITIONAL INFORMATION

ADDITIONAL INFORMATION, SUCH AS, BUT NOT LIMITED TO TAX DOCUMENTATION, OWNERSHIP INFORMATION, OPERATIONS OR CONTRACTS, MAY BE REQUIRED TO CONFIRM ELIGIBILITY, CLASS CODES, ESTIMATED PAYROLLS OR OTHERWISE PROCESS THE APPLICATION. ANY ADDITIONAL INFORMATION REQUESTED MUST BE FURNISHED BY THE EMPLOYER OR ITS REPRESENTATIVE.

12. PREMIUM PAYMENT

1. COVERAGE WILL NOT BE ASSIGNED UNTIL PAYMENT OF APPROPRIATE DEPOSIT PREMIUM. IF PAYMENT IS NOT RECEIVED WITH THIS APPLICATION, THE BUREAU WILL CALCULATE THE ESTIMATED ANNUAL PREMIUM ON THE BASIS OF AVAILABLE INFORMATION. DEPOSIT PREMIUM, PAYABLE TO THE NORTH CAROLINA RATE BUREAU, MUST BE IN THE FORM OF A CERTIFIED OR CASHIER'S CHECK, MONEY ORDER, CHECK OF A PREMIUM FINANCE COMPANY LICENSED IN NORTH CAROLINA OR CHECK OF THE AGENT OR PRODUCER.
2. IS THE PREMIUM FINANCED? ☐ YES ☐ NO IF YES, ATTACH A SIGNED COPY OF THE FINANCE AGREEMENT.

13. APPLICANT'S STATEMENT

THE UNDERSIGNED EMPLOYER (1) CERTIFIES THAT THE INFORMATION WHICH HAS BEEN GIVEN TO THE AGENT FOR THE COMPLETION OF THIS APPLICATION IS ACCURATE TO THE BEST OF THEIR KNOWLEDGE AND BELIEF AND (2) 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 DURING THE POLICY PERIOD AND FOR ONE YEAR AFTER.
2. TO COMPLY SUBSTANTIALLY WITH ALL LAWS, ORDERS, 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 HAD NO DIFFICULTIES WITH ANY AGENT OR COMPANY 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 EMPLOYEES; (e) THE HANDLING OF ANY CLAIM OR ACCIDENT REPORT EXCEPT THE FOLLOWING: _____

BY SIGNING BELOW I ACKNOWLEDGE THAT THE LOSS SENSITIVE RATING PLAN HAS BEEN EXPLAINED TO ME OR THAT AN EXPLANATORY NOTICE OR BROCHURE HAS BEEN PROVIDED TO ME AND I AGREE THAT I SHALL BE BOUND BY THE TERMS OF SUCH PLAN IF MY ESTIMATED ANNUAL PREMIUM OR PRELIMINARY PHYSICAL AUDIT PREMIUM MEETS OR EXCEEDS THE PREMIUM ELIGIBILITY REQUIREMENT.

THE INSURANCE TO BE PROVIDED IS THROUGH THE NORTH CAROLINA WORKERS COMPENSATION INSURANCE PLAN AND NOT THROUGH THE PRIVATE MARKET. VIOLATION OF ANY OF THESE AGREEMENTS, OR FAILURE TO PAY VALID WORKERS COMPENSATION INSURANCE PREMIUM CHARGES, MAY RESULT IN CANCELLATION OF ANY POLICY OF INSURANCE ISSUED UNDER THE NORTH CAROLINA WORKERS COMPENSATION INSURANCE PLAN.

PRINTED NAME **(MUST BE AN EXECUTIVE OFFICER OR OWNER)** SIGNATURE TITLE DATE

14. STATEMENT OF LICENSED AGENT OR PRODUCER OF RECORD

I, _____, DO HEREBY AFFIRM THAT I AM A LICENSED NORTH CAROLINA AGENT, AND PURSUANT TO NC GS 58-36-1(5), CERTIFY THIS APPLICANT WORKERS COMPENSATION INSURANCE RISK TO BE DIFFICULT TO PLACE.

PRODUCER OF RECORD? ☐ YES ☐ NO (PRODUCER OF RECORD MUST BE A LICENSED NORTH CAROLINA RESIDENT BROKER.)

INCLUDED IN THIS APPLICATION IS THE INFORMATION GIVEN TO ME BY THE APPLICANT. IF THE POLICY IS CANCELLED OR INSURANCE TERMINATED WHICH RESULTS IN A RETURN OF PREMIUM TO THE INSURED, I AGREE, UPON REQUEST, TO RETURN MY PROPORTIONATE SHARE OF SUCH RETURN PREMIUM.

AGENT/AGENCY NAME & MAILING ADDRESS	TELEPHONE NUMBER (Including Area Code):	FEIN/SOCIAL SECURITY NUMBER
	FAX (Including Area Code):	
	SIGNATURE	