



**SPECIAL INSURANCE SERVICES (SIS)  
PROFESSIONAL ASSURANCE RESOURCES (PAR)**

**Fax-A-Quote**

**Type of Proposal Requested:**

- Occupational Accident only  
 Occupational Accident w/Legal

**Please fax this completed form to Debbie Lynch-Baxter at 972-991-3936.  
 For assistance, please call (214) 291-1216 or (800) 767-6811 extension 1216  
 or via email at [dlynch-baxter@specialinc.com](mailto:dlynch-baxter@specialinc.com).**

Applicant Name \_\_\_\_\_ Requested Effective Date \_\_\_\_\_

Address \_\_\_\_\_ 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: \_\_\_\_\_

# of Full-Time EES 1099	# of Part-Time EES 1099	Classification Code	Annual Payroll by Class	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: \_\_\_\_\_ Deductible: \_\_\_\_\_ Waiting Period: \_\_\_\_\_ days  
 (\$100,000 - \$1,000,000 CSL available)                      (\$1,000 - \$500,000 deductible available)

Benefit Period: \_\_\_\_\_ Weekly Income Limit: \_\_\_\_\_ (75% up to \$600 standard to most policies)

**Please submit 3 years currently valued loss history below:** Valuation Date of loss information: \_\_\_\_\_

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

- |  |  |
|--|--|
| 1. If this applicant (or affiliate) is currently in the Texas Workers' Compensation System, do they have an experience modification factor of 200% or more?                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Has the applicant (or affiliate) ever had an Employer's Liability claim?  | <input type="checkbox"/> Yes <input type="checkbox"/> 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? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**If the answer to #2 or #3 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:** \_\_\_\_\_

*Note: To quote your case, we need a fax copy of your applicable inforce TX Agent's License and a fax copy of your E&O dec page.*