



**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 Lisa Mootz-Mulvihill at 972-991-3936.
 For assistance, please call (214) 291-1214 or (800) 767-6811 extension 1214
 or via email at lmootz@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.