

**APPLICATION FOR EMPLOYERS' LIABILITY COVERAGE
WEST VIRGINIA AND OHIO**

Please complete the following, answering each question. If not applicable, state so.

1 Named Insured: _____

2 Mailing Address: _____

3 All Physical locations: _____

4 Description of operations: _____

5 Contact Name, Title,
and Phone Number _____

6 If mining operator or contractor, please furnish MSHA number for each mine worked and or
contractor's MSHA number _____ Mine(s)
_____ Contractor

7 Years in business: _____ Years

8 Legal entity: _____ Corporation
_____ Sub S
_____ LLC
_____ Individual
_____ Partnership

9 Is proposed insured a subsidiary of any other entity? _____ No
_____ Yes

(if YES, details:) _____

10 Does proposed insured have any other sister companies or subsidiaries?

_____ No
_____ Yes

(If YES, complete details)

Name(s) of Sub(s): _____

Location(s) of sub(s): _____

Operation(s) of sub(s) _____

Is entity(s) insured for EL? _____ Yes
_____ No

(If YES, with who and what limits?)

Insurance Company: _____

Limits: _____

Deductible: _____

11 LIMITS OF COVERAGE REQUESTED: \$ _____

Primary limits: \$ _____

Deductible: requested \$50,000 _____
\$100,000 _____

12 Requested effective date? _____

13 Does applicant currently or plan to charter either aircraft or watercraft?

_____ Yes
_____ No

Limits of P&I? \$ _____

14 Does proposed insured furnish transportation for employees?

_____ Yes
_____ No

If YES, please furnish:

Type of transportation: _____

Frequency : _____

Number of employees: _____

15 Does the applicant have any employees who are subject to:

Longshoreman & Harbor Act? _____ Yes _____ No

Jones Act or MEL? _____ Yes _____ No

Federal Employees Liability Act? _____ Yes _____ No

16 Are there any:

Crane operations:	_____	Yes
	_____	No
Explosives used:	_____	Yes
	_____	No
Height exposure:	_____	Yes
	_____	No
Wrecking or demolition	_____	Yes
	_____	No
Tunneling, underground	_____	Yes
	_____	No
Nuclear exposure	_____	Yes
	_____	No

17 List all MSHA, OSHA and State violations and current disposition:
(If involved in healthcare, list CDC violations:

18 If any subcontractors, how does proposed insured control?

19 Rating Basis:

	Class code:	Base Rate	Payroll:
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Expiring	_____	_____	\$ _____
Mod:	_____	_____	\$ _____
Renewal	_____	_____	\$ _____
Mod	_____	_____	\$ _____

20 Comp Carrier:

21 Current carrier:

Limits:

\$ _____

22 Deductible/SIR

\$ _____

OD Coverage:	_____	Yes	_____	NO
Black Lung:	_____	Yes	_____	NO

23 Loss History:
**ATTACH CURRENTLY VALUED WC LOSS RUNS

Ever had an
EL or Stop
Gap Claim? _____ Yes _____ No

Loss details:

Are there any current circumstances that might give rise to an EL or Stop Gap
Claim? _____ Yes _____ No

Details _____

Involved in any grievance or other administrative hearings before the National
Labor Relations Board or under the Federal Fair Labor Standards Act?
_____ Yes _____ No

WARRANTY

MINIMUM EARNED REGARDLESS OF TIME IS 25%
NO RETURN PREMIUM AT AUDIT
COVERAGE IS OFFERED BY A SURPLUS LINES CARRIER
GUARANTY FUND IS NOT APPLICABLE TO SURPLUS LINES
CARRIER

Applicant company warrants to the best of its knowledge and belief that the
statements set forth herein are true and include all material information.

Applicant further warrants that if the information supplied on
this application changes between the date of this application and the inception
date of the policy period it will immediately notify Hehr & Associates, Inc. of any
such change(s).

The signing of this application does not bind the company to offer nor the applicant
to accept insurance, but it is agreed that this application shall be the basis of the
insurance should a policy be issued.

Insured Representative:

(Signature)

(Print Name)

(Title)

(Date)