Great American E&S Insurance Company
Administrative Offices
301 East 4th Street
Cincinnati, OH 45202
1-513-369-5000

Application for Primary Employer's Indemnity Policy

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

Application is hereby made for coverage(s), as specified per the attached signed quotation(s). The Primary Employer's Indemnity Policy is to become effective on _____, at 12:01 AM Central Standard Time at the address described below and provided that the premium is paid and Great American E & S Insurance Company ("Company") approves this Application. **This Application will become part of the Policy.**

Retail Agency Name & Address	**Retail Agent Name (please print) & Phone Number**
	Retail Agent Email Address
General Agent Name (please print) & Phone Number	**General Agent Email Address**

1. Legal Name of Applicant _____
   dba_____ Federal Tax ID Number (nine digits)_____
   RRE Number (Responsible Reporting Entity) _____
   Physical Address: _____
   City: _____ State: ____ Zip: _____
   Please list on a separate sheet of paper all Texas locations including the complete physical address, from which the applicant conducts business operations, number of employees per location, and FEIN number (if different from that listed above).

2. Contact Person Name (first, last):_____Title: _____
   Phone Number: _____ Phone Number 2: _____ Fax Number: _____
   Email Address: _____
   Mailing Address: _____
   City: _____ State: _____ Zip: _____

3. Are any affiliate companies to be covered? **No**
   If yes: Legal Name, Address: _____
   Relationship to applicant: _____
   If necessary, please list any additional affiliates, with the above information, on a separate sheet of paper.

   Name of Owner:_____ Title: _____ % of Ownership: _____
   Name of Owner:_____ Title: _____ % of Ownership: _____
   Name of Owner:_____ Title: _____ % of Ownership: _____

4. Are owners/officers/partners to be covered? **No** Are they on the State Employment Commission Report? **No**
   If they are to be excluded, please complete the owner/officer/partner exclusion request form.

5. Does the applicant currently have an ERISA Plan they wish to continue to use? **No** **If yes, please provide a copy of the full plan document and the Summary Plan Description (SPD). This must be approved in writing by the Company.**

6. Does the applicant have Bodily Injury reporting and record keeping procedures in place? **No**

7. Does the applicant have Bodily Injury investigation procedures in place? **No**

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The undersigned applicant fully understands and is agreeable to the following:

No coverage is in effect until approved in writing by the Company by way of a binder.

Primary Employer's Indemnity Policy - Premiums are paid by the insured to the Company using a self-bill system. The Payroll used for calculating premiums should be the most recent pay period available. As per the Policy's provisions, the Company may audit your payroll records at any time. If it is determined that premiums have been underpaid, the Company shall be entitled to recover such underpayments. The Surplus Lines Tax & Stamping Fee are payable on all billed premiums & fees.

A) The applicant requests coverage for a Policy of insurance as described above. The applicant also agrees to be bound by all the terms, conditions and limitations of the Policy applied for. The applicant further understands and agrees that: 1) Neither this Application nor the payment of any moneys to be applied shall guarantee insurance to become effective. In order for insurance to take effect on the date specified, the Company must accept and issue a binder of coverage. 2) The applicant agrees to pay the required premiums to the Company when due.

B) Acceptance of the request is subject to all of the following: (1) Company's requirements; (2) Terms of the Policy; (3) Company verification of the quoted premium; and (4) Company's verification of an acceptable ERISA document.

C) The Company will notify the applicant of any approval or declination of this Application.

D) The undersigned applicant understands that he or she may be subject initially to an on-site inspection as a prerequisite for coverage acceptance. The applicant also understands and agrees that he or she will be required to comply with any recommendations as a condition of coverage.

E) The undersigned applicant has reviewed with Agent (who signed below) and understands the coverage, limits, terms, conditions and exclusions of this Application and the Policy. The applicant understands that the Agent is not authorized by the Company to bind coverage. Further, no statement made by the Agent will bind the Company. This Application shall become a part of the Policy.

F) The undersigned applicant understands this coverage is written on an Indemnity/Reimbursement basis and he or she will be reimbursed in accordance with the Policy for approved amounts paid to employees and/or Providers for on-the-job injuries.

G) The undersigned applicant understands this coverage is written on a Combined Single Limit (CSL) basis. All coverage afforded under the Policy shall not exceed the CSL amount shown in the Policy's Declarations.

Applicant Signature (Authorized Representative) _____
Title _____ Date _____

The undersigned Agent warrants he or she has not represented the above coverage, as anything other than an employer reimbursement Policy for on-the-job employee related injuries.

Agent of Record Signature_____Date_____

Agency/Agent Printed Name_____
Address_____City_____State_____Zip_____
Phone_____ Fax_____

The insurance contract for which the employer is applying is with an insurer not licensed to transact insurance in this state and is issued and delivered as surplus lines coverage under the Texas insurance statutes. The Texas Department of Insurance does not audit the finances or review the solvency of the surplus lines insurer providing this coverage, and the insurer is not a member of the property and casualty insurance guaranty association created under Chapter 462, Insurance Code. Chapter 225, Insurance Code, requires payment of 4.85 percent tax on gross premium.

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Disclosure and Acknowledgment Concerning Workers' Compensation

This will acknowledge that in solicitation of the Great American E & S Insurance Company Primary Employer's Indemnity Policy, the Agent named below (herein referred to as "Agent"), explained to me the following facts about the Texas Workers' Compensation Act (the "Act"). The following facts were discussed, and as an employer I am aware of their importance. To my knowledge, no statements contrary to the following statements were made by the Agent to anyone employed by or representing me.

1. Workers' compensation insurance is a "No-Fault" system that affords coverage for my employees and protections for me which no alternative insurance plan can duplicate.
2. It is my responsibility, should I elect not to purchase workers' compensation insurance, to notify the Texas Department of Insurance, Division of Workers' Compensation ("DWC") at the time of such election by filing the appropriate form (currently the DWC Form 5). I must also annually file the appropriate form (currently DWC Form 5) with the DWC on the anniversary date of the original filing or if I have canceled my workers' compensation policy, on the anniversary of the cancellation date of the workers' compensation policy. I am aware of the penalty for failure to properly file can be as much as $25,000 per day. I also must notify my workers' compensation carrier, in the manner provided by the law, at the time of my election. All notices and elections must be made by certified mail, return receipt requested.
3. Agent has advised me that if I become a non-subscriber under the Act, I should seek the advice of competent legal counsel in meeting the provisions of the Act. Agent has advised me to seek legal advice for the current law as it applies to my situation.
4. I am aware that as a non-subscriber, should I purchase an alternative insurance product that provides occupational injury benefits for my employees, I may come under the Employee Retirement Income Security Act of 1974 (ERISA). I understand that it may be in my best interest to have a written occupational injury benefit plan, and to file this plan under ERISA with the U.S. Department of Labor. Such insurance and plan do not preempt a personal injury negligence lawsuit.
5. I understand that a safety program could help reduce the frequency and severity of on-the-job injuries and could also help me meet my responsibility to provide a "reasonably safe place to work" for our employees.

I acknowledge the option I have selected is solely my choice and the alternative plan I have chosen was not represented by Agent to any person as being a substitute for statutory workers' compensation insurance. Agent did not induce me or any representative of my company to reject Workers' Compensation. I have sought, or been given the opportunity to seek, competent legal counsel to advise me on this decision.

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I read the above and acknowledge Agent has discussed each of these items with me.

Signed this _____ day of _____, 20____.

_____	_____
Agent Signature	Employer Name (please print)
_____	_____
Agent Name (please print)	Signature - Officer/Owner
_____	_____
Witness	Name and Title (please print)

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ADDENDUM TO APPLICATION FOR PRIMARY EMPLOYER'S INDEMNITY

Request for Exclusion of Certain Officers/Owners/Partners

Applicant hereby requests that the individual officers/owners/partners of the Applicant listed below be excluded from coverage under the Great American E & S Insurance Company Primary Employer's Indemnity Policy for which the Applicant has applied. Applicant recognizes that Great American E & S Insurance Company will not provide any reimbursement to Applicant for benefits provided by Applicant to such officers/owners/partners. Applicant further recognizes that no employer's indemnity coverage shall be provided by Great American E & S Insurance Company to Applicant with respect to any occupational injury, disease, or condition suffered by any such officers/owners/partners as a result of employment with Applicant. Great American E & S Insurance Company shall not provide Applicant any reimbursement or indemnification for any liability, by settlement, judgment or otherwise, of Applicant to any such officers/owners/partners. Great American E & S Insurance Company shall not provide reimbursement or indemnification to Applicant for any attorney's fees, costs or other expenses incurred by Applicant in defending itself against any claims of such officers/owners/partners. The exclusion from coverage of officers/owners/partners shall be effective on the _____ day of _____, 20___.

Applicant	Printed Name
Authorized Signature	Title
Date	

OFFICER/OWNER/PARTNER REQUEST FOR EXCLUSION FROM COVERAGE

The undersigned officers/owners/partners hereby request to be excluded from coverage under the Great American E & S Insurance Company Primary Employer's Indemnity Policy for which Applicant has applied. It is further requested that no premiums be paid by Applicant to Great American E & S Insurance Company for any Primary Employer's Indemnity Policy which provides coverage for Occupational Injuries, Occupational Disease, or Cumulative Trauma suffered in the Scope of Employment with Applicant.

Printed Name and Title	Signature of Officer/Owner/Partner	Date
Printed Name and Title	Signature of Officer/Owner/Partner	Date
Printed Name and Title	Signature of Officer/Owner/Partner	Date
Printed Name and Title	Signature of Officer/Owner/Partner	Date
Printed Name and Title	Signature of Officer/Owner/Partner	Date

LOSS VERIFICATION

Applicant Name: _____

Federal Employer Tax ID Number or Social Security Number: _____

☐ **I verify that (I) the applicant named above has had no known losses in the previous (3) years.**

☐ **I verify that (I) the applicant named above has had the following employee occupational losses as listed:**

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

☐ **I verify that there have been no significant changes to the loss information provided to the Company at the time of underwriting the requested insurance coverage.**

The undersigned applicant verifies that all statements and any attached data regarding loss information provided to the Company to date is accurate and has not been altered or falsified in any manner.

Signature of Applicant: _____

Title: _____

Date: _____

ERISA PLAN WORKSHEET

An ERISA Plan and Summary Plan Description will be issued by Great American Insurance Agency, Inc. Please complete the following information to assist with the issuance of the Plan:

Complete Legal Name of Applicant's Company:

_____

Employer's Federal Tax I.D. No.: _____(nine digits)

Physical Address of Applicant: _____
ST: **TX** ZIP: _____

Mailing Address of Applicant: _____
ST: _____ ZIP: _____

Contact Person/ERISA Plan Administrator (printed name & title):

_____

Name & Address of contact for legal purpose, if differs from Plan Administrator above:

_____

Telephone Number of Contact: (_____)_____ Fax: (_____)_____

Email Address of Contact: _____

The Plan Identification Number will be "501" unless you have another employee welfare plan, such as a group health plan, which is designated "501." If you have another welfare benefit plan(s), what is the Plan Identification Number(s)? _____

_____

Do you (the applicant) currently have an ERISA Plan you wish to continue to use? If yes, please complete the following information:

Author of ERISA Plan:_____

Original Effective Date of ERISA Plan:_____

ERISA Plan Number: _____

Has a complete copy of the ERISA Plan document and Summary Plan Description (SPD) been submitted to Great American Insurance Agency, Inc.? N/A

Has the Plan been approved in writing by Great American Insurance Agency, Inc.? N/A

If "NO" to the above questions, please submit a complete copy of the ERISA Plan document and SPD to Great American Insurance Agency, Inc. immediately for Plan approval.