ASSURANCE RESOURCES, INC.

FAX-A-QUOTE

Type of Proposal Requested:
☐ *Occupational Accident only*
☐ *Occupational Accident /Legal*

Applicant Name ______________________________ Requested Effective Date ______________

Address _________________________________CITY _________________ST ___ZIP________ Nature of Business________________

Number of years in business:_____ Tax ID# _____________________Date of workersqcomp coverage rejection: ______________

Workersqcomp 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

What percentage of loads is tarped and/or strapped? ____________________% tarped ____________________% strapped

Does applicant perform any work at heights over 15 ft.? ☐Yes ☐No. If Yes, please explain:______________________________

Are Owners, Officers or Partners to be covered? ☐Yes ☐No. Are any affiliate companies to be covered? ☐Yes ☐No. If yes, please provide Legal Name, Address and number of employees at each location.

# of Full-Time		# of Part-Time		Occupation	Classification or Description
EEs	1099s	EEs	1099s		

Total Number of Employees _____________________Current WorkersqComp or Accident Premium $ ______________________

Waiver of Subrogation? ☐Yes ☐No Occupational Disease & Cumulative Trauma? ☐Yes ☐No CTD (to full retirement age)? ☐Yes ☐No

Combined Single Limit (Per Eligible Person per Accident): $1,000,000

Deductible (per any one Person, any one Occurrence):
☐ $0 ☐$500 ☐$1,000 ☐$2,500 ☐$5,000 ☐$10,000

Benefit Period: _________110 Weeks Elimination Period: ☐ 7days (Weekly Indemnity 75% up to $600)

Please submit 3 years (hard copy) current valued loss history: Valuation Date of loss information:______________________________

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

- Has this applicant (or affiliate) been in the Texas WorkersqCompensation System in the last 3 years? ☐Yes ☐ No
  If yes, have they had an experience modification factor of 1.50% or higher? ☐Yes ☐ No
- Has the applicant (or affiliate) ever had an Employerq Liability claim? ☐Yes ☐ No
- 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? ☐ Yes ☐ No
- Does the applicant have a Safety Program? ☐Yes ☐No Do you conduct random drug tests? ☐Yes ☐No

If you answered YES to any of these questions, please give a complete descriptions, dates, and amounts of claims on a separate sheet.

Agent and Applicant hereby acknowledge that: all answers and statements contained herein including any attached data, are true and complete; 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 this Fax-A-Quote shall become a part of the Policy should coverage be bound.

Agent: ______________________________**Phone:**______________________________

Address: ______________________________**Fax:** ______________________________

Agent Signature: ______________________________**Applicant Signature:** ______________________________

Please fax this completed form to (713) 432-1850.

For assistance, please call (713) 664-9770 or via e-mail at rcoatssr@assuranceresources.com