ACORD™ NEW JERSEY WORKERS COMPENSATION INSURANCE PLAN
APPLICATION FOR DESIGNATION OF AN INSURANCE COMPANY

DATE

COMPENSATION RATING AND INSPECTION BUREAU
60 PARK PLACE, NEWARK, NEW JERSEY 07102, (201) 622-6014

IMPORTANT - FILE IN DUPLICATE
Complete fully. See instruction sheet. Type or Print. Attach separate sheet, if necessary.

This employer is unable to purchase Workers Compensation and Employers Liability Insurance for its liability under the New Jersey Workers Compensation Law. At least three non-affiliated companies have declined to provide voluntary coverage. For that reason the employer applies for selection of an insurance company through the New Jersey Workers Compensation Insurance Plan.

BUREAU FILE NUMBER	COVERAGE REQUESTED EFFECTIVE DATE	NEW JERSEY EMPLOYER REGISTRATION #

1. NAME OF EMPLOYER	TELEPHONE NUMBER	FEDERAL EMPLOYER ID #/SOCIAL SECURITY #

2. MAILING ADDRESS (Including ZIP code)	3. DATE BUSINESS OR OPERATION BEGAN	4. LEGAL STATUS - IMPORTANT - REFER TO INSTRUCTIONS
		☐ INDIVIDUAL ☐ CORPORATION ☐ PARTNERSHIP ☐ SUBCHAPTER "S" CORP ☐ OTHER:

5. LOCATION OF ALL NEW JERSEY SHOPS, YARDS OR WORK PLACES

#	STREET, CITY, COUNTY, STATE, ZIP CODE	#	STREET, CITY, COUNTY, STATE, ZIP CODE

6. BOOKS AND RECORDS REFLECTING PAYROLLS

WHAT RECORDS DO YOU MAINTAIN SHOWING ALL PAYROLLS, AND WHERE (LOCATION) MAY THEY BE EXAMINED?

7. OWNERSHIP INFORMATION

LIST BELOW NAMES, TITLES, DUTIES AND APPROXIMATE ANNUAL SALARY OF CORPORATE OFFICERS. SIMILARLY, INCLUDE ANY PROPRIETORS AND PARTNERS WHERE THE NOTICE OF ELECTION-PROPRIETORS AND PARTNERS HAS BEEN COMPLETED. INCLUDE THEIR SALARIES IN THE PREMIUM COMPUTATIONS. ALSO GIVE THE PERCENT OF STOCK OWNED BY EACH OFFICER AND PARTNER. ATTACH SEPARATE SHEET IF NECESSARY.

NAME	TITLE	% OF STOCK OWNED	DUTIES	APPROXIMATE ANNUAL SALARY

IF YOU HAVE NOT INCLUDED THE OFFICER'S, OWNERS OR PARTNERS PAYROLL IN THE PREMIUM CALCULATION, EXPLAIN:

8. INSURANCE RECORD

ANY PREVIOUS NJ WORKERS COMP INSURANCE COVERAGE? ☐ YES ☐ NO

IF YES, WAS COVERAGE THROUGH: ☐ PLAN ☐ VOLUNTARY

REASON FOR FILING APPLICATION:

IF NO, ☐ NEW BUSINESS ☐ SELF INSURANCE ☐ OTHER:

INSURANCE RECORD - THREE PREVIOUS YEARS (ATTACH SEPARATE SHEET, IF NECESSARY)

STATE	LOCATION	INSURANCE COMPANY	POLICY NUMBER	POLICY PERIOD FROM	POLICY PERIOD TO	GOVERNING CLASS	ANNUAL PREMIUMS	AUDITED PAYROLL

9. INSURANCE COMPANIES WHO HAVE OFFERED/REFUSED INSURANCE

LIST BELOW NAMES AND REPRESENTATIVES OF THREE COMPANIES WHICH HAVE REFUSED COVERAGE IN THE PAST SIXTY DAYS. THE REPRESENTATIVES NAMED MUST BE FULL-TIME EMPLOYEES OF THE INSURANCE COMPANY. IF APPLICABLE, ONE OF THESE COMPANIES SHOULD BE THE ONE PROVIDING WORKERS COMPENSATION INSURANCE TO THE APPLICANT AT THE TIME OF APPLICATION. ALSO, HAVE YOU RECEIVED ANY OFFERS OF VOLUNTARY COVERAGE? ☐ YES ☐ NO

IF YES, EXPLAIN ON A SEPARATE SHEET.

INSURANCE COMPANY NAME	REPRESENTATIVE'S NAME

THERE IS A 15% PENALTY SURCHARGE TO THE ANNUAL PREMIUM FOR REJECTING ANY OFFER OF VOLUNTARY INSURANCE.

10. NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS

GIVE COMPLETE DESCRIPTION OF BUSINESS AND OPERATIONS INCLUDING PRODUCTS MANUFACTURED, SOLD OR SERVICED.

11. GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES; ATTACH SEPARATE SHEET IF NECESSARY	YES	NO	EXPLAIN ALL "YES" RESPONSES; ATTACH SEPARATE SHEET IF NECESSARY	YES	NO
1. DO YOU HAVE OPERATIONS IN STATES OTHER THAN NEW JERSEY? IF YES, LIST THE STATES AND LENGTH OF TIME IN BUSINESS BY STATE:			4. HAS ANY INSURANCE COMPANY EVER CANCELED YOUR WORKERS COMPENSATION POLICY FOR NONPAYMENT OR FOR ANY OTHER REASON?		
			5. YOU MUST ATTACH A COPY OF YOUR MOST RECENTLY FILED WR-30 "EMPLOYER REPORT OF WAGES PAID" OR ANY EQUIVALENT FEDERALLY REQUIRED RECORD, E.G. IRS 940, 941E, 942 OR 943 FORM. IF YOU DO NOT ATTACH THESE RECORDS, EXPLAIN.		
2. HAS THERE BEEN A NAME CHANGE OR A CONSOLIDATION, MERGER OR OTHER OWNERSHIP CHANGE DURING THE PAST THREE YEARS? IF YES, ATTACH A SEPARATE SIGNED OWNERSHIP STATEMENT ON EMPLOYERS LETTERHEAD WITH PREVIOUS BUSINESS NAME, OWNERS, INCLUDING PERCENTAGE OF STOCK, AND DATE OF CHANGE.			6. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS? IF YES, COMPLETE SUPPLEMENTAL EMPLOYEE LEASING APPLICATION.		
3. DO YOU OR ANY COMMONLY OWNED OR MANAGED ENTERPRISES OWE ANY UNPAID WORKERS COMPENSATION INSURANCE PREMIUMS?			7. DO YOU HAVE ANY TRUCKING OPERATIONS? IF YES, COMPLETE TRUCKERS SUPPLEMENTAL APPLICATION.		

12. CLASSIFICATION OF OPERATIONS

CLASSIFICATION PHRASEOLOGY	# OF EMPLOYEES	CLASS CODE	RATE	TOTAL PREMIUM BASIS TOTAL WAGES	PREMIUM
CLERICAL OFFICE EMPLOYEES		8810			
SALESPERSONS - OUTSIDE		8742			
DRIVERS NOC		7380			

* ENTER "NONE" IF EMPLOYER IS NOT SUBJECT TO EXPERIENCE RATING.

** IF THE RISK IS EXPERIENCE RATED THIS FACTOR IS APPLIED TO THE TOTAL ESTIMATED STANDARD PREMIUM IN ACCORDANCE WITH 3:14-8(13) OF THE MANUAL. THE FACTOR IDENTIFIED AS "PPAP" MAY BE FOUND ON THE EXPERIENCE RATING DATA (BELOW THE MODIFICATION).

*** IF ESTIMATED ANNUAL PREMIUM IS LESS THAN $500, THE DEPOSIT PREMIUM IS THE TOTAL AMOUNT. IF $500 OR MORE, SEND 40% OF THE TOTAL ESTIMATED ANNUAL PREMIUM, OR $500, WHICHEVER IS GREATER.

TOTAL PREMIUM SUBJECT TO THE EXPERIENCE MODIFICATION		
* PREMIUM MODIFIED TO REFLECT EXP MOD		
OTHER PREMIUM CHARGES		
TOTAL ESTIMATED STANDARD PREMIUM		
** PLAN PREMIUM ADJUSTMENT		
PREMIUM DISCOUNT (USE X TABLE), IF APPLICABLE		
(0900) EXPENSE CONSTANT		
TOTAL ESTIMATED PREMIUM		
(0935) SECOND INJURY FUND SURCHARGE		
(0936) UNINSURED EMPLOYERS FUND SURCHARGE		
TOTAL ESTIMATED COST $		
*** DEPOSIT PREMIUM WITH APPLICATION		

13. PREMIUM PAYMENT

THE ATTACHED CHECK FOR $ PAYABLE TO NJ WORKERS COMPENSATION INS PLAN REPRESENTS ADVANCE PREMIUM ACCORDING TO PARAGRAPH 3 OF THE PLAN.

14. EMPLOYER CERTIFICATION

I CERTIFY THAT I KNOW THE CONTENTS OF THIS APPLICATION AND THAT THE INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE. THE COMPENSATION RATING AND INSPECTION BUREAU WILL RELY ON THIS CERTIFICATION IN SELECTING AN INSURANCE COMPANY TO PROVIDE THE REQUESTED INSURANCE. ALSO, IN ALL MATTERS PERTAINING TO THIS INSURANCE, THE EMPLOYER WILL COOPERATE FULLY WITH THE INSURANCE COMPANY AND WILL TELL THE INSURANCE COMPANY PROMPTLY OF ANY CHANGES IN THIS INFORMATION DURING THE POLICY YEAR. IT IS FURTHER UNDERSTOOD THAT IF THERE IS WORKERS COMPENSATION LIABILITY UNDER THE LAW OF ANY OTHER STATE, OTHER ARRANGEMENT MUST BE MADE.

I UNDERSTAND THAT ANY INTENTIONAL FALSE OR MISLEADING INFORMATION CONCERNING ANY FACT IN THIS APPLICATION MAY SUBJECT ME TO PENALTIES AS ARE PROVIDED BY LAW.

EMPLOYERS SIGNATURE AND TITLE	DATE

15. PRODUCER CERTIFICATION

DESIGNATED LICENSED PRODUCER, IF ANY (INCLUDE ADDRESS)	FEDERAL EMPLOYER ID #/SOCIAL SECURITY NUMBER
	TELEPHONE NUMBER

I UNDERSTAND THAT INTENTIONAL MISSTATEMENT OF INFORMATION IN THIS APPLICATION MAY SUBJECT ME TO PENALTIES AS ARE PROVIDED BY LAW, INCLUDING, BUT NOT LIMITED TO LOSS OF LICENSE.

PRODUCERS SIGNATURE AND TITLE	DATE