GREAT AMERICAN INSURANCE GROUP | ECA Division

# Fax-A-Quote

14350 Proton Road / Dallas, Texas 75244, Phone: (972) 931-2026 or (800) 299-5250, Fax: (972) 931-2126,
Email: txnonsubscriberpolicy@gaic.com

Please remit this form along with a copy of your in force Texas Agent's Insurance license and Error & Omissions Dec Page

## Applicant Information

| | | Yes | No |
|---|---|---|---|
| Applicant Name _____ | Requested Effective Date _____ | | |
| Address _____ | City _____ | | |
| State TX | Zip _____ | Nature of Business _____ | |
| Number of years in business _____ | Tax ID# _____ | | |
| Date of workers' comp coverage rejection _____ | | | |
| Business Type: ☐ Corporation ☐ Partnership ☐ Other _____ | | | |
| Has worker's comp or occupational accident coverage ever been canceled, refused or non-renewed? **If yes**, please explain: _____ | | ☐ | ☐ |
| Is applicant subject to LPG or TxDOT Regulations? | | ☐ | ☐ |
| 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)*? **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.? **If yes**, please explain: _____ | | ☐ | ☐ |

## Work Information

| | Yes | No |
|---|---|---|
| Are Owners, Officers or Partners to be covered? | ☐ | ☐ |
| Are any affiliate companies to be covered? | ☐ | ☐ |

**If yes**, please provide Legal Name, Address and number of employees at each location.

| # of Full-Time W-2 | # of Full-Time 1099 | # of Part-Time W-2 | # of Part-Time 1099 | Classification Code | Annual Payroll by Class (as reported to IRS) | Classification or Description |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

## Work Information *Continued*

| | Yes | No |
|---|---|---|
| Total Number of Employees _____ Total Payroll $ _____ | | |
| Waiver of Subrogation? | ☐ | ☐ |
| Current Worker's Comp or Accident Premium $_____ | | |
| Occupational Disease & Cumulative Trauma? | ☐ | ☐ |

## Benefits to be Quoted

**PLEASE CALL FOR OTHER OPTIONS.*

| | Yes | No |
|---|---|---|
| CSL Benefit _____ ($300,000 - $5,000,000 CSL) SIR _____ ($1,000 - $500,000 (Self Insured Retention) | | |
| Benefit Period: ☐ 52 Wks ☐ 104 Wks ☐ 156 Wks | | |
| Weekly Income: (75% up to $700) _____ Waiting Period _____ days | | |
| 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) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

| | Yes | No |
|---|---|---|
| 1. Has this applicant (or affiliate) been in the Texas Workers' Compensation System in the last 3 years? | ☐ | ☐ |
| **If yes**, have they had an experience modification factor of 1.50% or higher? | ☐ | ☐ |
| 2. Has the applicant (or affiliate) ever had an Employer's Liability claim? | ☐ | ☐ |
| 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? | ☐ | ☐ |
| 4. Does the applicant have Employer's Excess Indemnity coverage? Carrier Name: _____ | ☐ | ☐ |
| 5. Does the applicant have a written Safety/Loss Control Program? Date Program initiated: _____ | ☐ | ☐ |

*Please provide a copy of the written Safety Program as well as any additional information regarding applicant's loss control practices. 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** _____ **Agent Email** _____

**Phone**_____ **Fax** _____

**Agent Signature**_____ **Date** _____

**Applicant Signature**_____ **Date** _____

**Submit**