Workers Compensation and Employers Liability Insurance Policy

Supplement to Application

Name: ____ Date: ____________________________

1. Do you consider Oklahoma as your principal place of business? ☐Yes ☐No
   If no, list the state you consider your principal place of business: _____________________________

2. Do you currently have a policy with CompSource? ☐Yes ☐No
   If yes, provide a policy number (if known): ____
   Who is your current insurance carrier? ____
   Policy number: ________________________________Policy effective date: _____________________
   Have you ever had a policy with CompSource Mutual Insurance Company? ☐Yes ☐No

3. Within the past 12 months, did you have coverage with CompSource Mutual Insurance Company through a professional, trade or group association?
   ☐Yes ☐No
   If yes, please list the association: ____

4. Do you own any other business entities in Oklahoma or in any other state(s)? ☐Yes ☐No
   If yes, list each named entity below including state, percentage of ownership and FEIN.
   (If more space is needed you may attach a separate page)

   Business name: **State:** **FEIN:** **Owner's name and percentage of ownership:**
   ____
   ____
   ____

   Do you need workers' compensation and employers' liability insurance coverage in the other states where you have operations? ☐Yes ☐No
   (If no, you will be required to provide proof of coverage for your operations in those states.)

5. Do you intend to obtain a quote for all Oklahoma business entities? ☐Yes ☐No
   If no, explain. (Provide proof of coverage will be necessary for all businesses):
   ____

6. Do you have employees who permanently work or reside in Oklahoma who may travel or work outside the state of Oklahoma? ☐Yes ☐No
   If yes, list state(s), frequency and duration of travel/work for each employee: _____________
   ____

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COMPSOURCE MUTUAL INSURANCE COMPANY

7. Do you have employees permanently working in Oklahoma whose contract of hire is outside the state of Oklahoma or; ☐Yes ☐No
   a. Who resides in a state outside of Oklahoma? ☐Yes ☐No
   If either question is yes, please list the contract of hire or state of residency for each employee:
   ____
   ____

8. Do you have a current workers' compensation policy in another state that extends coverage to residents of other states who are temporarily working in Oklahoma? ☐Yes ☐No
   If yes, attach a copy of the declaration page

9. Do any of your business entities have permanent operations or locations outside of Oklahoma?
   If yes, list the state(s): ____ ☐Yes ☐No

10. Do you intend to lease or provide employees to other businesses? ☐Yes ☐No

11. Is the business currently or ever filed for bankruptcy? ☐Yes ☐No
    If yes, explain: ____

12. Are you currently liquidating or terminating this business? ☐Yes ☐No
    If yes, explain: ____

13. Are you related to or associated with anyone in this business who has been denied coverage, cancelled, non-renewed or billed premium on a cancelled policy that remains unpaid with CompSource Mutual Insurance Company, CompSource Oklahoma or The State Insurance Fund? ("You" includes: any person, who directly or indirectly owns or controls or is the president, vice president, secretary, treasurer, manager, member, partner or stockholder of an employer seeking coverage under this application.)
    ☐Yes ☐No
    If yes, provide their name and affiliation with the business:
    ____

14. Do you currently employ or intend to employ any domestic employees? ☐Yes ☐No

15. Do you currently employ or intend to employ any farm employees? ☐Yes ☐No

16. Were social security numbers for all owners/officers provided on the ACORD application?
    ☐Yes ☐No
    If no, provide on the ACORD form. This information must be provided to process your application.

17. Do you or will you employ family members related by blood or marriage whether paid or unpaid?
    ☐Yes ☐No
    If yes, did you include their payroll in the total payroll and were the family members included in the total number of employees? ☐Yes ☐No
    Explain: ____

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18. Identify the name, address and telephone number of the contact(s) for your premium audit. List by state, if applicable. If the contact is the same as the primary contact, list "same". If necessary, attach a separate sheet.

Name:	Physical address:	State:	Phone:

Premium for this insurance coverage will be determined by manual rules, classifications, rates and rating plans applicable to each state. All required information is subject to verification and may result in changes to your policy during the premium audit.

For Oklahoma coverage, it is understood and agreed that any monies paid to or held by CompSource Mutual Insurance Company by or on behalf of the insured is pledged to secure payment of any amount due or which may become due to CompSource Mutual Insurance Company and may be applied to or offset by any amount due and that the venue of any action to collect premium shall be in District Court of Oklahoma County, Oklahoma.

By signing the application, I attest all of the above questions have been fully and completely answered and have not been willfully misrepresented in order to obtain insurance with CompSource Mutual Insurance Company. I understand that any person who willfully misrepresents any fact in order to obtain insurance with CompSource Mutual Insurance Company at less than the proper rate for such insurance shall be guilty of a felony. Any willful misrepresentation in the above answers is a violation of Title 85 et. al. I state under penalty of perjury under the laws of Oklahoma that the foregoing is true and correct.

The following is only applicable if you have elected to utilize an insurance producer to secure workers' compensation coverage on your behalf. I have authorized the insurance producer designated below to submit this information on my behalf, and to act as my agent of record for securing my workers' compensation insurance. This includes my express authorization that CompSource Mutual Insurance Company may provide my producer with any information associated with my policy.

The application must be signed by individual owner, partner, corporate officer or a limited liability corporation member. The undersigned applicant understands that coverage is not in effect until the signed application(s) is received with appropriate premium and eligibility is determined by CompSource Mutual Insurance Company.

______________________________ __________________________

Applicant's signature Date

______________________________ __________________________

Producer's signature Date

WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds for any insurance policy containing false, incomplete or misleading information is guilty of a felony.