



Mid-West Truckers Risk Management Association

Workers Compensation Underwriting Application

Please complete the following application. All information is essential in providing you with an accurate proposal and will be used in a confidential and professional capacity. [Return the application immediately upon completion.](#) It is not necessary to wait until the additional information requested below is received.

Please request current loss runs (claims history) from all previous and current workers compensation carriers for the current year and previous four years. A [sample letter \(Exhibit I\)](#) is included for your use in requesting these loss runs.

Request your Experience Modification Rating Worksheets from the National Council on Compensation Insurance. Please copy Exhibit II onto your company letterhead, sign and return to us. This will allow us to secure your most recent experience modification from NCCI with no additional cost to you.

Please include a copy of your current workers compensation declaration page.

Return the completed application and requested information to:

Missy Black
Cannon Cochran Management Services, Inc.
2 E. Main Street, Suite 208
Danville, IL 61832
1-800-252-5059, ext. 1276
or Fax to (217) 444-2498

IT IS NECESSARY TO PROVIDE DOCUMENTATION REFLECTING THE FINANCIAL CONDITION OF YOUR COMPANY ONLY IF YOUR TOTAL ANNUAL PAYROLL IS UNDER \$62,500. WE WILL NEED ONE OF THE FOLLOWING:

- **Financial Statement from your Certified Public Accountant OR**
- **Certification Statement from your bank verifying net worth and solvency**

THIS INFORMATION IS REQUIRED PRIOR TO PROCESSING THE APPLICATION.

THIS MUST BE TYPED ON YOUR COMPANY LETTERHEAD

EXHIBIT I

**SAMPLE LETTER REQUESTING CLAIM INFORMATION VALUED WITHIN THE LAST
90 DAYS FROM CURRENT AND PREVIOUS WORKERS COMPENSATION
INSURANCE CARRIER (S)
(For: 01/02, 02/03, 03/04, 04/05 & 05/06)**

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Current Date

(Carrier)
(Carrier Address)

RE: (Name of your organization)
Workers Compensation
(Policy Term(s))
(Policy #(s))

Gentlemen:

Please release all loss information on the captioned workers compensation policies immediately.

This letter authorized Cannon Cochran Management Services, Inc., to act on our behalf in securing the above loss information. We give them full approval to take any and all actions necessary to secure the loss information.

Please send the original copy of the complete loss runs directly to:

Missy Black
Cannon Cochran Management Services, Inc.
2 E. Main Street
Danville, IL 61832-5850

A copy of this information should be sent to us. We would appreciate your cooperation in seeing that this information is sent within 2 weeks of the date of this letter.

Thank you for your assistance.

Yours truly,

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NOTE: Please note that if you have had various Workers Compensation insurance carriers within the last five years, this letter must be sent to each carrier requesting claims information for the period of time that you were insured with them.

THIS MUST BE TYPED ON YOUR COMPANY LETTERHEAD

EXHIBIT II

**SAMPLE LETTER REQUESTING WORKERS COMPENSATION
EXPERIENCE RATING WORKSHEETS**

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Date

National Council on Compensation Insurance
P.O. Box 3098
Boca Raton, Florida 33431-0998

Attn: Industry Services

RE: Current and Prior Year Experience Rating Worksheets

Gentlemen:

This letter is to advise that we give full authorization for you to release the current and prior year Workers Compensation Experience Rating Worksheets directly to Cannon Cochran Management Services, Inc.

This firm is acting on our behalf in obtaining this data.

Please send the original copy of the worksheets directly to:

Missy Black
Cannon Cochran Management Services, Inc.
2 E. Main Street
Danville, IL 61832-5850

Thank you for your assistance.

Yours truly,

GENERAL INFORMATION

Name of Company: _____

Address: _____

Employment Number: _____ FEIN: _____

Telephone: _____ Fax: _____

Contact Person/Title: _____ County: _____

Company Status: Individual Limited Partnership Co-Partnership Corp

Are you a member of the Mid-West Truckers Association? Yes No

List of Owners/Officers:

Name	City, State	Title	Is Owner/Officer to be covered under WC coverage?
			YES / NO
			YES / NO
			YES / NO

Chartered under the laws of the State of _____ Date _____

Date of Commencement of Business in _____ Date _____

List of affiliates or subsidiaries and divisions to be included in the program:

Name	Principal Address (City, State, Zip)	Type of Business

Do you have any operations or do any business outside the State? Yes No

If yes, describe: _____

CURRENT POLICY INFORMATION

Please send a copy of your current workers compensation declaration page.

Current Workers Compensation Carrier: _____

Expiration Date: _____ Assigned Risk Pool? Yes No

Current Premium \$ _____ Current Agency _____

PAYROLL INFORMATION

Please provide audited payroll for each twelve month period listed below. Audited payroll worksheets have been provided to you from a previous carrier. These figures should correspond with the same 12 months as your previous Workers Compensation policies that were in force.

2001 – 02 Total Payroll _____
 2002 – 03 Total Payroll _____
 2003 – 04 Total Payroll _____
 2004 – 05 Total Payroll _____
 2005 – 06 Total Payroll _____

ESTIMATE ANNUAL PAYROLLS, BY CLASS, FOR THE NEXT TWELVE MONTHS. (INCLUDE ALL PAYROLL EXCEPT OWNERS/OFFICERS TO BE EXCLUDED)

CLASSIFICATION	CODE	NUMBER OF EMPLOYEES	ESTIMATED PAYROLL
Short Haul (Under 200 Miles)	7228	_____	_____
Long Haul (Over 200 Miles)	7229	_____	_____
Mechanics	8380	_____	_____
Clerical	8810	_____	_____
Sales	8742	_____	_____
Other Classifications	_____	_____	_____

OWNER/OPERATOR INFORMATION

Do you use independent owners/operators? Yes _____ No _____ Number _____

Have you included these owners/operators in your payroll estimates? Yes _____ No _____

If you have not included them in your payroll estimates, do you require owners/operators to purchase their own statutory workers compensation insurance coverage? Yes _____ No _____

Do you keep a copy of this certificate of insurance on file? Yes _____ No _____

**** All owners/operators must have statutory workers compensation coverage OR their payroll must be included under your policy. ****

VEHICLE INFORMATION

Number of Owned or Leased Vehicles: _____

Type of Goods Hauled: _____

What is The AVERAGE Radius of Travel? _____

What is The MAXIMUM Radius of Travel? _____

Does the Applicant Hold Intrastate and/or Interstate Licenses To Haul For Others?

Yes _____ No _____ ICC# _____ STATECC# _____

Does the Applicant Backhaul Goods For Others? Yes _____ No _____

LOSS CONTROL

Is there any formal loss control training in your company? Yes _____ No _____

If yes, please describe: _____

Name & title of the person designated for loss control coordination: _____

What medical facilities are available to your employees?

First Aid _____ Local Clinic _____ In-House Staff _____ Hospital _____

Do you employ a full-time Doctor/Nurse? Yes _____ No _____

If yes is chosen on the following questions, please provide a detailed explanation below.

Do you have operations involving the loading, unloading, repair or construction of watercraft or vessels including work performed on barges or docks? Yes _____ No _____

Do you have any foreign operations or employees who travel to foreign countries? Yes ___ No ___

Are you engaged in the manufacturing, production, refining, storage, distribution or transportation of gases, gasoline, flammables, hazardous wastes or materials? Yes ___ No ___

Have you been cited for OSHA violations? Yes ___ No ___

Do you provide any transportation of employees to or from the workplace? Yes ___ No ___

Has your work comp coverage been cancelled/non-renewed in the past five years? Yes ___ No ___

Do you now (or have future plans to) own, lease, or charter watercraft? Yes ___ No ___

Do you now (or have future plans to) own, lease, or charter aircraft? Yes ___ No ___