

# Ferch Agency

## Fax-A-Quote

**Type of Proposal Requested:**

- Occupational Accident only  
 Occupational Accident w/Legal  
 Employer's Excess Indemnity

Please fax completed form to Dan or Amanda at 512-342-2291; or email to [Amanda@FerchInsuranceGroup](mailto:Amanda@FerchInsuranceGroup) or [Dan@FerchInsuranceGroup.com](mailto:Dan@FerchInsuranceGroup.com)

Applicant Name \_\_\_\_\_ Requested Date: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State TX Zip \_\_\_\_\_ Nature of Business \_\_\_\_\_

Number of years in business: \_\_\_\_\_ Tax ID # \_\_\_\_\_ Date of workers' comp coverage rejection: \_\_\_\_\_

Has worker's comp 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

Does applicant perform any work at heights over 24 feet?  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 EE's	1099	# of Part-Time EE's	1099	Classification Code	Annual Payroll by Class (Including Tips)	Classification or Description

Total Number of Employees \_\_\_\_\_ Total Payroll \$ \_\_\_\_\_ Waiver of Subrogation?  Yes  No

Current Worker's Comp or Accident Premium \$ \_\_\_\_\_ Occupational Disease & Cumulative Trauma?  Yes  No

**Benefits to be Quoted: LIMITS VARY BY PRODUCT. PLEASE CALL FOR OTHER OPTIONS.**

CSL Benefit: \_\_\_\_\_ Deductible \_\_\_\_\_ Excess Limits \_\_\_\_\_  
 (\$100,000 - \$1,000,000 CSL available) (\$1,000 - \$500,000 deductible available) (\$1,000,000 to \$5,000,000 Limits available)

Benefit Period:  52 Wks  104 Wks  156 Wks Weekly Income Limit: (75% up to \$600) \_\_\_\_\_ Waiting Period: \_\_\_\_\_ days

Please submit 3 years loss history below: Valuation Date of loss information (no more than 60 days old): \_\_\_\_\_

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

- Has the applicant (or affiliate) been in the Texas Worker's Compensation system in the last 3 years?  
If yes, have they had an experience modification factor of 1.50% or higher?  Yes  No
- Has the applicant (or affiliate) ever had an Employer's 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 Employer's Excess Indemnity Coverage? Carrier Name: \_\_\_\_\_  Yes  No
- In the last 5 years, have you been issued any OSHA Citations?  Yes  No

If the answer to #2, #3, or #5 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: \_\_\_\_\_ General Agent: Dan Ferch Phone: 512.342.2242

Address: \_\_\_\_\_ Fax: 512.342.2291

Agent Signature: \_\_\_\_\_ Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_