

Application packet to Bind/Issue

Acord 130

Contractors Supplemental Application

Loss information :

- If prior coverage, please provide 3 year loss information or 3 year signed no- loss statement.
- Loss runs are required within 30 days of coverage being bound.
- If no prior coverage, please provide signed 3 year no-loss statement

Application for membership in a Self Insured Fund

Inclusion and/or exclusion forms if applicable

Statement of Assets and Liabilities (Balance Sheet)

Agreement to Pay Premiums and Reasonable Attorney's Fees and Costs in the Event Collection Becomes Necessary/Personal Guaranty Forms

Deposit check made payable to SCHBSIF

\$25.00 check made payable to SCWCC

If applicable:

- Mod Sheet
- If no prior coverage, please provide resume on all owners/officers showing at least 5 years experience.

NOTE: Coverage cannot be bound until original signed documents and payment checks are received by SCHBSIF. Faxed or E-Mailed copies of checks cannot be used to bind coverage. If you have any questions please contact the SCHBSIF office.



WORKERS COMPENSATION APPLICATION

DATE (MM/DD/YYYY)

AGENCY NAME AND ADDRESS		COMPANY:	
PRODUCER NAME:		UNDERWRITER:	
CS REPRESENTATIVE NAME:		APPLICANT NAME:	
OFFICE PHONE (A/C. No. Ext)		OFFICE PHONE:	MOBILE PHONE:
MOBILE PHONE:		MAILING ADDRESS (including ZIP + 4 or Canadian Postal Code)	
FAX (A/C. No.):		YRS IN BUS:	
E-MAIL ADDRESS:		SIC:	
CODE: SUB CODE:		NAICS:	
AGENCY CUSTOMER ID:		WEBSITE ADDRESS:	
E-MAIL ADDRESS:		CREDIT BUREAU NAME:	
SOLE PROPRIETOR <input type="checkbox"/>		CORPORATION <input type="checkbox"/>	
PARTNERSHIP <input type="checkbox"/>		SUBCHAPTER "S" CORP <input type="checkbox"/>	
LLC <input type="checkbox"/>		TRUST <input type="checkbox"/>	
JOINT VENTURE <input type="checkbox"/>		OTHER <input type="checkbox"/>	
FEDERAL EMPLOYER ID NUMBER		NCCI RISK ID NUMBER	ID NUMBER:
OTHER RATING BUREAU ID OR STATE EMPLOYER REGISTRATION NUMBER			

STATUS OF SUBMISSION**BILLING / AUDIT INFORMATION**

<input type="checkbox"/> QUOTE	<input type="checkbox"/> ISSUE POLICY	<input type="checkbox"/> BILLING PLAN	<input type="checkbox"/> PAYMENT PLAN	<input type="checkbox"/> AUDIT
<input type="checkbox"/> BOUND (Give date and/or attach copy)	<input type="checkbox"/> AGENCY BILL	<input type="checkbox"/> ANNUAL <input type="checkbox"/>	<input type="checkbox"/> AT EXPIRATION <input type="checkbox"/> MONTHLY	
<input type="checkbox"/> ASSIGNED RISK (Attach ACORD 133)	<input type="checkbox"/> DIRECT BILL	<input type="checkbox"/> SEMI-ANNUAL	<input type="checkbox"/> SEMI-ANNUAL <input type="checkbox"/>	
		<input type="checkbox"/> QUARTERLY % DOWN:	<input type="checkbox"/> QUARTERLY	

LOCATIONS

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

POLICY INFORMATION

PROPOSED EFF DATE	PROPOSED EXP DATE	NORMAL ANNIVERSARY RATING DATE	PARTICIPATING	RETRO PLAN
			NON-PARTICIPATING	
PART 1 - WORKERS COMPENSATION (States)	PART 2 - EMPLOYER'S LIABILITY	PART 3 - OTHER STATES INS	DEDUCTIBLES (N / A in WI)	AMOUNT / % (N / A in WI)
	\$ EACH ACCIDENT		<input type="checkbox"/> MEDICAL	<input type="checkbox"/> U.S.L. & H.
	\$ DISEASE-POLICY LIMIT		<input type="checkbox"/> INDEMNITY	<input type="checkbox"/> VOLUNTARY COMP
	\$ DISEASE-EACH EMPLOYEE			<input type="checkbox"/> FOREIGN COV
DIVIDEND PLAN/SAFETY GROUP	ADDITIONAL COMPANY INFORMATION			
SPECIFY ADDITIONAL COVERAGES / ENDORSEMENTS (Attach ACORD 101, Additional Remarks Schedule, if more space is required)				

TOTAL ESTIMATED ANNUAL PREMIUM - ALL STATES

TOTAL ESTIMATED ANNUAL PREMIUM ALL STATES	TOTAL MINIMUM PREMIUM ALL STATES	TOTAL DEPOSIT PREMIUM ALL STATES
\$	\$	\$

CONTACT INFORMATION

TYPE	NAME	OFFICE PHONE	MOBILE PHONE	E-MAIL
INSPECTION				
ACCTNG RECORD				
CLAIMS INFO				

INDIVIDUALS INCLUDED / EXCLUDED

PARTNERS, OFFICERS, RELATIVES (Must be employed by business operations) TO BE INCLUDED OR EXCLUDED (Remuneration/Payroll to be included must be part of rating information section.) Exclusions in Missouri must meet the requirements of Section 287.090 RSMo.

STATE	LOC #	NAME	DATE OF BIRTH	TITLE/ RELATIONSHIP	OWNER-SHIP %	DUTIES	INC/EXC	CLASS CODE	REMUNERATION/PAYROLL

PRIOR CARRIER INFORMATION / LOSS HISTORY

PROVIDE INFORMATION FOR THE PAST 5 YEARS AND USE THE REMARKS SECTION FOR LOSS DETAILS						LOSS RUN ATTACHED
YEAR	CARRIER & POLICY NUMBER	ANNUAL PREMIUM	MOD	# CLAIMS	AMOUNT PAID	RESERVE
	CO: POL #:					
	CO: POL #:					
	CO: POL #:					
	CO: POL #:					
	CO: POL #:					

NATURE OF BUSINESS / DESCRIPTION OF OPERATIONS

GIVE COMMENTS AND DESCRIPTIONS OF BUSINESS, OPERATIONS AND PRODUCTS: MANUFACTURING - RAW MATERIALS, PROCESSES, PRODUCT, EQUIPMENT; CONTRACTOR - TYPE OF WORK, SUB-CONTRACTS; MERCANTILE - MERCHANDISE, CUSTOMERS, DELIVERIES; SERVICE - TYPE, LOCATION; FARM - ACREAGE, ANIMALS, MACHINERY, SUB-CONTRACTS.

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	Y / N
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT / WATERCRAFT?	
2. DO / HAVE PAST, PRESENT OR DISCONTINUED OPERATIONS INVOLVE(D) STORING, TREATING, DISCHARGING, APPLYING, DISPOSING, OR TRANSPORTING OF HAZARDOUS MATERIAL? (e.g. landfills, wastes, fuel tanks, etc)	
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?	
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?	
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?	
6. ARE SUB-CONTRACTORS USED? (If "YES", give % of work subcontracted)	
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INSURANCE? (If "YES", payroll for this work must be included in the State Rating Worksheet on Page 2)	
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?	
9. ANY GROUP TRANSPORTATION PROVIDED?	
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?	
11. ANY SEASONAL EMPLOYEES?	
12. IS THERE ANY VOLUNTEER OR DONATED LABOR? (If "YES", please specify)	

GENERAL INFORMATION (continued)

EXPLAIN ALL "YES" RESPONSES	Y / N
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?	
14. DO EMPLOYEES TRAVEL OUT OF STATE? (If "YES", indicate state(s) of travel and frequency)	
15. ARE ATHLETIC TEAMS SPONSORED?	
16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?	
17. ANY OTHER INSURANCE WITH THIS INSURER?	
18. ANY PRIOR COVERAGE DECLINED / CANCELLED / NON-RENEWED IN THE LAST THREE (3) YEARS? (Missouri Applicants - Do not answer this question)	
19. ARE EMPLOYEE HEALTH PLANS PROVIDED?	
20. DO ANY EMPLOYEES PERFORM WORK FOR OTHER BUSINESSES OR SUBSIDIARIES?	
21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?	
22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME? If "YES", # of Employees: _____	
23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST FIVE (5) YEARS? (If "YES", please specify)	
24. ANY UNDISPUTED AND UNPAID WORKERS COMPENSATION PREMIUM DUE FROM YOU OR ANY COMMONLY MANAGED OR OWNED ENTERPRISES? IF YES, EXPLAIN INCLUDING ENTITY NAME(S) AND POLICY NUMBER(S).	

REMARKS (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

APPLICABLE IN TENNESSEE AND VERMONT: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO ANY PARTY TO A WORKERS COMPENSATION TRANSACTION FOR THE PURPOSE OF COMMITTING FRAUD. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, DC, FL, HI, MA, NE, OH, OK, OR, VT or WA; in LA, ME, TN and VA, insurance benefits may also be denied)

IN THE DISTRICT OF COLUMBIA, WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES.

IN MASSACHUSETTS, NEBRASKA, OREGON AND VERMONT, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, MAY BE COMMITTING A FRAUDULENT INSURANCE ACT, WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO CRIMINAL AND CIVIL PENALTIES.

IN WASHINGTON, IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

APPLICANT'S SIGNATURE (Must be Officer, Owner or Partner)	DATE	PRODUCER'S SIGNATURE	NATIONAL PRODUCER NUMBER
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SCHBSIF CONTRACTORS SUPPLEMENTAL APPLICATION

HOMEBUILDER % Residential _____
 ARTISAN
 OTHER % Commercial _____

Agency Name: _____
 Applicant _____ Effective Date _____
 Type of Business _____ Applicant's Cell/Mobile # _____
 E-mail Address: _____ Website Address: _____

Has the owner ever been insured or quoted by the SCHBSIF?
 Yes No If yes, policy number(s) _____
 Do you currently have Workers Compensation coverage in force? Yes No
 If yes, who is your current WC carrier? _____ If not in force, please advise last
 cancellation/expiration date for WC coverage: _____
 Years in Business _____ Years Experience _____ # of Employees _____

Previous FEIN's, DBA's and AKA's _____
 Payroll Past Year: Employees _____
 Payroll Past Year: Uninsured Subcontractors _____

What type of uninsured subs does the applicant use? _____
 Are insured subcontractors allowed to work without providing the applicant with a certificate of insurance?
 Yes No If Yes, Details: _____

Do you use any cash, casual labor, or labor services? Yes No If Yes, how many days per year is it
 used? _____ What is the estimated cost for cash, casual or labor services? _____
 If cash services used, how is it documented? _____

Any work performed outside the state of South Carolina? Yes No If Yes, please describe _____

 Please describe hiring procedures for employees: _____

.....
 Please complete the following sections as they apply to the applicant. If N/A, please note. Explain all
 "Yes" responses in remarks.

Fall Protection

1. Is Scaffolding used? Yes No
 2. If Yes, to what height? _____
 3. Are guard rails used on scaffolding? Yes No
 Describe in detail all fall protection used on job site (i.e. guardrails, harnesses, covers, etc.) and under what
 circumstances they are used: _____

Air Conditioning & Heating

1. Any Boiler Work Done? Yes No
 2. Any Asbestos Removal Done? Yes No

Carpentry

1. Any Roofing Done? If "yes", what % _____ Yes No
 2. Any Shop Work Done? Yes No
 3. Any Renovation Work Done? If "yes", what % _____ Yes No
 4. Any Gutting of Interior Load Bearing Walls? Yes No

Electrical Wiring

1. Any Underground Cable Work? Yes No

Excavation & Grading of Land and Septic Tank Installation

1. Depth-typical and maximum _____

2. Type of Excavation: Water Lines Yes No
Sewer Yes No
Septic Yes No
Basements Yes No
Other _____ Yes No

3. Any Work Done in Streets or Roads? Yes No

4. Are trench boxes or other protection used? Yes No

Describe when and how they are used. If no, explain: _____

Insulation

1. Any removal? If "yes, indicate what type and disposal Procedures Yes No _____

2. Indicate type of insulation work done _____

Landscaping

1. Any grading of land or excavation work done? Yes No
If "Yes", what % _____

2. Any spraying of bushes, lawn, etc, with pesticides, herbicides, or fertilizers? If "Yes", explain extent, how often and what is used? Yes No

3. Any Tree Trimming work done? Yes No
If "Yes", what % _____

Masonry

1. Do you excavate also? Yes No

Painting

1. Inside % _____ Outside % _____ Yes No

2. Any work done above two stories? Yes No

3. Any epoxies used? Yes No

4. Any lead paint removal done? Yes No

Plumbing

1. Any septic tank installation? Yes No

Remarks: Explanations as needed from responses above: _____

To the best of my knowledge all the information I have given about my business is true and correct. If information is found to be different as the result of my knowingly attempting to defraud the SCHBSIF, or information is concealed for the purpose of misleading, or another person files an application for insurance containing materially false information the SCHBSIF may send direct notice of cancellation.

Officer or Owner of Business

Date



No Loss Statement

I certify that there have been no losses, accidents or circumstances that might give rise to a claim for the following time period: _____ to _____

Applicant/Member Name (Please print)

Applicant/Member Signature

Member # (If applicable): _____

P O Box 7727 Columbia, SC 29202 * 800/678-8178 * 803/771-0566
Claims Fax 803/771-1598 * Policy Services/Admin. Fax 803/252-8581

RESUME

Name of Applicant: _____

of Years in Business: New Venture

of Years Experience: _____

I, _____, have experience working in the
_____ business for the past _____ years.

My experience includes the following:

Signature of Applicant

Date

SELF-INSURANCE DIVISION

P.O. Box 1715 • 1612 Marion Street
Columbia, South Carolina 29202-1715
(803) 737-5706

APPLICATION FOR MEMBERSHIP IN A SELF-INSURED FUND

1. Fund Name: _____

2. Applicant's Name: _____

3. Applicant's Address _____

4. Applicant's Telephone Number: (____) _____

5. Employer's Federal Identification Number: _____

6. The Employer is a: (check one)

(A) Corporation: Attach a list of officers and their residence address.

(B) Partnership: Attach a list of officers and their residence address.

(C) Sole Proprietorship: Name and Residence: _____

(D) Other. Explain _____

7. Who is your present workers' compensation insurance carrier:

8. In the most recent fiscal year what was your workers' compensation premium and experience modification for South Carolina?

Premium Amount: _____ Experience Modification: _____

9. List all employment locations in South Carolina.
(provide attachment if necessary)

Locations	Number of Employees
_____	_____
_____	_____
_____	_____

10. Provide the following information for workers' compensation claims for South Carolina for the past three years.

Year	Number of Claims	Amount Paid	Amount Incurred

For further information, refer to Article 15 of the South Carolina Workers' Compensation Commission's Regulations.

SELF-INSURANCE DIVISION

P.O. Box 1715 • 1612 Marion Street
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(803) 737-5706

11. Describe the nature of your business including products manufactured, sold or services provided.

12. Provide the following employment information for the current year.

Year _____

Employee Class Codes	Number of Employees	Estimated Payroll

13. Attach a current financial statement.

14. Attach a twenty-five dollar application fee. Make the check payable to the South Carolina Workers' Compensation Commission.

In consideration of the approval of this application, the applicant agrees to fully comply with the terms of the South Carolina Workers' Compensation Act and Regulations.

If the applicant is approved, it is agreed and acknowledged, that the applicant, along with the other members of the Fund will be jointly and severally liable, for any liability of the Fund, which is incurred during the applicants membership in the Fund.

By: Applicant's Name: _____

Signature: _____

Sworn and subscribed before me
this _____ day of _____ year _____

Notary Public for: _____

My commission expires: _____

Reserved for Commission Use Only	
Fund Number: _____	Effective Date: _____

For further information, refer to Article 15 of the South Carolina Workers' Compensation Commission's Regulations.

NOTICE OF ELECTION OF COVERAGE
UNDER WORKERS' COMPENSATION LAW

To: South Carolina Home Builders
Self-Insurers Fund

Effective Date _____
Unit # 010-_____
NCDI # _____
FEIN # _____

RE: _____

Please type or print the owners' name(s)

doing business as _____

Firm or Trade name

Street Address and City

I / we, sole proprietor or partner of the above named business, do hereby certify that I / we devote full time to the proprietorship or partnership and that I / we hereby elect to be included in the definition of employee for the purpose of entitlement to benefits under the workers' compensation coverage issued to this company.

Name of Owner or Partners:

Type or print name and position under signature

Date

Signature _____

Name & Position _____

Signature _____

Name & Position _____

Signature _____

Name & Position _____

THE COVERAGE SHALL BE EFFECTIVE THIRTY DAYS AFTER RECEIPT

Statement of Assets & Liabilities
(Balance Sheet)
(if CPA-prepared balance sheet is not available, use this form)
for the purpose of
SOUTH CAROLINA HOME BUILDERS SELF INSURERS FUND

Company Name _____ Date _____

A. Current Assets

Cash on Hand..... \$ _____
 Cash in Bank..... \$ _____
 Notes Receivable..... \$ _____
 Other _____..... \$ _____
 Other _____..... \$ _____
Total of Section A..... \$ _____

B. Fixed Assets

Machinery/Tools..... \$ _____
 Real Estate..... \$ _____
 Investment..... \$ _____
 Other _____..... \$ _____
 Other _____..... \$ _____
Total of Section B..... \$ _____

C. TOTAL ASSETS (A&B)..... \$ _____

D. Current Liabilities

Accounts Payable..... \$ _____
 Other _____..... \$ _____
 Other _____..... \$ _____
Total of Section D..... \$ _____

E. Long-Term Debt

Notes Payable..... \$ _____
 Bonded Indebtedness..... \$ _____
 Mortgage Indebtedness..... \$ _____
 Other _____..... \$ _____
 Other _____..... \$ _____
Total of Section E..... \$ _____

F. TOTAL LIABILITIES (D&E)..... \$ _____

G. OWNER'S EQUITY or NET WORTH.... \$ _____

(subtract line F from line C)

Signature of Company Owner _____

Note: Applications with negative equity (line G) will be declined

