

ASSURANCE RESOURCES, INC.

Request-A-QUOTE

Type of Proposal Requested:

- Occupational Accident only
 Occupational Accident /Legal

Applicant Name _____ Requested Effective Date _____

Address _____ City _____ St _____ Zip _____ Nature of Business _____

Years in business: _____ Tax ID# _____ DOT # _____

Workers' 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 TX DOT Regulations? Yes No**Within what radius does applicant haul?** _____ Equipment Type _____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: _____ Are all employees and contract labor based in Texas? Yes No

What percentage of loads are manually loaded or unloaded (use 0% if no manual (un)loading)? _____ % Loaded _____ % Unloaded

What percentage of loads is tarped and/or strapped? _____ % tarped _____ % strapped

Does applicant perform any work at heights over 15 ft.? 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 provideDo you contract companies that may have employees or contract labor working for them? Yes No. If yes, please explain on separate sheet.

Legal Name, Address and number of employees at each location.

# of Full-Time		# of Part-Time		Occupation	Classification or Description
W-2s	1099s	W-2s	1099s		

Total Number of Employees _____ Current Workers' Comp or Accident Premium \$ _____

Quote These Coverages: Waiver of Subrogation? Yes No CTD (to full retirement age? Yes NoIncrease Weekly Income benefit to \$850? Yes No Alternate Employer Endorsement? Yes NoOccupational Disease & Cumulative Trauma? Yes No Additional AD&D (\$150,000 incl.): \$250,000Additional Passenger? Yes No**Combined Single Limit (Per Eligible Person per Accident):** \$1,000,000 \$2,000,000(for larger groups only)**Deductible (per any one Person, any one Occurrence):** \$0 \$500 \$1,000 \$2,500 \$5,000 \$10,000 \$25,000 \$50,000 \$75,000 \$100,000

Policy Includes: Benefit Period: 110 Weeks Elimination Period: 7days (Weekly Indemnity 70% up to \$600)

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)

- Has this applicant (or affiliate) been in the Texas Workers' Compensation System in the last 3 years? Yes No
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 a Safety Program? Yes No Do you conduct random drug tests? Yes No

If you answered YES to any of these questions, please give a complete description, dates, and amounts of claims on a separate sheet.

Agent and Applicant hereby acknowledge that: all answers and statements contained herein including any attached data, are true and complete;

Insurer will rely solely on the information provided in this Request-A-Quote, along with any attached data, in considering whether to provide the requested insurance coverage; and this Request-A-Quote shall become a part of the Policy should coverage be bound.

Agent Name: _____ Phone: _____ Fax _____

Agent Signature: _____ Applicant Signature: _____

Please fax this completed form to (832) 668-5884.**For assistance, please call (713) 664-9770 local, (888) 266-6401 toll free or via e-mail at quotes@ari-usa.com**