Aero Alliance Insurance Services

WORKERS COMPENSATION INSURANCE APPLICATION

Print Form

Name of Applicant _____

Address _____

Applicant Is ☐ Individual ☐ Corporation ☐ Partnership ☐ _____

Years in Business _____

Producer Aero Alliance Insurance Services, 2000 Airport Road, Suite 101A, Atlanta, GA 30341 - PHONE 770-262-7042 FAX 770-234-6874

Employer's ID # _____ Rating Bureau ID # _____

☐ Quote Date ☐ Binder Date ☐ Issue Date _____

Location	Street	City	State	Zip Code
1.				
2.				
3.				
4.				
5.				

POLICY INFORMATION

Effective Date _____ Expiration Date _____ Normal Anniversary Rating Date _____

Payment Plan ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly ☐ _____

Audit Period ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly ☐ _____

If divided risk, Name of Carrier providing Non-Aviation Workers Compensation _____

Policy # _____ Expiration Date _____

RATING INFORMATION

State	Class Code	Categories, Duties or Classifications	Number of Employees	Estimated Amount of Remuneration	Rate	Estimated Annual Premium
1.						
2.						
3.						
4.						
5.						

Specify additional coverages & endorsements

☐ U.S.L.&H.

☐ Voluntary Compensation Endorsement

☐ Coverage "B" - Employer's Liability Increased Liability to _____

☐ Other: _____

Total	
Experience Modification	
Modified Premium	
Premium Discount	
Total Estimated Premium	

MINIMUM PREMIUM _____ DEPOSIT PREMIUM _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

INDIVIDUALS - INCLUDED OR EXCLUDED

Partners, Officers, Relatives to be included or excluded, Remuneration to be included must be a part of RATING INFORMATION section

Name	Age	Title and/or Relationship	Ownership Percentage	Duties	Included/ Excluded	Class Code	Remuneration
1.							
2.							
3.							
4.							

PRIOR EXPERIENCE

Provide information for past 5 years and use 'remarks' section below for loss details

Year	Insurer & Policy Number	Annual Premium	Modification	Number of Claims	Amount of Paid Claims	Reserved Claims

NATURE OF BUSINESS - DESCRIPTION OF OPERATIONS

Give comments and description of nature of business, operations, and services

AIRCRAFT FLEET

If more convenient, attach schedule from aircraft policy or reporting form

FAA Reg. #	Year, Make, & Model of Aircraft	Crew Seats	Passenger Seats	Uses

GENERAL INFORMATION

Explain "yes" in "remarks" section, or by separate attachment

1. Does Applicant own, operate, or lease aircraft? ☐ NO ☐ YES
2. Does Applicant operate aircraft outside the continental USA? ☐ NO ☐ YES
3. Maximum number of officers and/or employees in one aircraft at one time _____
4. Average number of officers and/or employees in one aircraft at one time _____
5. Total number of hours flown by officers and/or employees during year _____
6. Are independent contractors used? ☐ NO ☐ YES
7. Any work sublet without certificate of insurance ☐ NO ☐ YES
8. Is a formal safety program in operation ☐ NO ☐ YES
9. Any exposure to chemicals or explosives? ☐ NO ☐ YES
10. Any work performed off-shore? ☐ NO ☐ YES
11. Any part-time or seasonal employees? ☐ NO ☐ YES
12. Do employees travel out of state? ☐ NO ☐ YES
13. Any employees under 16 or 65 years of age? ☐ NO ☐ YES
14. Any pre-employment physicals required? ☐ NO ☐ YES
15. Any prior coverages declined, cancelled, or not renewed in the last 3 years? ☐ NO ☐ YES

Inspection Contact & Phone _____ Accountin Contact & Phone _____

Remarks: _____

Applicant's Signature/Date _____ Producer's Signature/Date _____