



**NORTH CAROLINA WORKERS COMPENSATION INSURANCE PLAN
APPLICATION FOR DESIGNATION OF AN INSURANCE COMPANY**

<p>This application must be typed or printed and submitted to:</p> <p align="center">NORTH CAROLINA RATE BUREAU</p> <p>P.O. BOX 176010 5401 SIX FORKS ROAD RALEIGH, NC 27619 RALEIGH, NC 27609</p> <p>or you may submit an electronic application via our website at www.ncrb.org, click on the "ManageAR" link.</p>	<p>A delay in coverage may result if you fail to:</p> <ol style="list-style-type: none"> 1. Fully answer <u>all</u> questions 2. Remit proper form or amount of deposit premium 3. Include required signatures <p align="center">For questions, please call: 919-582-1056</p>	<p>This application does NOT provide insurance coverage</p> <p align="center">FOR BUREAU USE ONLY</p> <p>Spectrum ID#</p> <hr/> <p>ManageAR ID#</p>
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------

Pursuant to and in compliance with NC GS 58-36-1(5), the undersigned employer hereby applies for the designation of an insurance company to provide insurance in accordance with the provision of the NC Workers Compensation Insurance Plan.

<p>1. APPLICANT NAME (Enter complete legal name of employer)</p> <hr/> <p>DBA Name:</p> <hr/> <p>FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN)</p> <hr/> <p>TELEPHONE # (Include Area Code)</p> <hr/> <p>FAX # (Include Area Code)</p>	<p>2. MAILING ADDRESS (Including ZIP Code)</p> <hr/> <p>3. LEGAL STATUS</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> INDIVIDUAL</td> <td><input type="checkbox"/> CORPORATION</td> <td><input type="checkbox"/> OTHER: _____</td> </tr> <tr> <td><input type="checkbox"/> PARTNERSHIP</td> <td><input type="checkbox"/> LIMITED LIABILITY CO</td> <td align="center"><i>(please specify)</i></td> </tr> </table> <p>4. REQUESTED EFFECTIVE DATE</p> <p align="right"><i>NC General Statute 58-36-1(5) may determine coverage effective date.</i></p>	<input type="checkbox"/> INDIVIDUAL	<input type="checkbox"/> CORPORATION	<input type="checkbox"/> OTHER: _____	<input type="checkbox"/> PARTNERSHIP	<input type="checkbox"/> LIMITED LIABILITY CO	<i>(please specify)</i>	<p>NUMBER OF YEARS IN BUSINESS</p>
<input type="checkbox"/> INDIVIDUAL	<input type="checkbox"/> CORPORATION	<input type="checkbox"/> OTHER: _____						
<input type="checkbox"/> PARTNERSHIP	<input type="checkbox"/> LIMITED LIABILITY CO	<i>(please specify)</i>						

5. NATURE OF BUSINESS / DESCRIPTION OF OPERATIONS

GIVE COMPLETE DESCRIPTION OF BUSINESS AND OPERATIONS, INCLUDING PRODUCTS MANUFACTURED, SOLD OR SERVICED.

6. ADDITIONAL BUSINESS NAMES & LOCATIONS OF ALL NORTH CAROLINA WORK PLACES (Show principal name and location first)

NOTE: If a PO Box is used as the mailing address in Section 2, then a physical NC location must be listed below.

#	NAME, STREET, CITY, STATE, ZIP CODE	#	NAME, STREET, CITY, STATE, ZIP CODE
1		3	
2		4	

PAYROLL OFFICE ADDRESS (Street, City, State & ZIP Code)	CONTACT PERSON & TELEPHONE NUMBER (Include Area Code)
---------------------------------------------------------	-------------------------------------------------------

REMARKS

13. APPLICANT'S STATEMENT

THE UNDERSIGNED EMPLOYER (1) CERTIFIES THAT THE INFORMATION WHICH HAS BEEN GIVEN TO THE AGENT FOR COMPLETION OF THE APPLICATION IS ACCURATE TO THE BEST OF THEIR KNOWLEDGE AND BELIEF AND (2) AGREES:

1. TO MAINTAIN A COMPLETE RECORD OF ALL PAYROLL TRANSACTIONS IN SUCH FORM AS THE INSURANCE COMPANY MAY REASONABLY REQUIRE AND THAT SUCH RECORD WILL BE AVAILABLE TO THE COMPANY AT THE DESIGNATED ADDRESS DURING THE POLICY PERIOD AND FOR ONE YEAR AFTER.
2. TO COMPLY SUBSTANTIALLY WITH ALL LAWS, ORDERS, RULES AND REGULATIONS IN FORCE AND EFFECT MADE BY THE PUBLIC AUTHORITIES RELATING TO THE WELFARE, HEALTH AND SAFETY OF EMPLOYEES.
3. TO COMPLY WITH ALL REASONABLE RECOMMENDATIONS MADE BY THE INSURANCE COMPANY RELATING TO THE WELFARE, HEALTH AND SAFETY OF EMPLOYEES.

THE UNDERSIGNED EMPLOYER ALSO CERTIFIES THEY HAVE HAD NO DIFFICULTIES WITH AN AGENT OR INSURANCE COMPANY IN REGARD TO: (a) PAYROLL RECORDS; (b) THE AMOUNT OF PREMIUM CHARGED; (c) THE PAYMENT OF PREMIUM; (d) THE CARRYING OUT OF ANY RECOMMENDATION MADE FOR THE PURPOSE OF SAFEGUARDING EMPLOYEES AND (e) THE HANDLING OF ANY CLAIM OR ACCIDENT REPORT EXCEPT THE FOLLOWING:

BY SIGNING BELOW I ACKNOWLEDGE THAT THE LOSS SENSITIVE RATING PLAN, IF APPLICABLE, HAS BEEN EXPLAINED TO ME BY MY AGENT. I AGREE THAT I SHALL BE BOUND BY THE TERMS OF SUCH PLAN IF MY ESTIMATED ANNUAL PREMIUM OR PRELIMINARY PHYSICAL AUDIT PREMIUM MEETS OR EXCEEDS THE PREMIUM ELIGIBILITY REQUIREMENT.

ADDITIONAL INFORMATION, SUCH AS, BUT NOT LIMITED TO: 1 - TAX DOCUMENTATION, 2 - OWNERSHIP INFORMATION, 3 - OPERATIONS OR CONTRACTS, MAY BE REQUIRED TO CONFIRM ELIGIBILITY, CLASS CODES, ESTIMATED PAYROLLS OR OTHERWISE PROCESS THE APPLICATION.

ANY ADDITIONAL INFORMATION REQUESTED BY A NORTH CAROLINA RATE BUREAU ASSOCIATE MUST BE FURNISHED BY THE EMPLOYER OR ITS REPRESENTATIVE WITHIN THE SPECIFIED TIME FRAME. FAILURE TO PROVIDE THIS INFORMATION TIMELY MAY RESULT IN A DELAY OF COVERAGE.

THE INSURANCE TO BE PROVIDED IS THROUGH THE **NORTH CAROLINA WORKERS COMPENSATION INSURANCE PLAN** AND NOT THROUGH THE PRIVATE MARKET. VIOLATION OF ANY OF THESE AGREEMENTS OR FAILURE TO PAY VALID WORKERS COMPENSATION INSURANCE PREMIUM CHARGED MAY RESULT IN CANCELLATION OF ANY POLICY OF INSURANCE ISSUED UNDER THE NORTH CAROLINA WORKERS COMPENSATION INSURANCE PLAN.

APPLICANT SIGNATURE (REQUIRED)

SIGNATURE MUST BE OF AN EXECUTIVE OFFICER OR OWNER AND THE SIGNER MUST BE LISTED IN SECTION 9 OF THE APPLICATION.

PRINTED NAME	TITLE
SIGNATURE	DATE

14. STATEMENT OF LICENSED AGENT

I, *(printed name of agent)* _____, DO HEREBY AFFIRM THAT I AM A LICENSED NORTH CAROLINA AGENT, AND PURSUANT TO NC GS 58-36-1(5), CERTIFY THIS WORKERS COMPENSATION INSURANCE RISK TO BE DIFFICULT TO PLACE WITHIN THE STANDARD MARKET.

I AM THE PRODUCER OF RECORD YES NO *(The Producer of Record must be a licensed North Carolina resident broker)*

INCLUDED IN THIS APPLICATION IS THE INFORMATION GIVEN TO ME BY THE APPLICANT. IF THE POLICY IS CANCELLED OR INSURANCE TERMINATED WHICH RESULTS IN A RETURN OF PREMIUM TO THE INSURED, I AGREE, UPON REQUEST, TO RETURN MY PROPORTIONATE SHARE OF SUCH RETURN PREMIUM.

OUT OF STATE AGENTS MUST FURNISH A COPY OF THE AGENT'S (Not Agency) NORTH CAROLINA NON-RESIDENT'S LICENSE.

- By checking this box, I certify that I have reviewed Section 13 of the Application with the applicant prior to his/her signing.
- By checking this box, I hereby acknowledge the signature to this Application as an original signature and request, on behalf of the applicant, the designation of an insurance company to provide insurance in accordance with the provisions of the NC Workers Compensation Insurance Plan, and I certify that I have reviewed the applicant's responsibilities with the applicant and will retain a copy of the completed Application with the applicant's signature for a period of not less than five (5) years.

AGENT	FEIN OR SOCIAL SECURITY NUMBER
AGENCY	TELEPHONE #
MAILING ADDRESS	FAX #
	E-MAIL ADDRESS
AGENT SIGNATURE (REQUIRED)	

SIGNATURE OF AGENT	DATE