

NOTE: ALL INFORMATION ON THIS PAGE IS CONFIDENTIAL

10. The following payroll facts are for the twelve- month period ended (date) _____

AMOUNT OF ARKANSAS PAYROLL BY OCCUPATIONAL CLASSIFICATION*

No. of Employees	Classification	Payroll	Manual Code	Rate Per \$100	Annual Premium
Total premiums paid for the above period					\$

*As furnished by your insurance carrier, if insured. If a new company, provide projected payroll for a one-year period.

11. If the financial statement provided for evaluation is not in the name of the applicant, please indicate the name of the company and FEIN (Federal Employer Identification Number) whose financial statement is being provided.

This financial statement is to be a certified, audited, bound statement. Date of Statement: _____

Name: _____ FEIN: _____

12. If a corporation, list below the names of officers, directors, and addresses of each:

If a partnership, list the names of general or limited partners and addresses of each: _____

Sole owner: _____ Address: _____

13. What company now is carrying your compensation insurance? _____

Were you assigned to this carrier? Yes No Current Expiration Date: _____

14. Who will serve as applicant's in-house staff administrator? _____

E-Mail Address: _____ Toll-Free: _____

Address: _____

Direct Telephone No.: _____ Fax No.: _____

15. Workers' Compensation claims will be handled by Self-Administer Third Party Administrator

Name: _____

E-mail Address (if self-administering) _____

Address: _____

Telephone No.: _____ Fax No.: _____ Toll-Free: _____

16. Do you plan to reinsure any part of the compensation risk? Yes No If yes, between what limits? Specific retention \$ _____ to \$ _____ Aggregate? Yes No

17. Safety, sanitation and welfare conditions:

Is your plant inspected by anyone other than a state authority? Yes No If yes, by whom? _____

18. Is your company self-insured in any other state? Yes No If yes, where? _____

19. Past accident experience: (workers' compensation only)

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A. Fiscal Year	B. Current Experience Modifier	C. Number of Deaths	D. Number of Injuries Causing Disability of 8 days or longer	E. No. of Accidents of all Kinds including those not compensable)	F. Total Compensation & Medical Paid	G. Estimated Amount Payable on Outstanding Cases

20. In consideration of the approval of this application, the applicant hereby expressly agrees as follows:

- (a) That this privilege may be revoked at any time in the discretion of the Arkansas Workers' Compensation Commission, as provided in Commission Rule 099.05.
- (b) That the applicant will fully discharge by cash payments all liabilities that may arise under the Arkansas workers' compensation laws.
- (c) The applicant agrees to deposit, as directed by the Commission, acceptable form of security to secure payment of compensation liabilities in the amount and manner as directed by the Commission.
- (d) This applicant agrees to pay to the Arkansas Workers' Compensation Commission the premium tax and initial fee of \$100.00 as required by law.

Impress
Corporate Seal
Here

(Applicant)

By _____
(Official and Title)

State of _____)

_____)

County of _____)

_____, being first duly sworn, appeared personally and declared that the facts set forth in the foregoing application are true to the best of his/her knowledge, information and belief.

Subscribed and sworn to before me this _____ day of _____, 2 _____.

(Seal)

(Notary)

My commission expires on the _____ day of _____, 2 _____.
(This affidavit may be sworn to before any person authorized to administer an oath.)

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IMPORTANT

When the applicant is a subsidiary company, the Commission requires that the parent company shall give a satisfactory guarantee that the applicant will fully and promptly pay all sums which are or may become payable under the provisions of the Arkansas workers' compensation laws and under the terms of the agreement contained in this application.