



**Insurance Services, Inc.**

Exclusive provider of the Gold Shield Advantage™ National Security Programs

Workers' Compensation • General Liability • Employment Practices Liability • Bonds

7234 West North Avenue, Elmwood Park, IL 60707-4200

In Illinois: (708) 452-1700 Toll Free : (800) 800-1704

Fax: (708) 452-1777

Web Site: www.izzoinsurance.com

Producer: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

City, State Zip: \_\_\_\_\_

E-mail: \_\_\_\_\_

Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

**WORKERS' COMPENSATION APPLICATION**

Please Type or Print

**IMPORTANT:** All questions must be answered before this risk can be considered.

1. Name: \_\_\_\_\_

2. Address: \_\_\_\_\_

3. Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

4. Contact for Inspection: \_\_\_\_\_ Title: \_\_\_\_\_

5. Fed. Employer's I.D. No.: \_\_\_\_\_  Corporation  Partnership  Individual  Other: \_\_\_\_\_

6. Proposed Effective Date: \_\_\_\_\_ to: \_\_\_\_\_ Is Work. Comp. coverage curenly in force?  Yes  No

7. **Mailing Address** (if different from above): \_\_\_\_\_ **Additional Office Locations:**

Address: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

8. Operations in any other states?  Yes  No If yes, list states: \_\_\_\_\_

9. Where is audit to be made? \_\_\_\_\_ Audit Contact: \_\_\_\_\_

10. How long in the Security Business? \_\_\_\_\_ How many years operating under this business name? \_\_\_\_\_

11. If in business less than three (3) years, give details of owner's background in security industry or related fields: \_\_\_\_\_

12. Total Number of Security Employees: \_\_\_\_\_ Full Time: \_\_\_\_\_ Part Time: \_\_\_\_\_ Armed: \_\_\_\_\_ Unarmed: \_\_\_\_\_

13. Average Guard Hourly Wage: \_\_\_\_\_ Minimum: \_\_\_\_\_ Maximum: \_\_\_\_\_

14. Number of Guard Hours Billed Annually: \_\_\_\_\_ Armed: \_\_\_\_\_ Unarmed: \_\_\_\_\_

15. How many Employees under age 21? \_\_\_\_\_ Full Time: \_\_\_\_\_ Part Time: \_\_\_\_\_

Describe Duties & Provide Work Schedule: \_\_\_\_\_

16. How Many Employees over age 65? \_\_\_\_\_ Full Time: \_\_\_\_\_ Part Time: \_\_\_\_\_

Describe Duties & Provide Work Schedule: \_\_\_\_\_

17. Are Employees Covered by Group Medical Insurance?  Yes  No

18. Number of Dogs in Operation: \_\_\_\_\_  Attended  Unattended

Types of Assignments involving the use of dogs: \_\_\_\_\_

19. Is applicant involved in any other operation?  Yes  No

If Yes, Describe: \_\_\_\_\_

20. With regard to your clients, do you assume any duties not related to security (i.e. janitorial, maintenance, housekeeping etc.)?  Yes  No If yes, describe: \_\_\_\_\_

21. Do you maintain general liability insurance?  Yes  No Carrier: \_\_\_\_\_ Expiration date: \_\_\_\_\_

22. List all clients to whom you assign armed personnel and their duties: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
23. Describe your training programs: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
24. Indicate your pre-employment screening procedures:
- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Fingerprint         | <input type="checkbox"/> Motor Vehicle Report  | <input type="checkbox"/> Psychological Testing            |
| <input type="checkbox"/> Criminal Background | <input type="checkbox"/> Employment References | <input type="checkbox"/> Employment-Conditional Physicals |
| <input type="checkbox"/> Drug Screening      | <input type="checkbox"/> Personal References   | <input type="checkbox"/> Other: _____                     |
25. Does applicant subcontract work to others?  Yes  No Are Certificates of Insurance evidencing Workers' Compensation coverage required from subcontractors?  Yes  No
26. Number of independent contractors: \_\_\_\_\_ Armed: \_\_\_\_\_ Unarmed: \_\_\_\_\_
27. Are any Waivers of Subrogation Provided?  Yes  No If yes, how many clients require waivers? \_\_\_\_\_
28. Does applicant own or use airplanes in business?  Yes  No If yes, attach aviation questionnaire.
29. Does applicant conduct any operations on dockside or shipboard?  Yes  No If yes, describe in detail: \_\_\_\_\_  
 \_\_\_\_\_
30. Is USL&H coverage required?  Yes  No
31. a) Does applicant own any autos used in business?  Yes  No If yes, number of company owned vehicles: \_\_\_\_\_  
 b) Other than travel to and from work, do any employees use vehicles in the course of their employment?  Yes  No  
 If yes, indicate type and number of vehicles:  
 Employee owned vehicles:  Yes  No #: \_\_\_\_\_ Client Owned Vehicles:  Yes  No #: \_\_\_\_\_  
 Bicycles:  Yes  No #: \_\_\_\_\_ Golf Carts or Cushmans:  Yes  No #: \_\_\_\_\_  
 How are they used in business? \_\_\_\_\_ Any emergency response?  Yes  No
- c) Do you provide or arrange for transportation of employees to or from any site?  Yes  No If yes, describe: \_\_\_\_\_  
 \_\_\_\_\_

32. **Insurance History**

- a) Is coverage now in Assigned Risk Pool?  Yes  No  
 b) Current Policy Number: \_\_\_\_\_

c) Paid & Reserved

	Number of				
	Policy Period	Name of Insurer	Premium	Losses	Claims
Expiring	_____	_____	_____	_____	_____
1st Prior	_____	_____	_____	_____	_____
2nd Prior	_____	_____	_____	_____	_____
3rd Prior	_____	_____	_____	_____	_____
4th Prior	_____	_____	_____	_____	_____

- d) Expiring Experience Modification: \_\_\_\_\_ New Experience Modification: \_\_\_\_\_
- e) Normal Anniversary Rating Date (N.A.R): \_\_\_\_\_
- f) Has there been a name change during the past three years?  Yes  No If yes, please give previous name and date of change: \_\_\_\_\_
- g) Has any insurer canceled or refused to renew coverage within the past three years? (Not applicable in OR, ME, or NE)  
 Yes  No If yes, explain: \_\_\_\_\_
- h) Are you in debt to any broker, agent, or insurance company for any unpaid premiums for workers' compensation coverage or audits?  Yes  No If yes, explain: \_\_\_\_\_  
 \_\_\_\_\_



**OWNERSHIP DATA** (List owners, partners, officers, and/or relatives to be included or excluded):

#	NAME	TITLE	OWNERSHIP %	DUTIES	INCL/EXCL	CLASS CODE	REMUNERATION*
1							
2							
3							
4							

\*Were these payrolls included in the estimated payrolls on Page 3?  Yes  No

Requested Employer's Liability Limits:	
\$	EACH ACCIDENT
\$	DISEASE - POLICY LIMIT
\$	DISEASE - EACH EMPLOYEE

Additional Comments - Provided by  Insured  Submitting Producer:

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***NO FINANCE OR BILLING CHARGES! PREMIUM WILL BE INVOICED IN INTEREST FREE INSTALLMENTS!***

***GOLD SHIELD ADVANTAGE™***

The undersigned hereby makes application for insurance. This application is subject to the conditions and agreements as stated herein. The undersigned applicant hereby expressly agrees that the insurance applied for herein shall not be effective until such application is approved at the home office of the insurance company and shall expire or otherwise terminate in accordance with the policy provisions.

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Signature of Applicant Title Date

**Notice to Applicants:** This application must be completed in full as the insurance company will rely on the information provided to prepare a premium quotation or to offer coverage. Furnishing false or misleading information, or concealing information concerning any material fact, may void insurance coverage, and may subject the individual to criminal prosecution.

**PRODUCER'S CERTIFICATION**

The producer also certifies that the information given, including premium information, is true to the best of his/her knowledge and belief.

Producer: \_\_\_\_\_  
Name (type or print) Signature Date Lic. No.

**Required with Submission:** (Please Attach)

1. Copy of your most recently filed IRS Form 941 (Employer Quarterly Federal Tax Return).
2. Copy of complete company loss statements (3 years minimum, 5 years requested).
3. Copy of declaration sheets from current policy, including payroll classification pages.