



**WORKERS COMPENSATION  
ADDITIONAL INFORMATION REQUEST**

Answer each question on behalf of all entities seeking insurance coverage, unless specifically requested otherwise. An Additional Information section is provided at the end of this document for any information that exceeds the space provided.

**GENERAL INFORMATION**

Proposed First Named Insured And Other Named Insureds:		Today's Date (mm/dd/yyyy):
Proposed Effective Date (mm/dd/yyyy):	Proposed Expiration Date (mm/dd/yyyy):	
Risk Manager:	Email Address:	Telephone Number:
State:	Federal ID Number:	

**REQUIRED ATTACHMENTS AND INFORMATION**

- Include the following with the submission:
- Workers Compensation ACORD Application
  - NCCI Experience Modification Worksheets (if not available, provide the past 3 years of full Workers Compensation Payroll Audits.)

**WORKERS COMPENSATION INFORMATION**

1. Do you have a return to work or light-duty program? .....  Yes  No  
*If yes, what percentage of your employees (based on payroll) participate in the program?* \_\_\_\_\_ %
2. Are the following classes covered by the return-to-work or light-duty program?
  - a. Police.....  Yes  No
  - b. Fire .....  Yes  No
3. Identify any employee classes that are exempt from your return-to-work or light-duty program:  
 \_\_\_\_\_  
 \_\_\_\_\_

4. Indicate all volunteer workers that are included in your Workers Compensation Program:

Type of Volunteer	Number Volunteers	Payroll Equivalent	Rostered*
Court Ordered Community Service			<input type="checkbox"/>
Emergency Medical Responders, Ambulance, Search and Rescue Workers			<input type="checkbox"/>
Firefighters			<input type="checkbox"/>
Inmates/Work Release			<input type="checkbox"/>
Police, Sheriff, Police Chaplin			<input type="checkbox"/>
Other:			<input type="checkbox"/>
Other:			<input type="checkbox"/>
Other:			<input type="checkbox"/>
Other:			<input type="checkbox"/>

\*Some states require volunteers to be "rostered" to be eligible for coverage. Indicate that the individual is rostered to have the person included.

5. If there are more than 100 employees at a single location during one shift period, provide the following information:

- a. Location Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_
- b. What is the maximum number of employees at the location above at any one time? \_\_\_\_\_
- c. What is the building height (number of stories)? \_\_\_\_\_
- d. Are flammable liquids or heavy combustible load present?.....  Yes  No
- e. Is there underground parking beneath building? .....  Yes  No

**IMPORTANT NOTICE REGARDING COMPENSATION DISCLOSURE**

For information about how Travelers compensates independent agents, brokers, or other insurance producers, please visit this website:

[http://www.travelers.com/w3c/legal/Producer\\_Compensation\\_Disclosure.html](http://www.travelers.com/w3c/legal/Producer_Compensation_Disclosure.html)

If you prefer, you can call the following toll-free number: 1-866-904-8348. Or you can write to us at Travelers, Enterprise Development, One Tower Square, Hartford, CT 06183.

**FRAUD STATEMENTS – ATTENTION APPLICANTS IN THE FOLLOWING JURISDICTIONS**

**ALABAMA, ARKANSAS, DISTRICT OF COLUMBIA, MARYLAND, NEW MEXICO, AND RHODE ISLAND:** Any person who knowingly (or willfully in MD) presents a false or fraudulent claim for payment of a loss or benefit or who knowingly (or willfully in MD) presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**COLORADO:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**FLORIDA:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**KANSAS:** Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the insurance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

**KENTUCKY, NEW YORK, OHIO, AND PENNSYLVANIA:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 and subjects such person to criminal and civil penalties. (In New York, the civil penalty is not to exceed five thousand dollars (\$5,000) and the stated value of the claim for each such violation.)

**LOUISIANA:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**MAINE, TENNESSEE, VIRGINIA, AND WASHINGTON:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**NEW JERSEY:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**OKLAHOMA:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**OREGON:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

## SIGNATURES

Producer information only required in Florida and Iowa.

Authorized Representative Signature*: <b>X</b>	Authorized Representative Name – Printed:	Date (mm/dd/yyyy):
Producer Signature*: <b>X</b>	State Producer License No (required in FL):	Date (mm/dd/yyyy):
Agency:	Agency Contact:	Agency Phone Number:

\* If you are electronically submitting this document, apply your electronic signature to this form by checking the Electronic Signature and Acceptance box below. By doing so, you agree that your use of a key pad, mouse, or other device to check the Electronic Signature and Acceptance box constitutes your signature, acceptance, and agreement as if actually signed by you in writing and has the same force and effect as a signature affixed by hand.

- Electronic Signature and Acceptance – Authorized Representative
- Electronic Signature and Acceptance – Producer

## ADDITIONAL INFORMATION

This area may be used to provide additional information to any question. Please reference the question number.