



New Venture – No Prior Coverage Application

Résumé of Owner Experience

1. Business Name: _____
2. Owner Name: _____
3. Industry / Type of Work Performed: _____
4. Years of Industry Experience: ____
5. Years of Industry Management/Leader Experience: ____
6. Employment History for Last Three Years (Employer Name, Years Employed, City & State):

7. Hiring Practices (Check References, MVRs, Drug Screens, Physicals, etc.):

8. Has the company purchased, taken over, or merged with another company or operation?
(including taking over or hiring of employees). If yes, provide details:

Report of Claims Experience

To the best of my knowledge, I have had ____ claims, totaling \$_____ (paid and reserve) within the past three (3) years.

There are ____ open claims and ____ claims involving an employee losing time from work.

I understand that my policy, if accepted, is subject to possible cancellation or non-renewal if the company loss runs and/or experience mod history shows a discrepancy from the information stated herein.

Return to Work (RTW) – Light Duty Program

We are committed to providing and promoting a safe and healthy workplace for our employees. Preventing accidents, injuries and illnesses is our primary objective. When an employee is injured on the job, a return-to-work process to assist the employee in returning to work as soon as medically feasible. We will arrange for immediate, appropriate medical attention for employees who are injured on the job. We will attempt to create opportunities for them to return to safe, transitional work assignments as soon as medically possible. The process may have different names (return-to-work program, modified work assignments, transitional work); however, our goal remains the same: to return injured employees to safe work. If an injured employee is unable to perform all the tasks of the original job, we will make every effort to provide a transitional work assignment that meets the injured worker's capabilities. The success of this process involves the combined efforts of management, employees, our designated medical provider(s) and our workers' compensation insurance carrier.

Applicant Name and Signature _____

Agent Name and Signature _____