



WORLD EVENTS INSURANCE
SPORTS | LEISURE | ENTERTAINMENT

Workers Compensation - Info Form

Completion of this enrollment form confirms your desire to obtain insurance through World Events' Workers Compensation program. The submission of this enrollment form and/or acceptance of payment does not guarantee coverage. Certain operations are not eligible for coverage by this program. WORLD EVENTS INSURANCE reserves the right to decline any request for coverage.

TO AVOID PROCESSING DELAYS, PLEASE: COMPLETE ALL SECTIONS, SIGN AND DATE, REMIT PAYMENT.

CLIENT INFORMATION:

NAMED INSURED (as it should appear on the policy)		
Doing business as (DBA)		
ADDRESS		
CITY	STATE	ZIP

CONTACT INFORMATION:

FIRST NAME	LAST NAME
PHONE	ALTERNATIVE PHONE
FAX	EMAIL ADDRESS

OPERATING LOCATION (S) if different from mailing address:

LOCATION #1: SQUARE FOOTAGE: _____			
ADDRESS	CITY	STATE	ZIP
LOCATION #2 SQUARE FOOTAGE: _____			
ADDRESS	CITY	STATE	ZIP

DATES

Coverage will begin the day after the completed enrolment form and premium are received and approved by World Events, or on a later date you specify below. (If renewing coverage, please provide the expiration date of your current policy)

START MY COVERAGE ON THIS DATE: ____/____/____

UNDERWRITING QUESTIONS

- | | | |
|--|-----|----|
| 1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT/WATERCRAFT? | Yes | No |
| 2. DO/HAVE PAST, PRESENT OR DISCONTINUED OPERATIONS INVOLVE(D) STORING, TREATING, DISCHARGING, APPLYING, DISPOSING, OR TRANSPORTING OF HAZARDOUS MATERIA? | Yes | No |
| 3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET? | Yes | No |
| 4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER? | Yes | No |
| 5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS? | Yes | No |
| 6. ARE SUB-CONTRACTORS USED? (If "YES", give % of work subcontracted) | Yes | No |
| 7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INSURANCE? | Yes | No |
| 8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?
(If "YES", payroll for this work must be included in the State Rating Worksheet on Page 2) | Yes | No |
| 9. ANY GROUP TRANSPORTATION PROVIDED? | Yes | No |
| 10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE? | Yes | No |
| 11. ANY SEASONAL EMPLOYEES? | Yes | No |
| 12. IS THERE ANY VOLUNTEER OR DONATED LABOR? (If "YES", please specify) | Yes | No |
| 13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS? | Yes | No |
| 14. DO EMPLOYEES TRAVEL OUT OF STATE?
(If "YES", indicate state(s) of travel and frequency) | Yes | No |
| 15. ARE ATHLETIC TEAMS SPONSORED? | Yes | No |
| 16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE? | Yes | No |
| 17. ANY OTHER INSURANCE WITH THIS INSURER? | | |
| 18. ANY PRIOR COVERAGE DECLINED/ CANCELLED/NON-RENEWED
IN THE LAST THREE (3) YEARS? (Not applicable in MO) | Yes | No |
| 19. ARE EMPLOYEE HEALTH PLANS PROVIDED? | Yes | No |
| 20. DO ANY EMPLOYEES PERFORM WORK FOR OTHER BUSINESSES OR SUBSIDIARIES? | Yes | NO |
| 21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS? | Yes | No |
| 22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME?
If "YES", #of Employees: | Yes | No |
| 23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST FIVE (5) YEARS?
(If "YES", please specify) | Yes | No |
| 24. ANY UNDISPUTED AND UNPAID WORKERS COMPENSATION PREMIUM DUE FROM YOU OR ANY COMMONLY
MANAGED OR OWNED ENTERPRISES?
IF YES, EXPLAIN INCLUDING ENTITY NAME(S) AND POLICY NUMBER(S). | Yes | No |

Name(s) of independent Contractor at your facility	Does this individual carry their Liability Insurance?
	<input type="checkbox"/> Yes, their limit of coverage is \$ _____ <input type="checkbox"/> No, purchasing the optional coverage available with this program
	<input type="checkbox"/> Yes, their limit of coverage is \$ _____ <input type="checkbox"/> No, purchasing the optional coverage available with this program
	<input type="checkbox"/> Yes, their limit of coverage is \$ _____ <input type="checkbox"/> No, purchasing the optional coverage available with this program
	<input type="checkbox"/> Yes, their limit of coverage is \$ _____ <input type="checkbox"/> No, purchasing the optional coverage available with this program

INDIVIDUALS INCLUDED/EXCLUDED:

STATE	LOC #	NAME	DATE OF BIRTH	TITLE/RELATIONSHIP	OWNER-SHIP%	INCL/EXCL
CA :	1					

EMPLOYEE RAITING:

LOC #	CLASS CODE	CATEGORIES, DUTIES, CLASSIFICATION	# OF FULL TIME	# OF PART TIME	ESTIMATED ANNUAL PAYROLL
1 :					

PRIOR CARRIER INFORMATION/LOSS HISTORY:

YEAR	CARRIER	POLICY NUMBER	ANNUAL PREMIUM	MOD	# OF CLAIMS	AMOUNT PAID	RESERVE
 :							

CERTIFICATE REQUESTS

COMPLETE THIS SECTION TO REQUEST ADDITIONAL CERTIFICATES. PROVIDE SEPARATE REQUESTS FOR EACH ADDITIONAL CERTIFICATE NEEDED.		
INDICATE TYPE OF CERTIFICATE THAT YOU ARE REQUESTING: <input type="checkbox"/> ADDITIONAL INSURED <input type="checkbox"/> EVIDENCE OF COVERAGE		
CERTIFICATE HOLDER/ENTITY NAME:		
MAILING ADDRESS:		
CITY:	STATE:	ZIP:
RELATIONAHIP TO YOU: <input type="checkbox"/> OWNER/LESSOR OF PREMISES <input type="checkbox"/> BANK <input type="checkbox"/> LEINHOLDER		
DATE CERTIFICATE NEEDED BY:		<input type="checkbox"/> PRIMARY ENDORSEMENT <input type="checkbox"/> WAIVER OF SUBROGATION
/ /		
SPECIAL CERTIFICATE LANGUAGE NEEDED (please explain or attach information):		

COVERAGE EXCLUSIONS

IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO . ANY PARTY TO A WORKERS COMPENSATION TRANSACTION FOR THE PURPOSE OF COMMITTING FRAUD. PENALTIES INCLUDE ' IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF 1 MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND ' SUBJECTS THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, FL, HI, MA, NE, OH, OK, OR- _ _ TN o-r VT--; in _/, DC, LA, ME, VA and WA, insurance benefits may also be denied)

DOCUMENT DELIVERY (You will receive a certificate sowing evidence that coverage has been bound)

☐ EMAIL TO:

☐ FAX TO:

☐ MAIL TO:

ADDRESS:

I understand that the insurance company, in determining whether to provide insurance coverage, will rely on the information contained in this form and all other information being submitted. I hereby warrant, represent and confirm that, to the best of my knowledge, all information provided is complete, true and correct. World Events Insurance receives compensation from the insurance company in consideration for its performance of insurance services that include, but are not limited to; selling of policy. The insurance company compensates World Events Insurance based on a predetermined calculation of ten percent of the total premium.

I understand that, subject to applicable laws, World Events Insurance will invest the premium and, in accordance with the permission of the insurer, will receive any interest or other income that the premium generates prior to remittance to the insurer. I am aware that the insurance company expects accurate reporting for my premium calculation. I understand that my books and records may be examined or audited by the insurance company at any time during the coverage period and up to three years thereafter. Intentional misrepresentation or misreporting may jeopardize coverage.

I further acknowledge that I have reviewed all information provided with this enrollment form and understand the exclusions which apply, as well as the activities and operations for which coverage is not provided.

Applicant signature _____ **Date:** _____

Printed name: _____ **Title:** _____

**COVERAGE IS CONTINGENT UPON RECEIPT OF PAYMENT,
NO COVERAGE WILL BE DEEMED IN EFFECT UNTIL THE ACCURATE PAYMENT IS RECEIVED
BY THE COMPANY OR THEIR REPRESENTATIVE**



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