



THE BROKERAGE STORE, INC.

FAX-A-QUOTE

Type of Proposal(s) Requested:
Occupational Accident Only
Occupational Accident w/Legal
Employer's Excess Indemnity

4091 DeZavala Rd., #3
San Antonio, TX 78249
(210) 366-4800 (800) 366-4810
Fax: (210) 366-1388

Please fax or e-mail this completed form with 3 years loss history to:
Rochelle Delgado at The Brokerage Store, Inc.
Fax # (210) 366-1388 Email: rochelle@thebrokeragestore.com

Applicant Name Requested Effective Date
Address CITY ST ZIP Nature of Business
Number of years in business: Tax ID# Date of workers' comp coverage rejection:
Has worker's comp or occupational accident coverage ever been canceled, refused or non-renewed? Yes No
If Yes, please explain:

Business Type: Corporation Partnership Other:
Is applicant subject to LPG or TxDOT Regulations? Yes No. Within what radius does applicant haul?:

Does applicant handle, store, or engage in transport of hazardous materials (including but not limited to explosive, caustic, poisonous or flammable materials)? Yes No. If Yes, please explain:

Please specify commodities hauled:
What percentage of loads are manually loaded or unloaded (use 0% if no manual (un)loading)? % Loaded % Unloaded

Does applicant perform any work at heights over 24 ft.? Yes No. If Yes, please explain:

Are Owners, Officers or Partners to be covered? Yes No. Are any affiliate companies to be covered? Yes No. If yes, please provide Legal Name, Address and number of employees at each location.

Table with 5 columns: # of Full-Time EES 1099, # of Part-Time EES 1099, Classification Code, Annual Payroll by Class (Including Tips), Classification or Description

Total Number of Employees Total Payroll \$ Waiver of Subrogation? Yes No
Current Worker's Comp or Accident Premium: \$ Occupational Disease & Cumulative Trauma? Yes No

Benefits to be Quoted: LIMITS VARY BY PRODUCT. PLEASE CALL FOR OTHER OPTIONS.

CSL Benefit: Deductible: Excess Limits:
(\$100,000 - \$1,000,000 CSL) (\$1,000 - \$500,000 deductible) (\$1,000,000 to \$5,000,000 Limits available)

Benefit Period: 52 Wks 104 Wks 156 Wks Weekly Income: (75% up to \$600) Waiting Period: days

Please submit 3 years (hard copy) current valued loss history: Valuation Date of loss information:

Table with 4 columns: Year, Carrier, Total Losses, Description of Each Loss in Excess of \$5,000 (Use separate sheet if necessary)

- 1. Has this applicant (or affiliate) been in the Texas Workers' Compensation System in the last 3 years?
2. Has the applicant (or affiliate) ever had an Employer's Liability claim?
3. Has the applicant (or affiliate) ever had an Occupational Disease (e.g. Black Lung, silicosis, lead poisoning, cancer, etc.) or Cumulative Trauma (e.g. carpal tunnel, stress, etc.) claim?
4. Does the applicant have Employer's Excess Indemnity coverage? Carrier Name:
5. In the last 5 years, have you been issued any OSHA citations?

If the answer to #2, #3 or #5 is YES, please give a complete descriptions, dates, and amounts of claims on a separate sheet.

Agent and Applicant hereby acknowledge that: (a) all answers and statements contained herein, including any attached data, are true and complete; (b) Insurer will rely solely on the information provided in this Fax-A-Quote, along with any attached data, in considering whether to provide the requested insurance coverage; and (c) this Fax-A-Quote shall become a part of the Policy should coverage be bound.

Agent: Phone:
Address: Fax:
Agent Signature: Applicant Signature: