Base Agency

1099 | PROTECT

WORK INSURANCE

Wellness & Occupational RisK Covering YOU at WORK

ACCOUNT APPLICATION

Benefit Selection

$190 **WORK Select Plus [WSP41]** ○

$215 **WORK Select Elite [WSE42]** ○

Business Information

Request Effect Date

1st of THIS or NEXT Month: _____ SIC Code (if known):_____

Legal Name:_____ Business type (INC,LLC, ...): _____

Street: _____ City: _____ State:____ ZIP:_____

Email: _____ EIN #: _____ # Years in Business: _____

Contact First Name: _____ Last:_____ Phone:_____

Overview of Contracted Task:

How are Participants Compensated?: _____

Do you execute a Contractor Agreement with the Participants?: _____

Are all Participants over the age of 23 and under the age of 65?: _____

Total Number of Participants: _____

Signature of Account Applicant: _____ Date: _____

Agency Name: _____ City:_____State:_____ Zip:_____

Contact Name First: _____ Last: _____ Phone: _____

Email: _____

Signature of Producer: _____ Date: _____

Base Agency

Loss Statement

Date: _____

To whom it may concern,

Regarding: _____ (Name of Account)

Please select the reflecting period for this statement:

In the last 3 Years:

- **I/We have sustained loss(s) totaling $_____ and filed #_____ claims within the selected reflecting period,**
- **I/We have no knowledge or reason to anticipate additional claim(s) or loss(s) within the selected reflecting period, either within the named company or any associated or previously owned entities.**

I understand that this warranty will be incorporated into the insurance contract.

Signature of Account: Date:

Warranty:
The purpose of this loss letter is to assist in the underwriting process; information contained herein is specifically relied upon in the determination of insurability. The undersigned, therefore, warrants that the information contained herein is true and accurate to the best of his/her knowledge, information, and belief. This no loss letter shall be the basis of any insurance that may be issued and will be part of such policy. Please note that it is essential to provide accurate and truthful information in this statement.

CERTIFICATE HOLDER (IF NEEDED)

Complete only if a certificate holder must be listed on the Certificate of Insurance. Leave blank if not applicable.

Certificate Holder Name:

Street Address:

City: **State:** **ZIP:**