September 28, 2012

CIRCULAR LETTER TO ALL MEMBER COMPANIES

Re: Workers Compensation Insurance

Revised Application for Designation of An Insurance Company (ACORD 135 NC)
Revised Instructions for Completing ACORD 135 NC Application (ACORD 136 NC)

The Bureau has adopted and the North Carolina Department of Insurance has approved a revision to the Application for Designation of An Insurance Company (ACORD 135 NC) and the Instructions for Completing ACORD 135 NC Application (ACORD 136 NC) effective October 1, 2012 for use in connection with the North Carolina Workers Compensation Insurance Plan. The new versions of these forms have an edition date of 2012/10 and will become the mandatory form to be used for designation of an insurance company through the North Carolina Workers Compensation Insurance Plan. All previous versions of the application should be replaced as those forms will no longer be accepted by the Bureau.

The revision to these forms has been made to reflect the change in the physical address of the North Carolina Rate Bureau that occurred in August 2012.

This update will also be reflected in the ManageAR electronic online assigned risk application.

Effective October 1, 2012, ACORD applications, Instructions and/or ACORD order forms may be obtained from ACORD Customer Service at 1-800-444-3341 or www.acord.org. Agents and companies currently affiliated with ACORD will then be able to order and receive the revised ACORD 135 NC and ACORD 136 NC. Agents and companies who have ACORD forms software should contact their software vendors to request that the revised ACORD 135 NC and ACORD 136 NC be included in the vendor's next release. Additionally, a PDF version of the ACORD 135 NC and ACORD 136 NC will be available in the ManageAR System which is located inside of the Member Services area of the NCRB website: www.ncrb.org.

If you have any questions, please contact our Information Center at 919-582-1056 or via email at wcinfo@ncrb.org.

Sincerely,

Sue Taylor

Director of Insurance Operations

ST:dms

Attachments

C-12-8

# NORTH CAROLINA WORKERS COMPENSATION INSURANCE PLAN
# APPLICATION FOR DESIGNATION OF AN INSURANCE COMPANY

| This application must be typed or printed and submitted to: | A delay in coverage may result if you fail to: | This application does **NOT** provide insurance coverage |
|---|---|---|
| **NORTH CAROLINA RATE BUREAU**<br>P.O. BOX 176010 RALEIGH, NC 27619<br>2910 SUMNER BOULEVARD RALEIGH, NC 27616<br>**or** you may submit an electronic application via our website at **www.ncrb.org**, click on the "**ManageAR**" link. | 1. Fully answer all questions<br>2. Remit proper form or amount of deposit premium<br>3. Include required signatures<br>**For questions, please call: 919-582-1056** | **FOR BUREAU USE ONLY**<br>**Spectrum ID#**<br>**ManageAR ID#** |

*Pursuant to and in compliance with NC GS 58-36-1(5), the undersigned employer hereby applies for the designation of an insurance company to provide insurance in accordance with the provision of the NC Workers Compensation Insurance Plan.*

| | |
|---|---|
| 1. APPLICANT NAME (Enter complete legal name of employer) | 2. MAILING ADDRESS (Including ZIP Code) |
| DBA Name: | |
| FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN) | |
| TELEPHONE # (Include Area Code) | 3. LEGAL STATUS<br>☐ INDIVIDUAL ☐ CORPORATION ☐ OTHER: ______ *(please specify)*<br>☐ PARTNERSHIP ☐ LIMITED LIABILITY CO<br>NUMBER OF YEARS IN BUSINESS |
| FAX # (Include Area Code) | 4. REQUESTED EFFECTIVE DATE — *NC General Statute 58-36-1(5) may determine coverage effective date.* |

## 5. NATURE OF BUSINESS / DESCRIPTION OF OPERATIONS

GIVE COMPLETE DESCRIPTION OF BUSINESS AND OPERATIONS, INCLUDING PRODUCTS MANUFACTURED, SOLD OR SERVICED.

## 6. ADDITIONAL BUSINESS NAMES & LOCATIONS OF ALL NORTH CAROLINA WORK PLACES (Show principal name and location first)

NOTE: If a PO Box is used as the mailing address in Section 2, then a physical NC location must be listed below.

| # | NAME, STREET, CITY, STATE, ZIP CODE | # | NAME, STREET, CITY, STATE, ZIP CODE |
|---|---|---|---|
| 1 | | 3 | |
| 2 | | 4 | |

| PAYROLL OFFICE ADDRESS (Street, City, State & ZIP Code) | CONTACT PERSON & TELEPHONE NUMBER (Include Area Code) |
|---|---|
| | |

## REMARKS


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## 7. GENERAL INFORMATION

### Coverages and Ownership

| | YES | NO |
|---|---|---|
| 1a. HAS THERE BEEN PREVIOUS WORKERS COMPENSATION INSURANCE COVERAGE IN NORTH CAROLINA? *If "NO", please check one:* ☐ NEW BUSINESS ☐ SELF INSURED ☐ OTHER: ______ (Please specify) | | |
| 1b. HAS THERE BEEN PREVIOUS WORKERS COMPENSATION INSURANCE IN ANY OTHER STATE? | | |
| 2a. IS THERE ANY UNPAID WORKERS COMPENSATION PREMIUM DUE FROM YOU OR ANY COMMONLY MANAGED ENTERPRISES? *If "YES", please provide the following information:* | | |

**Named Insured:**

**Insurance Company:** **Policy Number:**

**Explain:**

| | YES | NO |
|---|---|---|
| 2b. IS THERE ANY UNPAID WORKERS COMPENSATION PREMIUM IN DISPUTE FROM YOU OR ANY COMMONLY MANAGED ENTERPRISES? *If "YES", please provide the following information:* | | |

**Named Insured:**

**Insurance Company:** **Policy Number:**

**Explain:**

| | YES | NO |
|---|---|---|
| 3. HAS THERE BEEN A NAME CHANGE, CONSOLIDATION, MERGER OR OWNERSHIP CHANGE DURING THE PAST FIVE YEARS? *If "YES", please provide the following information and attach a completed:* **ERM - 14** | | |

**Previous Name(s):**

**Date of Change:**

### Subcontractors

| | YES | NO |
|---|---|---|
| 4. DO YOU USE SUBCONTRACTORS AS PART OF YOUR WORK FORCE? | | |

### Professional Employer Organizations

| | YES | NO |
|---|---|---|
| 5. DO YOU LEASE WORKERS FROM A LABOR CONTRACTOR? *If "YES", please attach a completed:* **CLIENT SUPPLEMENTAL APPLICATION** | | |
| 6. DO YOU LEASE WORKERS TO A CLIENT COMPANY? *If "YES", please attach a completed:* **LABOR CONTRACTOR SUPPLEMENTAL APPLICATION (SIDE A)** | | |
| 7. ARE YOU SEEKING TO COVER THESE LEASED WORKERS? *If "YES", please attach a completed:* **LABOR CONTRACTOR SUPPLEMENTAL APPLICATION (SIDE A & B)** | | |

### Truckers

| | YES | NO |
|---|---|---|
| 8. DO TRUCKING CLASSIFICATIONS APPLY? *If "YES", please attach a completed:* **TRUCKERS SUPPLEMENTAL APPLICATION** | | |

### Other State Coverages

| | YES | NO |
|---|---|---|
| 9. ARE THERE ANY OPERATIONS IN STATES OTHER THAN NORTH CAROLINA? *If "YES", list states:* | | |
| 10. ARE YOU REQUESTING COVERAGE FOR ANY OF THESE STATES? *If "YES", list states:* | | |

NOTE: *Extension of coverage to other states is subject to designated carrier review and approval. Coverage may not be available in some states.*

## 8. INSURANCE RECORD

PLEASE PROVIDE WORKERS COMPENSATION POLICY INFORMATION FOR THE THREE PREVIOUS YEARS

| STATE | INSURANCE COMPANY | POLICY NUMBER | POLICY PERIOD FROM | TO | ANNUAL PREMIUM |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

## 9. CORPORATE OFFICERS, SOLE PROPRIETORS, PARTNERS OR MEMBERS OF A LIMITED LIABILITY COMPANY

PROVIDE A COMPLETE LIST OF THE NAMES AND TITLES, AS WELL AS THE ADDITIONAL PERTINENT INFORMATION, AS IT PERTAINS TO ALL OFFICERS, SOLE PROPRIETORS, GENERAL PARTNERS OR MEMBERS OF A LIMITED LIABILITY COMPANY. PLEASE NOTE THAT THE ANNUAL SALARY IS REQUIRED REGARDLESS OF ELECTION OR REJECTION OF COVERAGE.

| NAME | DATE OF BIRTH | TITLE | % of Ownership | DUTIES | COVERAGE ELECT | COVERAGE REJECT | CLASS CODE | APPROX ANNUAL SALARY |
|---|---|---|---|---|---|---|---|---|
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EXECUTIVE OFFICERS OF A CORPORATION ARE AUTOMATICALLY COVERED UNDER THE ACT. ANY EXECUTIVE OFFICER MAY BE SPECIFICALLY EXCLUDED FROM COVERAGE. THE PAYROLL, SUBJECT TO INDIVIDUAL MINIMUM OR MAXIMUM LIMITATIONS AS SHOWN ON THE NORTH CAROLINA RATE PAGES FOR ALL COVERED OFFICERS, MUST BE INCLUDED IN THE PREMIUM CALCULATION SECTION.

SOLE PROPRIETORS, PARTNERS AND MEMBERS OF A LIMITED LIABILITY COMPANY ARE NOT AUTOMATICALLY COVERED UNDER THE ACT. ANY SOLE PROPRIETOR, PARTNER OR MEMBER OF A LIMITED LIABILITY COMPANY MAY ELECT TO BE COVERED. THE PAYROLL, AS SHOWN ON THE NORTH CAROLINA RATE PAGES FOR THOSE COVERED INDIVIDUALS, MUST BE INCLUDED IN THE PREMIUM CALCULATION SECTION.

## REMARKS

## 10. CALCULATION OF NORTH CAROLINA ESTIMATED ANNUAL / DEPOSIT PREMIUM

| EMPLOYEE DUTIES OR CLASSIFICATION PHRASEOLOGY | CLASS CODE | ADD USL&H YES | ADD USL&H NO | # OF EMPLOYEES | TOTAL PAYROLL | RATE | PREMIUM |
|---|---|---|---|---|---|---|---|
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**Employer Limits of Liability**

Standard Limits of Liability of $100,000 / $100,000 / $500,000 apply to all NC Assigned Risk workers compensation policies. Increased limits can be requested for an additional premium.

**Do you want to increase the Employer Limits of Liability?**

☐ **YES** ☐ **NO** *If "YES", please select one:*

☐ **$500,000 / $500,000 / $500,000**

☐ **$1,000,000 / $1,000,000 / $1,000,000**

**Request for Any Additional Coverages**

DEPOSIT PREMIUM IS DETERMINED BY TAKING A PERCENTAGE OF THE ESTIMATED ANNUAL PREMIUM. THE PERCENTAGE VARIES WITH THE AMOUNT OF THE ESTIMATED ANNUAL PREMIUM (SEE BELOW)

| ESTIMATED ANNUAL PREMIUM | PAYMENT BASIS | MINIMUM DEPOSIT PERCENTAGE | ADDITIONAL PAYMENTS DURING YEAR |
|---|---|---|---|
| UNDER $5,000 | ANNUAL | 100% OF ANNUAL | NONE |
| AT LEAST $5,000 | SEMIANNUAL | 75% OF ANNUAL | ONE |
| AT LEAST $10,000 | QUARTERLY | 50% OF ANNUAL | THREE |

SUCH ADDITIONAL PAYMENTS SHALL BE IN EQUAL AMOUNTS. THE SUM OF WHICH, WHEN ADDED TO THE DEPOSIT PREMIUM, SHALL EQUAL 100% OF ESTIMATED ANNUAL PREMIUM. ESTIMATED ANNUAL PREMIUM AND THE PAYMENT SCHEDULE ARE SUBJECT TO ADJUSTMENT AT INTERIM OR FINAL AUDIT, AND A RISK MAY SELECT A HIGHER DEPOSIT PREMIUM AT INCEPTION.

THE ABOVE "DEPOSIT PREMIUM" TABLE IS FOLLOWED BY THE DESIGNATED CARRIERS. THE DESIGNATED CARRIER, BASED ON SOUND UNDERWRITING PRACTICES, HAS THE RIGHT TO MAKE APPROPRIATE CHANGES IN THE PAYMENT BASIS WHICH THE EMPLOYER HAS SELECTED. THE DESIGNATED CARRIER WILL GIVE THE REASONS FOR ANY CHANGE.

| | |
|---|---|
| **TOTAL MANUAL PREMIUM** | |
| Increased Limits of Employers Liability | |
| Balance to Increased Limits | |
| **TOTAL SUBJECT PREMIUM** | |
| Experience Modification | |
| **TOTAL MODIFIED PREMIUM** | |
| ARAP Surcharge | |
| Charge for Non-ratable Element | |
| Balance to Minimum Premium at Standard Limits | |
| **TOTAL STANDARD PREMIUM** | |
| Expense Constant | |
| Terrorism | |
| Catastrophe (Other than Certified Acts of Terrorism) | |
| **ESTIMATED ANNUAL PREMIUM** | |
| Required Deposit Premium | |
| Loss Sensitive Rating Plan Premium | |
| **TOTAL REQUIRED DEPOSIT PREMIUM** | |

## 11. PREMIUM PAYMENT

1. Coverage will NOT be assigned until receipt of payment of required deposit premium
2. Deposit premium, *payable to the NC Rate Bureau*, must be in the following form(s):
   - Certified or Cashier's Check
   - Money Order
   - Agency Check
   - Premium Finance Company Check
   - EFT (for on-line submissions only)
3. Is the premium financed? ☐ YES ☐ NO *(If "YES", attach a copy of the finance agreement)*
4. Name of Finance Company: ______________________________

## 12. REMARKS

## 13. APPLICANT'S STATEMENT

THE UNDERSIGNED EMPLOYER (1) CERTIFIES THAT THE INFORMATION WHICH HAS BEEN GIVEN TO THE AGENT FOR COMPLETION OF THE APPLICATION IS ACCURATE TO THE BEST OF THEIR KNOWLEDGE AND BELIEF AND (2) AGREES:

1. TO MAINTAIN A COMPLETE RECORD OF ALL PAYROLL TRANSACTIONS IN SUCH FORM AS THE INSURANCE COMPANY MAY REASONABLY REQUIRE AND THAT SUCH RECORD WILL BE AVAILABLE TO THE COMPANY AT THE DESIGNATED ADDRESS DURING THE POLICY PERIOD AND FOR ONE YEAR AFTER.
2. TO COMPLY SUBSTANTIALLY WITH ALL LAWS, ORDERS, RULES AND REGULATIONS IN FORCE AND EFFECT MADE BY THE PUBLIC AUTHORITIES RELATING TO THE WELFARE, HEALTH AND SAFETY OF EMPLOYEES.
3. TO COMPLY WITH ALL REASONABLE RECOMMENDATIONS MADE BY THE INSURANCE COMPANY RELATING TO THE WELFARE, HEALTH AND SAFETY OF EMPLOYEES.

THE UNDERSIGNED EMPLOYER ALSO CERTIFIES THEY HAVE HAD NO DIFFICULTIES WITH AN AGENT OR INSURANCE COMPANY IN REGARD TO: (a) PAYROLL RECORDS; (b) THE AMOUNT OF PREMIUM CHARGED; (c) THE PAYMENT OF PREMIUM; (d) THE CARRYING OUT OF ANY RECOMMENDATION MADE FOR THE PURPOSE OF SAFEGUARDING EMPLOYEES AND (e) THE HANDLING OF ANY CLAIM OR ACCIDENT REPORT EXCEPT THE FOLLOWING:

______________________________

______________________________

______________________________

BY SIGNING BELOW I ACKNOWLEDGE THAT THE LOSS SENSITIVE RATING PLAN, IF APPLICABLE, HAS BEEN EXPLAINED TO ME BY MY AGENT. I AGREE THAT I SHALL BE BOUND BY THE TERMS OF SUCH PLAN IF MY ESTIMATED ANNUAL PREMIUM OR PRELIMINARY PHYSICAL AUDIT PREMIUM MEETS OR EXCEEDS THE PREMIUM ELIGIBILITY REQUIREMENT.

ADDITIONAL INFORMATION, SUCH AS, BUT NOT LIMITED TO: 1 - TAX DOCUMENTATION, 2 - OWNERSHIP INFORMATION, 3 - OPERATIONS OR CONTRACTS, MAY BE REQUIRED TO CONFIRM ELIGIBILITY, CLASS CODES, ESTIMATED PAYROLLS OR OTHERWISE PROCESS THE APPLICATION.

**ANY ADDITIONAL INFORMATION REQUESTED BY A NORTH CAROLINA RATE BUREAU ASSOCIATE MUST BE FURNISHED BY THE EMPLOYER OR ITS REPRESENTATIVE WITHIN THE SPECIFIED TIME FRAME. FAILURE TO PROVIDE THIS INFORMATION TIMELY MAY RESULT IN A DELAY OF COVERAGE.**

THE INSURANCE TO BE PROVIDED IS THROUGH THE **NORTH CAROLINA WORKERS COMPENSATION INSURANCE PLAN** AND NOT THROUGH THE PRIVATE MARKET. VIOLATION OF ANY OF THESE AGREEMENTS OR FAILURE TO PAY VALID WORKERS COMPENSATION INSURANCE PREMIUM CHARGED MAY RESULT IN CANCELLATION OF ANY POLICY OF INSURANCE ISSUED UNDER THE NORTH CAROLINA WORKERS COMPENSATION INSURANCE PLAN.

**APPLICANT SIGNATURE *(REQUIRED)***

SIGNATURE MUST BE OF AN EXECUTIVE OFFICER OR OWNER AND THE SIGNER MUST BE LISTED IN SECTION 9 OF THE APPLICATION.

| PRINTED NAME | TITLE |
|---|---|
| SIGNATURE | DATE |

## 14. STATEMENT OF LICENSED AGENT

I, *(printed name of agent)* ______________________________ , DO HEREBY AFFIRM THAT I AM A LICENSED NORTH CAROLINA AGENT,

AND PURSUANT TO NC GS 58-36-1(5), CERTIFY THIS WORKERS COMPENSATION INSURANCE RISK TO BE DIFFICULT TO PLACE WITHIN THE STANDARD MARKET.

I AM THE PRODUCER OF RECORD ☐ **YES** ☐ **NO** *(The Producer of Record must be a licensed North Carolina resident broker)*

INCLUDED IN THIS APPLICATION IS THE INFORMATION GIVEN TO ME BY THE APPLICANT. IF THE POLICY IS CANCELLED OR INSURANCE TERMINATED WHICH RESULTS IN A RETURN OF PREMIUM TO THE INSURED, I AGREE, UPON REQUEST, TO RETURN MY PROPORTIONATE SHARE OF SUCH RETURN PREMIUM.

**OUT OF STATE AGENTS MUST FURNISH A COPY OF THE AGENT'S *(Not Agency)* NORTH CAROLINA NON-RESIDENT'S LICENSE.**

☐ **By checking this box, I certify that I have reviewed Section 13 of the Application with the applicant prior to his/her signing.**

☐ **By checking this box, I hereby acknowledge the signature to this Application as an original signature and request, on behalf of the applicant, the designation of an insurance company to provide insurance in accordance with the provisions of the NC Workers Compensation Insurance Plan, and I certify that I have reviewed the applicant's responsibilities with the applicant and will retain a copy of the completed Application with the applicant's signature for a period of not less than five (5) years.**

| | |
|---|---|
| **AGENT** | **FEIN OR SOCIAL SECURITY NUMBER** |
| **AGENCY** | **TELEPHONE #** |
| **MAILING ADDRESS** | **FAX #** |
| | **E-MAIL ADDRESS** |

**AGENT SIGNATURE *(REQUIRED)***

| SIGNATURE OF AGENT | DATE |
|---|---|

# NORTH CAROLINA WORKERS COMPENSATION INSURANCE PLAN
# INSTRUCTIONS FOR COMPLETING ACORD 135 NC APPLICATION

## NORTH CAROLINA RATE BUREAU

| | | | |
|---|---|---|---|
| *Mailing Address:* | **PO BOX 176010, RALEIGH, NORTH CAROLINA 27619-6010** | *Phone:* | **(919) 582-1056** |
| *Physical Address:* | **2910 SUMNER BOULEVARD, RALEIGH, NC 27616** | *Fax:* | **(919) 783-7467** |
| | | *Website:* | **www.ncrb.org** |

If you are completing a manual version of the ACORD 135 NC, the numbers of this instruction sheet correspond to the numbered sections on the application form itself. Attach extra sheets to the application if you need more space.

An electronic application is available on our website to agents that have established a NCRB Web User Account. If you already have an account set up, you may visit us at www.ncrb.org and click on the link for ManageAR to complete the application. Agents interested in setting up an account can access the registration form on our website as well.

**GENERAL**

- Failure to fully answer all questions, attach supplemental applications, remit proper form or amount of deposit premium and/or include required signatures may result in a delay of coverage.
- Premium payment and supplemental applications, if applicable, must accompany the application. If an application is submitted without proper premium and/or completed supplemental applications, the Rate Bureau, on the basis of available information, will calculate the estimated annual premium for you. Coverage will not become effective until after the proper premium and/or supplemental applications are received with the properly completed application, pending the effective date rules below (Section 4).
- North Carolina General Statute 58-36-1(5) and the approved North Carolina Workers Compensation Insurance Plan will govern the processing of the application and the assignment of coverage.

**MAILED APPLICATIONS (PAPER COPY)**

- Submit the application, supplemental applications, ERM-14 and any additional documentation to the NC Rate Bureau. Make a copy and keep it for your records.

**ELECTRONIC APPLICATIONS (ManageAR)**

- Submit the application via ManageAR to the NC Rate Bureau. A paper copy of the ACORD 135 NC can be printed from the system for your records. All supplemental applications, ERM-14 and additional pages of documentation must be faxed to the NC Rate Bureau. The fax number is 919-783-7467.

**SECTION 1. APPLICANT NAME**

- Show the complete legal name of the employer(s). If the applicant is a proprietorship or a partnership the full name(s) of the proprietor or general partners must be included. Include the business telephone and fax numbers, including area code, and the applicant's Federal Employers Identification Number.
- The insured named first on the Policy Information Page is given certain rights and responsibilities by the language of the policy contract. If more than one applicant employer is listed on the application, the one intended to receive these rights and responsibilities should be named first.

**SECTION 2. MAILING ADDRESS**

- Show the applicant's complete and exact mailing address, to include city, state and Zip code.

**SECTION 3. LEGAL STATUS**

- Select the proper box to designate the legal status of the primary applicant. If you check "other", please identify the applicable legal status.
- Indicate the number of years the applicant has been in business in North Carolina.

**SECTION 4. REQUESTED EFFECTIVE DATE**

- NC GS 58-36-1(5) states that coverage will be bound as follows:

To secure a requested effective date, the employer or its representative must submit to the Plan Administrator a fully completed and signed application, using an approved application submission method.

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**Depending on the application submission method, the earliest effective date for coverage will be established in the following manner:**

**Application Submission Table 1**

| **If the application (including the estimated annual or deposit premium) is submitted by regular mail and the envelope containing the application has . . .** | **Then the earliest effective date will be 12:01 a.m. on the day after . . .** |
|---|---|
| A legible U. S. postmark | Postmark |
| An illegible U. S. postmark | Receipt of the application by the Plan Administrator |
| A private postage meter mark only | Receipt of the application by the Plan Administrator |
| Internet postage with a legible cancellation stamp | The date on the cancellation stamp |
| Internet postage without a cancellation stamp or with an illegible cancellation stamp | Receipt of the application by the Plan Administrator |

**Application Submission Table 2**

| **If the application (including the estimated annual or deposit premium) is submitted by overnight mail and . . .** | **Then the earliest effective date will be 12:01 a.m. on the day after . . .** |
|---|---|
| The package containing the application has proof of mailing that can be verified | The application was sent to the Plan Administrator |
| The package containing the application does not have proof of mailing or proof of mailing cannot be verified | Receipt of the application by the Plan Administrator |
| Proof of mailing (i.e., certified mail receipt) provided by agent | Postmark |
| Proof of mailing cannot be obtained | Receipt of the application by the Plan Administrator |

**Application Submission Table 3**

| **If the application (including the estimated annual or deposit premium) is hand-delivered to the Plan Administrator . . .** | **Then the earliest effective date will be 12:01 a.m. on the day following receipt by the Plan Administrator** |
|---|---|

**Application Submission Table 4**

| **If the application (including any necessary supplemental applications) is submitted through the Rate Bureau's ManageAR system and . . .** | **Then the earliest effective date will be 12:01 a.m. on the day after . . .** |
|---|---|
| The estimated annual or deposit premium is submitted electronically via a valid electronic funds transfer | Receipt of the completed online submission |
| The estimated annual or deposit premium is submitted via regular or overnight mail | Postmark |

**IF AN APPLICANT EMPLOYS A COMBINATION OF ANY OF THE ABOVE DESCRIBED METHODS OF SUBMISSION, THE BUREAU SHALL APPLY THE ABOVE DESCRIBED RULES USED TO DETERMINE THE EARLIEST EFFECTIVE DATE BASED ON THE METHODS OF SUBMISSION EMPLOYED AND THE EARLIEST EFFECTIVE DATE OF COVERAGE SHALL BE THE LATEST EFFECTIVE DATE OF SUCH METHODS EMPLOYED BY THE APPLICANT.**

**SECTION 5. NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS**

- Completely describe the business or operations of the applicant. This information is needed to establish proper classification code assignments. Do not simply include the wording for a classification code.
- If the applicant is a service organization, describe the nature and details of the operation.
- If the applicant is a merchant, describe the products sold and any operations that involve the preparation of merchandise for sale and indicate if sales are retail or wholesale (if both, give percentage of each).
- If the applicant is a manufacturer, list the raw materials, processes and products manufactured.
- If the applicant is a contractor, describe the type of construction, erection or repair work performed and the type of equipment used. Describe the nature of any sub-contract arrangements.

**SECTION 6. ADDITIONAL BUSINESS NAMES & LOCATIONS OF ALL NORTH CAROLINA WORK PLACES**

- Enter the physical address of all permanent North Carolina locations from which the applicant operates. A post office box is not acceptable here.
- If a PO Box is used as the mailing address in Section 2, a physical North Carolina address must be entered in this Section.
- Enter the company name and physical address of the location where payroll records are maintained. A post office box is not acceptable here, unless it is the Payroll Office address. Include the name and telephone number of the person to contact regarding the applicant's payroll records.

**SECTION 7. GENERAL INFORMATION**

- Answer all questions by selecting yes or no.
- Provide any additional details or clarification as required.
- Complete the ERM-14 and/or proper supplemental application form(s) if the applicant leases employees or operates an employee leasing or trucking business.

**SECTION 8. INSURANCE RECORD**

- Provide the previous record of workers compensation insurance coverage for the applicant for the three (3) previous years.

**SECTION 9. CORPORATE OFFICERS, SOLE PROPRIETORS, PARTNERS OR MEMBERS OF A LLC**

- List the name, date of birth, title, percentage of ownership, duties, class code and approximate annual salary of each executive officer, the sole proprietor, each general partner or each member of a limited liability company and indicate whether coverage for each individual is elected or rejected. The annual salary is required regardless of election or rejection of coverage.
- Executive officers of a corporation are automatically covered under North Carolina law; however, any executive officer may be specifically excluded from coverage by endorsing the insurance policy to exclude such executive officer. The payroll, subject to the individual minimum and maximum limitations as shown on the state rate pages, for all covered executive officers must be included in the "total payroll" in Section 10 and used to calculate estimated annual premium.
- Sole proprietors, partners and members of a limited liability company are not automatically covered under North Carolina law; however, the sole proprietor, any partner or any member of a limited liability company may elect to be included as an employee, if actively engaged in the operation of the business and the insurer is notified of the election to be included. The fixed payroll amount, as shown on the state rate pages, for covered sole proprietors, partners or members of a limited liaibility company must be included in the "total payroll" in Section 10 and used to calculate estimated annual premium.

**SECTION 10. CALCULATION OF NC ESTIMATED ANNUAL/DEPOSIT PREMIUM**

- List separately employee/department duties or classification phraseology, class code, number of employees, an accurate estimate of the annual payroll, the rate and calculated premium.
- If United States Longshore and Harbor Workers (USL&H), increased limits of Employer Liability and/or other coverages are requested, indicate these in the appropriate space(s).
- Any premium $200,000 or more is subject to the mandatory Loss Sensitive Rating Plan (LSRP) and additional premium may be required.
- For an estimated annual premium in excess of $5,000, a percentage of the annual premium may be calculated as the deposit premium.

**SECTION 11. PREMIUM PAYMENT**

- Premium, payable to the North Carolina Rate Bureau, may be made by agency check, cashier's or certified check, money order, check of a premium finance company licensed in North Carolina or via Electronic Funds Transfer (EFT) for electronic web submissions.
- The estimated annual premium or proper deposit premium must be received before an assignment of coverage can be made.
- If the premium is financed, attach a copy of the signed premium finance agreement and provide the name of the premium finance company in the space provided.

**SECTION 12. REMARKS**

- Document any additional information you feel will assist in the processing of the application or to explain any issues or concerns.

**SECTION 13. APPLICANT'S STATEMENT**

- The application is incomplete unless it has been signed by an individual (i) certifying the accuracy of the information that was given to the agent and used to complete the application and (ii) agreeing to comply with basic provisions of the North Carolina Workers Compensation Insurance Plan. The individual signing the application must be the sole proprietor if the applicant is a proprietorship, a partner if the applicant is a partnership, a member if the applicant is a limited liability company or an executive officer if the applicant is a corporation.
- Additional information may be requested before an assignment of coverage can be made. Any additional information requested should be promptly submitted.
- Any requested information required by the North Carolina Rate Bureau must be provided within the specified time frame in order to prevent the return of the application with no coverage assigned.

**SECTION 14. STATEMENT OF LICENSED AGENT OR PRODUCER OF RECORD**

- North Carolina law [GS 58-36-1(5)] requires that the applicant employer be "certified to be 'difficult to place' by any fire and casualty insurance agent who is licensed in this State".
- The application is incomplete unless it has been signed by the agent.
- The application may be signed by an out-of-state agent to whom the North Carolina Department of Insurance has issued a non-resident fire and casualty agent license. A non-resident agent cannot qualify as a producer of record. A copy of the agent's non-resident license must be submitted with the application for verification purposes.
- Select the box to indicate if the agent is a producer of record (a licensed North Carolina resident broker).
- The agent must certify (by checking box) that Section 13 has been explained to the applicant.
- The agent must acknowledge (by checking box) that the agent's signature is original, that the applicant's responsibilities as they pertain to coverage in the North Carolina Workers Compensation Insurance Plan have been reviewed with the applicant. In addition, the agent agrees to retain a copy of the completed application, with the applicant's signature for a period of not less than five (5) years.
- Include the name of agent, complete agency name, mailing address, telephone and fax numbers, e-mail address and either the Federal Employer Identification Number for the agency or the Social Security Number for the agent.