# Convergence Employee Leasing, Inc.
## Client Underwriting Submission
## Request for Proposal

Client: _____ FEIN: _____

dba: _____ Years in Business: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ Fax: _____

Owner: _____ Contact: _____

Type of Business: ☐ Sole Prop. ☐ Corp. ☐ Non-Profit ☐ L.L.C. ☐ P.C. ☐ Partnership ☐ L.L.P.

Description of Operations:_____

_____

Employee Information / Payroll

| Class Code | Rate | #EE's | Duties | *Annual Payroll* |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Workers' Compensation History

| Year | Carrier | Policy # | MOD | # of Claims | Paid Losses | Total Incurred |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

(Three years of lost runs may be required from current or past carriers)

I attest that the claims information is, to the best of my knowledge, correct. I also attest that no outstanding premiums are owed to any other carrier or Professional Employer Organization.

_____ _____

Signature & Title Date

General Risk Information

| | Yes * | No | N/A |
|---|---|---|---|
| Does applicant own, operate, or lease aircraft/watercraft? | | | |
| Any past, present, or discontinued operation involving storing, treating, discharging, applying, disposing, or transporting hazardous material? | | | |
| Any work performed under, on, or above water? | | | |
| Any work which may be subject to the Jones Act, USL&H, or FELA? | | | |
| Is applicant engaged in any other type of business? | | | |
| Any work performed underground or above 15 feet? | | | |
| Are sub-contractors and/or independent contractors used? | | | |
| If "yes" are all subcontractors and employees covered by workers compensation? | | | |
| Are copies of certificates of insurance kept? | | | |
| Is there a written safety program in place? (attach copy) | | | |
| Is there a drug free work place program in place? | | | |
| Do you currently have a light duty program in place? | | | |
| Do you "full pay" during periods of disability or reduced work? | | | |
| Any group travel, ride-share programs, or tool or vehicle allowances provided? | | | |
| Do employees travel out of state or of country in the scope of the job? | | | |
| Do you provide company vehicles? | | | |
| Are MVR checked on all drivers? | | | |
| Does the radius of operation of vehicles exceed 200 miles? | | | |
| Are first aid kits kept on-site? | | | |
| Is there any volunteer or donated labor? | | | |
| Are athletic teams sponsored? | | | |
| Does the company require safety equipment to be worn? | | | |
| Are scaffolds, ladders, or man lifts used? | | | |
| Do you use or lease any labor from other employers? | | | |
| Any part time or seasonal employees used? | | | |
| Any employees under 16 or over 60 years of age? | | | |
| Does employee turnover exceed 25%? | | | |
| Any prior coverage declined, canceled, or non-renewed in the past three years? | | | |

*Explain any Yes responses here:_____

_____

_____

Signature: _____ Date: _____

## CONTRACTORS SUPPLEMENTAL APPLICATION

**COMPANY NAME** _____ **YEARS IN BUSINESS** _____

**PHYSICAL ADDRESS** _____

**TELEPHONE NUMBER** _____ **WEB SITE** _____

**LIST THE NAMES OF ALL OWNERS, PARTNERS OR PRINCIPLES**

_____

_____

_____

_____

**# F/T EMPLOYEES** _____

**AVERAGE TENURE** _____

**ANNUAL PAYROLL** $ _____

**FEIN #** _____

**STATE LICENCES (LIST ALL STATE LICENSES, AND DATES ISSUED)**

_____

_____

**STATES WHERE YOU PERFORM WORK**

_____

_____

**PROVIDE A COMPLETE DESCRIPTION OF OPERATIONS**

_____

_____

_____

| | | | | |
|---|---|---|---|---|
| 1 | **WHAT PERCENTAGE OF YOUR WORK IS PERFORMED WHEN YOU WORK AS A SUBCONTRACTOR FOR OTHERS?** | | | % |
| 2 | **WHAT PERCENTAGE OF YOUR WORK IS PERFORMED FOR YOU BY SUBCONTRACTORS YOU HIRE?** | | | % |
| | DESCRIBE ALL WORK SUBCONTRACTED TO OTHERS: | | | |
| 3 | **DO YOU EVER HIRE P/T, SEASONAL OR TEMPORARY EMPLOYEES?** | | | |
| 4 | **WHAT PERCENTAGE OF YOUR ANNUAL PAYROLL IS PAID TO P/T, SEASONAL OR TEMPORARY EMPLOYEES?** | | | % |
| 5 | **WHAT PERCENTAGE OF YOUR WORK IS:** **RESIDENTIAL** % **COMMERCIAL** % | | **Y** | **N** |
| 6 | **DO YOU OFFER MEDICAL OR HEALTH BEENFITS TO YOUR F/T EMPLOYEES?** | | | |
| 7 | **DO YOU OFFER 401K, PROFIT SHARING OR BONUSES TO YOUR F/T EMPLOYEES?** | | | |
| 8 | **DO YOU PROVIDE TRANSPORTATION TO AND FROM JOBSITES FOR YOUR EMPLOYEES?** | | | |
| 9 | **DO YOU HAVE A FORMAL SAFETY PROGRAM? (IF "YES" PLEASE PROVIDE A COPY)** | | | |
| 10 | **DO YOU EVER PERFORM WORK BELOW A DEPTH OF 2' OR ABOVE A HEIGHT OF 6'?** | | | |

**IF THE ANSWER TO # 10 ABOVE IS "YES" PROVIDE A DETAILED DESCRIPTION AND MAXIMUM DEPTHS AND HEIGHTS**

_____

_____

| | | | |
|---|---|---|---|
| 11 | **HAVE YOU EVER HAD INSURANCE COVERAGE CANCELLED FOR NON-PAYMENT OF PREMIUM ?** | | |
| 12 | **DO YOU REQUIRE PRE-EMPLOYMENT DRUG TESTS FOR ALL EMPLOYEES?** | | |
| 13 | **DO YOU REQUIRE RANDOM DRUG TESTING FOR ALL EMPLOYEES?** | | |
| 14 | **DO YOU CHECK MVRs ANNUALLY FOR ALL EMPLOYEES?** | | |

15 **PLEASE ATTACH THE FOLLOWING TO THIS APPLICATION:**

- ☐ A LIST OF ALL MOTOR VEHICLES OWNED BY THE COMPANY
- ☐ A LIST OF ALL MECHANICAL/ELECTRICAL/MOTORIZED EQUIPMENT OWNED AND USED IN THE PERFORMANCE OF WORK
- ☐ A LIST OF ALL EQUIPMENT RENTED OR LEASED (REGULARLY OR OCCASIONALLY) FOR THE PERFORMANCE OF WORK

16 **FOR ANY COMPANY IN BUSINESS FOR LESS THAN 24 MONTHS, PLEASE PROVIDE THE FOLLOWING:**

- ☐ RESUMES FOR ALL OWNERS, PARTNERS OR PRINCIPLES
- ☐ COPIES OF THE DRIVERS LICENSE FOR ALL OWNERS, PARTNERS OR PRINCIPLES

| | | | |
|---|---|---|---|
| 17 | **HAVE ANY OF THE OWNERS/PARTNERS/PRINCIPLES:** | **Y** | **N** |
| | FILED FOR BANKRUPCY IN THE PAST 5 YEARS | | |
| | OWNED OR OPERATED ANY OTHER COMPANY IN THE PAST 5 YEARS? | | |
| | IF THE ANSWER TO THE ABOVE IS "YES", PROVIDE A LIST OF NAMES, FEINS, AND YEARS OF OPERATION | | |

NAME _____ SIGNATURE _____ DATE _____

# SUNZ Insurance Company - Loss History Affidavit

This affidavit shall be utilized to validate and acknowledge a prospective company's workers' compensation loss experience, or the lack thereof, when Carrier, PEO and/or Payroll Company generated loss runs or declarations are not being presented.

**This affidavit must be completed by an owner/officer.**

**Company Information:**

I, _____ certify that _____
**(Print Owner/Officer Name)** **(Company Legal Name)**

and any related business entities through common ownership/ interest, as well as any predecessor companies listed below, if any:

_____,
**(Common Ownership/Related Entities)**

**Loss History Acknowledgement:**

☐ has not experienced any work related injuries and/or reported any workers' compensation claims and certify that no current or former employees have reported an injury in the prior 3 years from the date this form is signed.

☐ has experienced work related injuries and/or reported workers' compensation claims in the prior 3 years.

**Present all(**) injuries and details below:**

| Name of Injured Employee | Month & Year of Injury | Type of Injury | Total Cost of the Claim | Insurance Carrier, PEO and/or Payroll Co |
|---|---|---|---|---|
| | | | $ | |
| | | | $ | |
| | | | $ | |
| | | | $ | |
| | | | $ | |

****If more claims exists, within the prior 3 year period, please present on another sheet of paper using the same format.**

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 misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

**Owner/Officer (Sign): _____ Title/Position:_____ Date: _____/_____/_____**
**Electronic Signatures are not accepted**

**PEO Representative Acknowledgement**

I attest that I have counseled the aforementioned business owner/ officer regarding the presentation of loss data for underwriting.

**PEO Name: _____ Date: _____/_____/_____**

**PEO Representative Name (Print): _____ Sign: _____**

**Digital signatures are prohibited for use on this and any other document presented to SUNZ Insurance Company.**

# CONVERGENCE EMPLOYEE LEASING, INC.
# HEIGHT AFFIDAVIT

I hereby attest that the employees of _____ (Client), do not and will not perform work in excess of 20 feet or 2 stories in height. I understand that Convergence Employee Leasing, Inc. does not and will not extend workers' compensation coverage to the employees of any client who performs any work in excess of 20 feet or 2 stories.

Further, I understand that if an employee of Client is injured as a result working above these height restrictions, the employee may not be covered by Convergence's workers' compensation policy.

Signed:_____Date:_____
Client Authorized Officer Signature

Print Name:_____
Client Authorized Officer

# RESUME

## IF BUSINESS IS INCORPORATED LESS THAN 3 YEARS AGO OR IF A SOLE PROPRIETOR PLEASE COMPLETE AND SUBMIT THIS RESUME FORM

**Individual's name:**
**Company Name:**
**Address:**
**Phone:**

**Describe your current company's business operations, clients served, territory covered, etc.**

**Previous Experience for past 5 years:**

**Job Title:**
**Company Name:**
**Start Date:**
**End Date:**

**Job Responsibility/Duties:**

**Job Title:**
**Company Name:**
**Start Date:**
**End Date:**

**Job Responsibility/Duties:**

**Job Title:**
**Company Name:**
**Start Date:**
**End Date:**

**Job Responsibility/Duties:**