

# USL&H AND STATE ACT WORKERS COMPENSATION For Large Accounts – Over \$125,000 in Premium

## PROGRAM SUMMARY

TYPE	USL&H and State Act Workers Compensation
MINIMUM PREMIUM	\$125,000
PROGRAM AVAILABILITY	Coverage is available in all states and will offer the combination of State Act with USL&H Coverage (except monopolistic states, where federal only coverage may be offered) including Outer Continental Shelf Lands Act.
SECURITY	Domestic, Licensed carriers
SUBMISSION REQUIREMENTS	<ul style="list-style-type: none"> <li>• Fully completed WC Acord Application</li> <li>• Fully completed Large Account Supplementals (attached)</li> <li>• At least 4 years and current year loss runs – not over 3 months old</li> <li>• Latest NCCI MOD worksheet</li> <li>• If in business LESS THAN 3 years OR no prior coverage: Resumes detailing experience this type operation and an explanation of why no prior coverage</li> </ul>

**SEND YOUR SUBMISSION TO: [SUBMIT@LIGMarine.com](mailto:SUBMIT@LIGMarine.com) OR FAX IT TO: 727-578-9977**



**LIG Marine Managers**  
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[SUBMIT@LIGMarine.com](mailto:SUBMIT@LIGMarine.com)  
 Longshore-Large Accounts Application

# LARGE ACCOUNT SUPPLEMENTAL WORKERS COMPENSATION AND LONGSHORE ACCOUNT SUMMARY

*Please type or print legibly*

Name of Insured:						Proposed Inception Date:				
Eff. Date	Expiry Date	Carrier	Payroll \$	Experience Mod	Premium \$	Claims				
						Paid \$	Outstanding \$	Total \$	#	Valuation Date
Totals										

Any owned / chartered aircraft ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any exposure working on watercraft in navigation?	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>HISTORICAL PAYROLL SUMMARY BY CLASS CODE SUPPLEMENTAL</b>						
Class Codes	2009	2008	2007	2006	2005	TOTAL
						\$
						\$
						\$
						\$
						\$
<b>Total</b>	\$	\$	\$	\$	\$	\$

- It is vital we have a minimum of 3 years and current experience in order to quote. "As attached" is not sufficient
- This history should be for all workers compensation and longshore payroll, premium and losses combined
- Payroll history is vital
- Premium history is required unless risk has been in leasing
- Loss information must include number of claims and must be no more than 3 months old



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# Supplemental Workers' Compensation Application

Insured: \_\_\_\_\_ Web Address: \_\_\_\_\_

Detailed Description of Operations:

Are there any other commonly owned businesses which are separately insured? \_\_\_\_\_ Yes \_\_\_ No  
 If Yes, explain: \_\_\_\_\_

Are there any states in which the insured operates that are covered elsewhere? \_\_\_\_\_ Yes \_\_\_ No  
 If Yes, explain: \_\_\_\_\_

## PRIOR PAYROLL AND PREMIUM INFORMATION

	Current Year	Prior Year	Prior Year	Prior Year	Prior year
Premium					
Payroll					

## HIRING PRACTICES AND BENEFITS

Written Applications Used..... ___ Yes ___ No References Checked..... ___ Yes ___ No Pre-Employment Physicals..... ___ Yes ___ No MVR Checked..... ___ Yes ___ No Volunteer Labor Used..... ___ Yes ___ No Are Any of the Following Alternate Employer Organizations Used: <i>Professional Employer Organization (PEO), Temporary Staffing Company,</i> <i>Outsourcing Services Provider?</i> ..... ___ Yes ___ No If Yes, Explain: _____	Drug Screening (check those that apply): ___ Pre-Placement ___ Random ___ Post-Accident Employee Unions..... ___ Yes ___ No Group Medical Benefits Provided..... ___ Yes ___ No If Yes, % of employees covered..... ___% Average Wage (Governing Class Code).....\$ ___/Hour Employee Turnover Rate..... ___% Average Employee Tenure ..... ___ Year(s) Group Transportation Provided..... ___ Yes ___ No
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## MANAGEMENT AND SAFETY PRACTICES

Owners/Officers Active In Operations... ___ Yes ___ No Employee Supervision..... ___ Yes ___ No Formal Safety Program..... ___ Yes ___ No Safety Training/Orientation..... ___ Yes ___ No Safety Director..... ___ Yes ___ No Safety Committee..... ___ Yes ___ No Formal Accident Investigation..... ___ Yes ___ No	Light Duty/Early Return To Work Program..... ___ Yes ___ No Designated Medical Provider..... ___ Yes ___ No Maximum Weight Lifted Manually..... ___ lbs Personal Protective Equipment Use Enforced ___ Yes ___ No ___ N/A Any Outstanding Loss Control Recommendations From Prior Workers Compensation Carrier..... ___ Yes ___ No If Yes, Explain: _____
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## EMPLOYEE CONCENTRATION AND ADDITIONAL EXPOSURES

Describe any situation in which there is a concentration of 250+ employees in a single location (attach additional sheets if necessary)

Location Address (Street, City, Zip Code +4)	# of Employees
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Is There An Emergency Response/Evacuation Plan In Place..... Yes \_\_\_ No \_\_\_

if stop gap coverage is requested, provide annual premiums paid in ND, OH, WA, and WY.  
 If foreign travel exposure is requested, provide countries visited, work performed and total number of days per year.  
 If coverage for volunteer labor is requested, provide how many, duties, total annual hours for all volunteers.

Signature: _____	Information Supplied By: ___ Broker ___ Insured	Date: _____
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