November 18, 2005

CIRCULAR LETTER TO ALL MEMBER COMPANIES

Re: Revised Application for Designation of an Insurance Company (ACORD 135NC) and Revised Instruction Sheet (ACORD 136NC)

The Bureau has adopted and the North Carolina Department of Insurance has approved a revised Application for Designation of an Insurance Company (ACORD 135NC) and a revised instruction sheet (ACORD 136NC) effective November 1, 2005 for use in connection with the North Carolina Workers Compensation Insurance Plan. The previous version of the application form (ACORD 133NC) will be accepted through December 31, 2005. Effective January 1, 2006, the ACORD 135NC will become the mandatory form to be used for designation of an insurance company through the North Carolina Workers Compensation Insurance Plan.

The most significant revisions to the application are listed below. A version of the updated application with **all** revisions highlighted is attached for your review.

- Section 1, ***Applicant Name*** **-** A field has been added for "dba" (Doing Business As) names or trade names of the entity.

- Section 7, ***General Information*** - A question has been added in regards to the use of subcontractors.

- Section 9, ***Corporate Officers, Sole Proprietors, Partners Or Members Of A Limited Liability Company*** - This section has been changed to collect additional information applicable to the owner(s) and/or officer(s) of the business. The date of birth, percentage of ownership and Class Code associated with each officer/owner must be listed in Section 9, regardless of the election or rejection of coverage.

- Section 10, ***Calculation of North Carolina Estimated Annual/Deposit Premium*** - Revisions in this section include fields related to the USL&H (United States Longshore & Harbor Workers Act) exposure, and the calculation of the Foreign and Domestic Terrorism charges.

- Section 12, ***Remarks*** - This section can be used to communicate pertinent information to the Rate Bureau.

ACORD Applications, Instructions and/or ACORD order forms may be obtained from ACORD Customer Service (1-800-444-3341) or at www.acord.org. Agents and companies currently affiliated with ACORD will now be able to order and receive ACORD 135NC and ACORD 136NC at no additional cost. Agents and companies who have ACORD forms software should call their software vendors to request that the ACORD 135NC and ACORD 136NC be included in the vendor's next release.

Additionally, a fillable version of the ACORD 135NC, as well as the ACORD 136NC, are available on the NCRB website: www.ncrb.org. If you have any questions, please contact the NCRB Information Center at 919-582-1056 or wcinfo@ncrb.org.

Sincerely,

Sue Taylor

Director of Workers Compensation

ST:dg

C-05-13

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

CLEAR FORM

This application must be typed or printed and submitted to:

NORTH CAROLINA RATE BUREAU

P.O. BOX 176010
RALEIGH, NC 27619

5401 SIX FORKS ROAD
RALEIGH, NC 27609

or you may submit an electronic application via our website at **www.ncrb.org**, click on the "**ManageAR**" link.

A delay in coverage may result if you fail to:

1. Fully answer all questions
2. Remit proper form or amount of deposit premium
3. Include required signatures

For questions, please call: 919-582-1056

This application does **NOT** provide insurance coverage

FOR BUREAU USE ONLY

Spectrum ID#

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)

DBA Name:

FEIN OR SOCIAL SECURITY NUMBER — *If applicant employer has a Federal Employer Identification Number (FEIN), this must be entered. If not, please enter the Social Security Number (SSN) of the primary owner.*

TELEPHONE # (Include Area Code)

FAX # (Include Area Code)

2. MAILING ADDRESS (Including ZIP Code)

3. LEGAL STATUS

☐ INDIVIDUAL ☐ CORPORATION ☐ OTHER: _____ *(please specify)*
☐ PARTNERSHIP ☐ LIMITED LIABILITY CO

NUMBER OF YEARS IN BUSINESS

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)

7. GENERAL INFORMATION

Coverages and Ownership

	YES	NO
1. HAS THERE BEEN PREVIOUS WORKERS COMPENSATION INSURANCE COVERAGE IN NORTH CAROLINA OR ANY OTHER STATE? *If "NO", please check one:* ☐ NEW BUSINESS ☐ SELF INSURED ☐ OTHER: _____ (Please specify)	☐	☐
2. IS THERE ANY UNPAID WORKERS COMPENSATION PREMIUM DUE OR IN DISPUTE FROM YOU OR ANY COMMONLY MANAGED ENTERPRISES? *If "YES", please provide the following information:* **Named Insured:** _____ **Insurance Company:** _____ **Policy Number:** _____ **Explain:**	☐	☐
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

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

8. DO TRUCKING CLASSIFICATIONS APPLY? *If "YES", please attach a completed:* **TRUCKERS SUPPLEMENTAL APPLICATION**	☐	☐

Other State Coverages

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

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.

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

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	
Foreign Terrorism	
Domestic Terrorism (DTEC)	
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**