



AFC Insurance, Inc.
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PIZZA OWNERS PROGRAM WORKERS COMPENSATION APPLICATION

NAPO Membership #: _____

Business Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____

Telephone: _____ Fax: _____

Restaurant Address: _____

(List additional locations on attached form)

City: _____ State: _____ Zip: _____

Number of all owned locations: _____

Federal Identification No.: _____ State Identification Number: _____

Requested effective date: _____

Present experience modification factor: _____ % (If any, attach worksheet)

Employees (excluding owners/executive officers)		
Classification	Number	Annual Payroll
Restaurant ()		\$
Clerical 8810		\$
Delivery 7380		\$

Owners/Executive Officers			
Name	Coverage for Workers Comp?	Total Annual Income	Class Code
	<input type="checkbox"/> Yes <input type="checkbox"/> No	(If yes) \$	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	(If yes) \$	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	(If yes) \$	

List all employees that are relatives of owner(s):

Name	Relationship to Whom	Resides with Relatives
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

WORKERS COMPENSATION APPLICATION GENERAL INFORMATION

Name of Business: _____

- Is this a new business venture? Yes No
- Does Applicant own, operate or lease aircraft/watercraft? Yes No
- Are athletic teams sponsored? Yes No
- Are employee health plans provided? Yes No
- Are owners covered by major medical policy for non-work related illness or injury? Yes No
- Any prior coverage declined/canceled/non-renewed in last 3 years? Yes No
- Is applicant engaged in any other type of business? Yes No
- Are sub-contractors used to clean the restaurant? Yes No
- Any sub-contracting work allowed without certificates? Yes No
- Is there a formal safety program followed in restaurant? Yes No
- Does waitress services take all orders at tables or booths? Yes No
- Do you have any employees with disabilities? Yes No
- Do customers order food at counter from limited menu? Yes No
- Are you eligible for premium discounts for state file programs? Yes No

If yes, please list: _____

Prior claims reported reports were ordered from present agent on: _____

CLAIMS STATEMENT

The undersigned declares:

For the purpose of applying for insurance coverage, I confirm that there were NO losses for the past 4 years from date of this statement EXCEPT as indicated below:

Date of Loss	Description of Injury	No. Days off Work	Total Claim Cost
			\$
			\$

PRIOR POLICY(IES)/LOSS HISTORY:

Company/Policy Number _____ Exp. Date _____

Company/Policy Number _____ Exp. Date _____

During the past 3 years, has any coverage been cancelled, non-renewed, declined or placed in non-standard markets? Yes No

Have there been any claims or occurrences that may give rise to a claim for the prior three (3) years? Yes No

If yes, attach summary including date of loss, amount paid and description of loss.

Authorization:

I/We understand that no liability is created or assumed by the insurance company until and unless the policy applied for has been issued.

I/We understand that this application is not the policy and in no way supplements, augments, or changes any of the language of the policy. For specific coverage information, please refer to your policy contract.

I/We affirm that the information contained herein is true to the best of my/our knowledge and that it shall be the basis for which this policy issued. I/We hereby authorize the release of claim information from any prior insurer to the Company or its representatives.

Print Name: _____

Signature: _____ Date: _____

WORKERS COMPENSATION APPLICATION ADDITIONAL LOCATIONS

Business Name: _____

List all additional locations below:

2.			
	City:	State:	Zip:
3.			
	City:	State:	Zip:
4.			
	City:	State:	Zip:
5.			
	City:	State:	Zip:
6.			
	City:	State:	Zip:
7.			
	City:	State:	Zip:
8.			
	City:	State:	Zip:
9.			
	City:	State:	Zip:
10.			
	City:	State:	Zip: