LAC SELF-INSURED FUND
WORKERS' COMPENSATION INSURANCE
PRE-APPLICATION CHECKLIST

DATE:_________________

Contact Name: ____

Company Name or D/B/A ____

Mailing Address:____

Phone #________________________Cell#____________________Fax#__________________

Describe business operations:___________________________________

____

Previous work comp carrier/agent:________________________________

(If yes, we need 3 year Loss Run/History Report from agent. Fax to 318.322.3172 with this form)

Federal Tax ID #: ___________________Requested date of coverage:______________________

Amount of Annual Payroll:_____________________________________

No. of Employees:_______ Do you transport employees? Yes ( ) No ( ) If yes, maximum number of employees per conveyance? _______

Additional insured(s):____

Additional insured's tax number(s):_______________________________

Is all land in Louisiana?___________ If not, where do the employees live and state which state were they hired?___________________________________

Address or approximate location of land & Parish:___________________

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Does applicant have any employees subject to USL&H, Jones Act or Federal Employers Liability?

____

Does applicant own or lease any aircraft of watercraft?_________________

Name of owners/partners/officers:________________________________

____

Who referred you to us? Comments:_______________________________

____

You may email, mail, or fax this form

latoya_welch@ajg.com

3000 Kilpatrick Blvd • Suite 100 • Monroe, LA 71201

Fax # 318.322.3172

If you have questions regarding this form call 1.800.798.2999. This form does not bind coverage nor does it obtain your membership into the LAC SIF. This form is used only to begin the application process. Once received you will be contacted.