

**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: _____

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

Does applicant own or lease any aircraft or watercraft? _____

Name of owners/partners/officers: _____

Who referred you to us? Comments: _____

You may email, mail, or fax this form

latoya_thomas@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.