



# Member Insurance

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## WORKERS' COMPENSATION SUPPLEMENTAL APPLICATION

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1. Proposed effective date: \_\_\_\_\_
2. Federal Tax Identification Number: \_\_\_\_\_
3. Payroll by Job Classification by State \_\_\_\_\_:      Number of Employees:
  - a. Guards \$ \_\_\_\_\_      \_\_\_\_\_
  - b. Sales Staff \$ \_\_\_\_\_      \_\_\_\_\_
  - c. Clerical \$ \_\_\_\_\_      \_\_\_\_\_
  - d. Investigative \$ \_\_\_\_\_      \_\_\_\_\_
  - e. Alarm Installation \$ \_\_\_\_\_      \_\_\_\_\_
  - f. Supervision \$ \_\_\_\_\_      \_\_\_\_\_

4. **If working in more than one State, on a separate sheet of paper supply the same information as in number 3.**

5. Partners/Officers

Name	Title	% Ownership	Include/Exclude	Remuneration
<u>Description of Duties:</u>				

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<u>Description of Duties:</u>				

**ISPLA Workers' Compensation Supplemental Application**

6. Are any subcontractors used in your business?  Yes  No If yes, what services do they provide?

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6. Number of employees: \_\_\_\_\_

7. Do you lease employees from others?  Yes  No:

8. What is the maximum number of employees at any one location at the same time? \_\_\_\_\_

9. Do you provide any group transportation?  Yes  No

10. Do employees have exposures to navigable waters or upon ships?  Yes  No

11. Describe all claims resulting in wage losses:

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## Current Carrier Information: Workers' Compensation

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Policy Information:

Insurance Company	Effective Dates	Payroll	Experience Modification	Total Annual Premium

1. Has any carrier ever cancelled or refused to renew your policy?  Yes  No

If yes, describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Other Coverages Desired (attach appropriate Acord form applications)

Property: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Crime: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Hired and Non-Owned Auto: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Disclosure/Authorization/Declarations

WARNING NOTICE): Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

The undersigned Applicant authorizes the Company, its agents, and representatives to secure claims information from my current and previous insurance carriers.

THE UNDERSIGNED DECLARES THAT TO THE BEST OF THEIR KNOWLEDGE AND BELIEF THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERSIGNED TO PURCHASE INSURANCE, NOR DOES REVIEW OF THE APPLICATION BIND THE INSURER TO ISSUE A POLICY. IT IS AGREED, HOWEVER, THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED.

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Applicant Signature

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Date

The undersigned agent or broker additionally agrees to be responsible for any earned premium developed on any policy issued based on this application.

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Agent or Broker Signature

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Date