AMERIND Tribal Workers' Compensation (TWC) Application

NOTE: All questions must be answered in order to obtain quote

QUOTE #:

EMPLOYER INFORMATION	
Name of Entity:	
Mailing Address:	Physical Location (if more than one, refer to page 2):
City State Zip Code	
Proposed Term of Coverage:	Employer Federal Identification No:
NOTE: Please complete a separate application for each Tribal Business Enterprise participating in the Tribal Workers' Compensation risk pool. If all Tribal operations or business enterprises are conducted under a single business name, complete one application and indicate the appropriate payroll and employee count for each operation under the Classification section of the application.	
Primary Contact:	Alternate Contact:
Phone:	Phone:
Fax:	Fax:
Email:	Email:

OPERATIONAL INFORMATION

Business Entity Type (check all that apply)

- Federally Recognized Tribe
- Tribal Trade Name
- Tribal Government
- Indian Housing Authority
- Tribally Designated Housing Entity
- Partnership
- Limited Liability Partnership (LLP)
- Limited Liability Company (LLC)
- Federal Corporation (Section 17)
- Sole Proprietorship
- Other Corporation
- Other: ____

State Recognized Tribe (State allows the tribe to follow its own sovereignty and rules): Yes No

Tribal Worker's Compensation Ordinance or Law? Yes No (if "Yes," please attach copy)

Tribal Business License Ordinance or Law? Yes No (if "Yes," please attach copy)

UNDERWRITING INFORMATION

Please indicate Yes or No if the following applies to your organization:			***If No is selected, describe below***
1. Are all operations conducted on Tribal Land?	Yes	No	
2. Full time Risk Manager or Safety Officer	Yes	No	
3. Are employee health plans provided?	Yes	No	
4. Medical doctors/nurses/emergency medical technicians on staff	Yes	No	
5. Medical facilities within the Reservation/ Community:			
IHS Clinic	Yes	No	
638 Contracted Health Care	Yes	No	
Private Health Care	Yes	No	
6. Written Emergency Response Procedures	Yes	No	
7. "Return to Work" Program for Injured Employees	Yes	No	
8. Pre-Employment Drug Testing	Yes	No	
9. Post-Accident Drug/Alcohol Testing	Yes	No	
10. New Employee Orientation Program	Yes	No	
11. Is a Safety program in operation?	Yes	No	
12. Lock Out/Tag Out Program for Industrial Equipment	Yes	No	
13. Any work performed underground or above 15 feet?	Yes	No	
14. Hazardous Materials Handling Program	Yes	No	
15. Tribal Court System	Yes	No	

16. Does the applicant operate any vehicles? Yes No

If "Yes," number of vehicles owned or leased:

Passenger car	Buses/Vans (with more than 14 passengers)
Sport utility vehicles	Heavy Trucks (26,000 - 46,000 lbs. GVW)
Light/Medium trucks / Vans	Extra Heavy Trucks/Tractors (over 46,000 lbs. GVW)

If "Yes," how often are employee Driving Records checked?

17. Does applicant provide transportation to/ from the workplace?] Yes No

If "Yes," average number of employees in any one vehicle:

18. Does the Applicant own, lease, or charter aircraft?	Yes	No	If "Yes," additional information will be required
19. Does the Applicant own, operate or lease watercraft?	Yes	No	**NOTE:** We do not provide coverage per federal acts.
20. Are Subcontractors used?	Yes	No	**NOTE**: We do not provide coverage for subcontractors.
21. Any prior coverage Declined / Canceled / Non-Renewed in the last three (3) years?	Yes	No	

CONCENTRATION OF RISK IDENTIFICATION
Provide listing of locations to be covered: (Attach supplemental page if needed)

Location #	Physical Address	Description	Maximum Number of Employees at any ONE time*

*Employees = Total number of employees on site and maximum number of employees on site at any one time per work shift.

CLASSIFICATIONS

Location #	Class Code	Classification Description	Operation or Department	Payroll	# of Employees
	<8810>	<Example: Tribal Government>	<Judicial Clerks>	$<xxx,xxx,xxx>	

ADDITIONAL COMMENTS

ADDITIONAL INFORMATION REQUIRED
All Covered Employers
Please attach a copy of the following (if applicable): Current Workers Compensation policy. Workers Compensation loss experience for the past three years. Experience Modification worksheet for current/expiring year.
All Covered Tribal Enterprise And Construction Employers
Please attach a copy of the following: Most recent annual financial statement

CERTIFICATION
I, as the authorized officer, agent, or official of the organization below, have completed the application to participate in the AMERIND Tribal Workers' Compensation. I verify that the information provided in this application is true and correct based upon my knowledge, information and belief, and I have disclosed all known hazards and conditions that could give rise to a claim under the Tribal Workers' Compensation policy. I understand any false, misleading, or incomplete statement relied on by Tribal Workers' Compensation in underwriting this application for coverage will void the Tribal Workers' Compensation policy.

Submitted By:

____________________ Printed Name of Authorized Representative

____________________ Authorized Representative Signature

__________ Date

____ Entity Name

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