

InsuranceTek Inc.

Phone #888-505-1555

Fax # 800-521-1528

Workers Compensation Application

Company Name _____

Mailing _____

Phone # _____
 Date _____

Contact Name _____

Yrs in Bus _____

Email Address _____

Fed. ID # _____

**Individual
LLC**

**Partnership
Corporation**

Proposed EFF Date _____

Current Ins Co: _____ Expiration Date: _____ Years w/Co _____

Liability Limits	
\$	Each Accident
\$	Policy Limit
\$	Each Employee

Waiver of Subro Naming

Location Address _____
 (Copy if more than one state)

Employee Class	Payroll	# of Employees
Office/Clerical		
Insurance Investigations		
Process Servers		
Other PI Classes		
Security Armed		
Security Unarmed		
Home Inspections		
Janitorial		
Landscape		
Maintenance		
Handyman		

Employers Liability will be included when available

No deductible will apply unless requested

Offshore Coverage Available

Please provide declaration of prior insurance to ensure we include your experience rate

Owners/Partner/Officers		Included or Excluded			
Name	D.O.B.	% of Own	I/E	Social Sec #	Duties
	/ /				Payroll
	/ /				
	/ /				

WC-10 NOTICE OF ELECTION OR REJECTION OF WORKERS' COMPENSATION COVERAGE GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF ELECTION OR REJECTION OF WORKERS' COMPENSATION COVERAGE

The use of this type of form is required under most State Labor Laws. Please ensure you understand your state Workers' Compensation Law.

A. CORPORATION / LIMITED LIABILITY COMPANY	
I, _____ <small>(Type or Print Name)</small>	, certify that I am a officer/member of _____ <small>(Employer)</small>
_____ <small>(Office Held)</small>	_____ <small>(Street Address)</small>
<input type="checkbox"/> I elect to be covered for Workers' Compensation	_____ <small>City / State / Zip Code</small>
<input type="checkbox"/> I elect to to reject Workers' Compensation _____ <small>(Date)</small>	
<small>(NOTE: A maximum of five (5) officers / members may be exempted)</small>	

B. SOLE PROPRIETOR OR PARTNER	
I, _____, certify that I am a <input type="checkbox"/> Sole Proprietor	of _____ <small>(Business Name)</small>
<input type="checkbox"/> I elect to be covered for Workers' Compensation	<input type="checkbox"/> Partner
<input type="checkbox"/> I elect to to reject Workers' Compensation _____ <small>(Date)</small>	

C. SUB-CONTRACT LABOR	
I, _____, certify that as the employer or representative of _____	, that <small>(Business Name)</small>
<input type="checkbox"/> I elect to provide Workers' Compensation on subcontract laborers with projected costs of \$ _____	
<input type="checkbox"/> I elect to reject Workers' Compensation to extend _____ <small>(Date)</small>	

D. CERTIFICATION		
I hereby certify that the information listed is true and correct		
Print Name - Position	Business Phone Number and Ext.	Signature
Business Address		
Dated this _____ Day of _____ / _____ <small>(Month) (Year)</small>		
<small>A COPY OF THIS FORM MUST BE FILED WITH YOUR CURRENT WORKERS' COMPENSATION CARRIER. IF YOU DO NOT HAVE A CARRIER, THIS FORM MUST BE FILED WITH THE STATE BOARD OF WORKERS' COMPENSATION AT 270 PEACHTREE STREET, N.W., ATLANTA, GEORGIA 30303-1299. NOTE: DO NOT SEND TO THE BOARD IF THERE IS INSURANCE COVERAGE</small>		

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404 -656-3818 OR 1-800-533-0662 OR VISIT <http://www.sbcw.georgia.gov>

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).