SmartComp SOLUTIONS
Payroll • Workers Comp • HR • Benefits

REQUEST FOR PROPOSAL

Submit To: **SmartComp Solutions**
Email: Submit@smartcompinc.com
Fax: 727-471-5562
Phone: 727-471-5559

Company Name: FEIN:

DBA (If any): Years in Business:

Sole Prop. ☐ Corporation ☐ Non-Profit ☐ LLC ☐ Partnership ☐

Owner's Name:	Contact Name:
Phone:	Phone:
Fax:	Fax:
Email:	Email:

Mailing Address:

City: State: Zip:

Additional Locations:
1.
2.
3.
4.

Description of Operations:

*Does this client have current Workers Comp Coverage? Yes ☐ No ☐ *If No, Complete pages 3 & 4 - Loss History Affidavit *If Yes, Complete below & attach carrier Loss History Report

Current Comp Carrier: Expiration Date:

Policy #: Desired Payroll Frequency: Weekly

State	WC Code	Description	# of EE's	Annual Payroll

Prospect Client Name: _____

Workers' Comp Questionnaire	Yes	No	Explained Below
SEE "EXPLAIN IF" & COMMENT BY NO. or USE N/A WHERE APPROPRIATE			
1. Does applicant own, operate or lease aircraft/watercraft?	☐	☐	
2. Any past, present or discontinued operations which have involved exposure to chemicals, painting or hazardous materials?	☐	☐	
3. Any work performed under, on or above water?	☐	☐	
4. Any work which may be subject to Jones Act, USL&H or FELA?	☐	☐	
5. Any work performed underground or higher than 15 feet above ground level?	☐	☐	
6. Any operations include excavation, tunneling, road boring, earth moving or other underground work?	☐	☐	
7. Any operations exposure to radioactive/nuclear materials?	☐	☐	
8. Any fatalities in the past five years?	☐	☐	
9. Is applicant involved in any business other than that specified in the description of operations?	☐	☐	
10. Does employee turnover exceed 30% annually?	☐	☐	
11. Do employees travel out of state or out of country? If so, scope of travel?	☐	☐	
12. Any group travel, ride-share programs, or tool or vehicle allowances provided?	☐	☐	
13. Are physicals required after offers of employment are made?	☐	☐	
14. Does the radius of operations of vehicles exceed 200 miles?	☐	☐	
15. Are MVRs checked on all drivers?	☐	☐	
16. Is a "managed care" provider utilized?	☐	☐	
17. Is a written safety program in place?	☐	☐	
18. Has applicant been inspected by OSHA in the past three years?	☐	☐	
19. Was applicant cited for any violations? If so, explain.	☐	☐	
20. Was applicant fined? If so, how much?	☐	☐	
21. Is a drug-testing program in effect?	☐	☐	
22. Is an early return/light duty program in place?	☐	☐	
23. Does applicant "full pay" during periods of disability or reduced work?	☐	☐	
24. Are any subcontractors used? If yes, list percent, type and location of work subcontracted.	☐	☐	
a. Are all subcontractors insured?	☐	☐	
b. If so, does applicant keep copies of certificates of insurance?	☐	☐	
25. Any prior coverage declined, cancelled or non-renewed in the past three years?	☐	☐	
26. Have there been any losses in the last three years?	☐	☐	
27. Are any employees enrolled in a group health plan? If yes, what percentage?	☐	☐	

Comments:

_____ _____

Signature Date

Please complete if no prior coverage for past 3 years

Workers' Compensation Loss History Affidavit

I, _____, do herby certify and swear that
(name of owner or officer)

_____have incurred _____ injuries within
(company name)

the last 36 months. Please list the injuries and the cost in the table

below.

Date of Claim	Name of Injured	Amount of Claim	Open or Closed	Description of Injury

Note: If there have been no injuries write "None" in the table above

Explanation if an individual claim amount exceeds $15,000

_____
_____
_____
_____
_____
_____
_____

Company Name _____

Signanture _____

Title/Position _____ Date _____

Any person who knowingly and with intent to injure, defraud, or deceive any insurer file, statement of claim, or an application containing any false, incomplete, or misleading information with the purpose of avoiding or reducing the amount of premiums for workers' compensation coverage or conceal information pertinent to the computation and application of an experience rating modification factor, is guilty of a felony of the third degree or as otherwise punishable as provided under the law.

Please complete if no prior coverage for past 3 years

This affidavit shall be utilized to validate and acknowledge a prospective company's workers' compensation loss experience, or the lack thereof, when Carrier, PEO and/or Payroll Company generated loss runs or declarations are not being presented.

This affidavit must be completed by an owner/officer.

Company Information:

I, _____ certify that _____
(Print Owner/Officer Name) **(Company Legal Name)**

and any related business entities through common ownership/ interest, as well as any predecessor companies listed below, if any:

_____,
(Common Ownership/Related Entities)

Loss History Acknowledgement:

❑ has not experienced any work related injuries and/or reported any workers' compensation claims and certify that no current or former employees have reported an injury in the prior 3 years from the date this form is signed.

❑ has experienced work related injuries and/or reported workers' compensation claims in the prior 3 years.

Present all(**) injuries and details below:

Name of Injured Employee	Month & Year of Injury	Type of Injury	Total Cost of the Claim	Insurance Carrier, PEO and/or Payroll Co
			$	
			$	
			$	
			$	
			$	

****If more claims exists, within the prior 3 year period, please present on another sheet of paper using the same format.**

It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers' compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines, and denial of insurance benefits. Any person who knowingly, and with intent to defraud any insurance company or another person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

Owner/Officer (Sign): _____ **Title/Position:**_____ **Date:** _____/_____/_____

PEO Representative Acknowledgement

I attest that I have counseled the aforementioned business owner/ officer regarding the presentation of loss data for underwriting.

PEO Name: _____ **Date:** _____/_____/_____

PEO Representative Name (Print): _____ **Sign:** _____

Digital signatures are prohibited for use on this and any other document presented to SUNZ Insurance Company.