



BYRNE - KIM & ASSOCIATES
Insurance Services, Inc.

30100 Town Center Dr, Ste O, PMB. 317. Laguna Niguel, CA 92677
Tel (949) 249-2540
Fax (949) 270-3704

Workers' Compensation Application

Name (First Named Insured & Other Named Insured's). _____

Contact Name: _____
DBA: _____
Proposed Effective Date: _____
Mailing Address: _____

Work Telephone#: _____ Work Fax #: _____
Email Address: _____ Web Address: [www.](#) _____

Business Entity: _____ Year Business Start: _____
FEIN or S.S. #: _____

Nature of Business/Description of Operations by Premise(s)

List other States you have operations, or Workers' Compensation in effect: _____

Please list information below: (leave class code blank if unsure, payroll actual or estimated)

Class Code: _____ Payroll: \$ _____ Description: _____
#Full Time: _____ # Part Time: _____ #Seasonal: _____

Class Code: _____ Payroll: \$ _____ Description: _____
#Full Time: _____ # Part Time: _____ #Seasonal: _____

Class Code: _____ Payroll: \$ _____ Description: _____
#Full Time: _____ # Part Time: _____ #Seasonal: _____

Class Code: _____ Payroll: \$ _____ Description: _____
#Full Time: _____ # Part Time: _____ #Seasonal: _____

Please explain any Yes answers:

1. Does applicant own/lease/operate any aircraft or watercraft? Y / N
2. Do/Have you at any time had operation involved in: storing, treating, discharging, disposing, transporting of hazardous materials? Y / N
3. Any work performed below ground or higher than 15 feet? Y / N
4. Any work performed in/on or over water? Y / N
5. Does applicant own or operate any other type of business? Y / N
6. Does applicant use contractors? if yes please give percentage sub-contracted Y / N
7. Does applicant use contractors with out certificates of insurance? Y / N
8. Does applicant have a written safety program or injury illness prevention program in force? Y / N
9. Does applicant provide any group transportation? Y / N
10. Does applicant hire any seasonal employees? Y / N
11. Does applicant use any volunteer employees? Y / N
12. Do any of your employees travel out of state? (if yes please give frequency and distances traveled) Y / N
13. Does applicant sponsor any sports events or teams? Y / N
14. Are physicals required by all employees? (if yes before employment or post employment) Y / N
15. Has applicant had any prior coverage Declined/Cancelled or Non-Renewed within the last 3 years? Y / N
16. Does applicant provide employee health plans? (if yes what percentage is paid by employer) Y / N
If Yes: Providers Name: _____
17. Do you exchange/lease to or from employees from any other businesses? Y / N
18. Do you have any employees that work from home? Y / N
19. Has any principal of the business declared bankruptcy in the last seven year? Y / N
20. Was this operation all or part of an existing business that was purchased or acquired? Y / N
Prior business owners name and address:
Name: _____
Address: _____
Name of Business: _____
Is the prior owner(s) related to the new owner(s)? No Yes, Relationship: _____

Have the operations changed since the business was acquired (e.g., from a bakery to a restaurant)? No Yes, please explain: _____

- Were more than 50% of the current employees hired since the acquisition? Y / N
Are those new employees earning more than 50% of the payroll? Y / N

Employment Applications:

1. Do you have a complete application? Y / N
2. Do you perform Reference Checks? Y / N
3. Pre/Post employment physicals? Y / N
4. Motor Vehicle record check? Y / N
5. Drug/Substance abuse test? Y / N
6. Orthopedic back test? Y / N

Please explain any YES Answers: _____

Prior Carrier Information/Loss History (provide last 3 years Loss History & Details Required)

Year:	Carrier:	Policy#:	Annual Premium:	# of Claims:	Amount Paid:
1.					
2.					
3.					
4.					
5.					

IMPORTANT NOTE: This form is provided as a convenience to you. We will make a good faith effort to obtain competitive quotes for your review. Depending on the type of business, we may require more information and will contact you if necessary. Your submission of this form DOES NOT guarantee that any binding offers will be forthcoming from insurers we represent.

Signature: _____

Print Name: _____

Date: _____

Title of person signing: _____

Please note any incomplete application will only delay the quoting process.

Fax this form upon completion our office will fax you a notice of receipt within 24 hours, and may contact you for further information if needed. Fax (949) 270-3704