Traders Insurance Company

Ground Floor Alexander Building, Beach Road, San Jose Village
P.O. Box 502473, Saipan, MP 96950
Tel: (670) 234-7788/7789/7798/7799 Fax: (670) 234-8899
Website: www.tradersinsco.com

Protection and Commitment

WORKER'S COMPENSATION APPLICATION FORM

This proposal is to be completed by the proposer or an authorized representative of the proposer.

All questions should be answered fully and accurately.

Signing of this proposal does not bind company to offer or the proposer to accept insurance. But it is agreed that this proposal shall be the basis of any insurance issued. No inference should be made however from the inclusion of any question in this proposal that the subject matter to which that question relates will be covered under the policy. The policy terms are only as stated in the policy which should be read carefully.

Attention is drawn to the proposer's obligations at law to disclose all material facts which would affect the issuance of the proposed insurance.

If there is insufficient space to complete the proposal, please attach additional sheets.

BROKER : ______________________ CONTACT PERSON : ______________________

EMPLOYER'S NAME : ______________________

DBA : ______________________

MAILING ADDRESS : ______________________

TELEPHONE NO. : ____________ FAX NO. : ____________ E-MAIL ADDRESS : ______________________

TYPE OF BUSINESS : INDIVIDUAL CORPORATION PARTNERSHIP OTHERS

YEARS IN BUSINESS : ____________ LOCATION OF WORKPLACE : ______________________

NATURE OF BUSINESS : ______________________

PREVIOUS/EXISTING INSURANCE CO. : ______________________ POLICY NO. : ____________ **EXPIRATION DATE :** ____________

HAD YOUR WORKERS COMPENSATION INSURANCE DECLINED, CANCELLED OR RENEWAL REFUSED? NO YES

HAD AN ACCIDENT (AS EMPLOYEER) WITHIN THE LAST THREE (3) YEARS? NO YES ______________________

EFFECTIVE DATE : ______________________ EXPIRY DATE : ______________________

NAME OF EMPLOYEES	CATEGORY	SALARY		ESTIMATED ANNUAL SALARY	RATE	PREMIUM
		Per Hour	Per Month			
		ANNUAL SALARY			**PREMIUM**	

EXPENSE CONSTANT ____________

PREMIUM DUE ____________

DECLARATION

I/We hereby apply for insurance against risks as set out in the Company's "Workmen's Compensation" Policy and I/We hereby declare that the above particulars and answers are true and complete in every respect and that no material fact has been suppressed or withheld, and I/we agree that this proposal and declarations shall be the basis of the contract between myself/ourselves and the Company, and I/we further agree to accept a Policy subject to the usual conditions prescribed by the Company, and endorsed on its Policy, and to pay the first premium there under when called upon to do so.

Signature of Applicant : ______________________ **Date :** ______________________

WORKERS' COMPENSATION COMMISSION

NMI RETIREMENT FUND

P.O. Box 501247 C.K., Saipan, MP 96950
Phone: (670) 664-8024 / Fax: (670) 664-8074

This Certificate of Compliance is hereby filed in accordance with Section 9346 of Public Law 6-33.

PART I. EMPLOYER'S INFORMATION

NAME OF EMPLOYER: ____________________

OTHER NAME OR DOING BUSINESS AS (DBA): ____________________

MAILING ADDRESS: ____________________

TELEPHONE NUMBER(S): ____________________

TYPE OF BUSINESS: SOLE PROPRIETOR CORPORATION PARTNERSHIP ASSOCIATION OTHERS ____________

DATE OF HIRED OR ARRIVAL IN THE CNMI: ____________________(ATTACHED PROOF)

DRAW AREA MAP IN THE BACK (LOCATION OF YOUR BUSINESS)

PART II. INSURANCE COVERAGE

CHECK ONE BOX BELOW TO DESCRIBE THE STATUS OF YOUR INSURANCE COVERAGE:

NEW RENEWAL SWITCHED CARRIER

NAME OF INSURANCE CARRIER: ____________________

NO. OF EMPLOYEES COVERED: ____________ ESTIMATED PREMIUM: $ ____________

EFFECTIVE DATE OF POLICY: ____________ EXPIRATION OF POLICY: ____________

PLEASE ATTACHED INSURANCE POLICY

Declaration: I hereby, declare under penalty of perjury that the information contained in this Certificate of Compliance is true and correct to the best of my knowledge. I also understand that I am responsible to file this Notice of Compliance within 30 days each year upon renewal of my insurance coverage.

____________________ ____________________ ____________________

Name and Title Signature Date