



Workers' Compensation Program Underwriting Application

Alliance of Schools for Cooperative Insurance Programs

16550 Bloomfield Avenue • Cerritos, CA 90703 • PH:(562) 404 -8029 FAX: (562) 404-8038 • www.ascip.org

I. Workers' Compensation Coverage Exposure

*Total Payroll for all employees (full time, part-time, temporary)**

Coverage Years	Current District Carrier/TPA	Full Time Equivalent	Total Payroll
2018 - 2019 (Estimated)	_____	_____	\$ _____
2017 - 2018 (Best Estimate)	_____	_____	\$ _____
2016 - 2017 (Actual)	_____	_____	\$ _____
2015 - 2016 (Actual)	_____	_____	\$ _____
2014 - 2015 (Actual)	_____	_____	\$ _____
2013 - 2014 (Actual)	_____	_____	\$ _____

II. Current Excess Coverage Carrier _____ Retention Level \$ _____

III. Current Workers Comp Rate _____

Please type an "X" in the appropriate spaces below for sections IV and V.

IV. ASCIP Program Options: [] Dollar One [] \$150,000 SIR [] \$250,000 SIR [] \$350,000 SIR [] \$500,000 SIR

V. Does the District provide the following:

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	New Hire Orientation with Safety Training	<input type="checkbox"/>	<input type="checkbox"/>	Safety committee meetings
<input type="checkbox"/>	<input type="checkbox"/>	Pre-employment screening	<input type="checkbox"/>	<input type="checkbox"/>	Medical Provider Network (MPN)
<input type="checkbox"/>	<input type="checkbox"/>	Pre-employment drug testing	<input type="checkbox"/>	<input type="checkbox"/>	Accident investigations review
<input type="checkbox"/>	<input type="checkbox"/>	Formal Return to Work Program	<input type="checkbox"/>	<input type="checkbox"/>	Workers Comp Nurse Triage
<input type="checkbox"/>	<input type="checkbox"/>	Written Injury & Illness Prevention Plan	<input type="checkbox"/>	<input type="checkbox"/>	Out of State/Country Field Trips

VI. Number of Labor Code 132a and Labor Code 4553 claims filed against the District since July 1, 2008 _____
(Please write in the number of claims, zero or unknown in the blank)

VII. Requested Date of ASCIP Coverage: _____

Name/Title

Telephone

District

Date

Taxpayer Identification Number _____

**Payroll includes gross wages, salaries, bonuses, vacation, holiday and sick pay, overtime payments and all substitutes for money earned during the policy period by employees and officers of your District and other persons for whom voluntary coverage is provided under the policy.*

Please complete form and submit via email to wc_info@ascip.org along with ten (10) coverage years of workers' compensation detailed loss runs (all open/closed claims) valued within the past sixty (60) days in Excel format.

Print and/or save completed form for your records. To complete multiple forms, press "RESET FORM."