



Request for Proposal (RFP)

Producer Name: _____ Date: _____ Date Requested: _____

Producer Phone: _____ Fax: _____ Email: _____

I. APPLICANT INFORMATION SECTION

FEIN: _____ Yrs in Business: _____ License No. _____

Client (legal) Name: _____ DBA: _____

Names and Titles of Owners: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Contact: _____ Title: _____

Phone: _____ Fax: _____ E-Mail: _____

Please Select One:

- Corp S-Corp LLC Sole Prop Partnership

Employees: _____ Payroll Frequency: Weekly Bi-Weekly Monthly Semi-Monthly

Current Payroll Provider, *if outsourced*: _____

Will Client Utilize Direct Deposit? _____ If so, what is the percentage of EE's? _____

Benefits Requested - Please check all that apply.

- Health Flex spending Employee Assistance 401(k) Plan

Documentation **Required** for Proposal (for each state of operation)

- Copy of Workers' Compensation Declaration Page(s), including detail of payroll by W/C class, Modifier, and any applicable premiums, discounts or surcharges.
- Three years Worker' Compensation loss runs

**If you are with an existing PEO, you need to provide only the most recent Invoice and a description of Benefits*

II. NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS

Please provide a brief description of type of business & operation:

III. REVENUE RATING INFORMATION

SIC Code(s): _____ All states of operation: _____ No. Locations: _____

Job Description or Comp Code	Current Rate	# of Employees <i>Full/Part Time</i>	Discounts <i>*if any</i>	Est. Annual Payroll <i>(per class code)</i>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

IV. LOSS HISTORY

* Please indicate if "None", Must provide copy of Loss Runs

Year	Line	# of Claims	Amount Paid	Reserve Amount	Total Paid
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

I declare that to the best of my knowledge and understanding, **Cal-Pay Services, Inc.** is acting as a Marketing Arm for the PEO/Staff Leasing Company and not as a Workers Compensation Provider. Furthermore, I declare that to the best of my knowledge the information provided in this application is true and acknowledge that the information in this Client Application will be supplied to the insurance company providing workers' compensation insurance coverage. I understand that 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.

Signature _____ Date _____

UNDERWRITING QUESTIONNAIRE

Please explain all items if answered "YES" in detail in the space provided below

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

Additional Comments:

Submitted By: _____

Date: _____