



The Source for Workers' Compensation Insurance

SUPPLEMENT TO APPLICATION FOR \_\_\_\_\_ Date \_\_\_\_\_
(Applicant's Name)

- 1. Do you consider Oklahoma as your principal place of business?
2. Do you have a policy with CompSource Oklahoma at the present time or have you had one in the past?
3. Within the last twelve (12) months, did you have coverage with CompSource Oklahoma through a professional, trade or group association?
4. Do you own any other business entities in Oklahoma or in any other state(s)?
5. Do you intend to obtain a quote for all Oklahoma business entities?
6. Do you have employees who permanently work or reside in Oklahoma who may travel or work outside the state of Oklahoma?
7. Do you have employees permanently working in Oklahoma whose contract of hire is outside the state of Oklahoma or;
8. Do you have a current workers' compensation policy in another state that extends coverage to residents of other states who are temporarily working in Oklahoma?
9. Do any of your business entities have permanent operations or locations outside of Oklahoma?
10. Do you intend to lease or provide employees to other businesses?
11. Have you ever filed bankruptcy or is the business currently in bankruptcy?
12. Are you currently in the process of liquidation or termination of this business?
13. Are you related to or associated with anyone in this business who has been denied coverage, cancelled, non-renewed or billed premium on a cancelled policy that remains unpaid with CompSource Oklahoma or The State Insurance Fund?

14. Do you currently employ or intend to employ any domestic employees?  YES  NO
15. Do you currently employ or intend to employ any farm employees?  YES  NO
16. Were Social Security Numbers for all owners/officers provided on the ACORD application?  YES  NO  
If not, please do so. *(Failure to provide this data could result in a delay in processing your application)*
17. Do you, or will you, employ family members, related by blood or marriage, whether paid or not?  YES  NO  
If yes, were the family member's payroll included in the total payroll and;  YES  NO  
Were the family members included in the total number of employees?  YES  NO  
Explain \_\_\_\_\_

18. Identify the name, address and telephone number of the person you wish us to contact for a premium audit by state, if applicable. List "same" if the premium audit contact information is the same as your mailing address. If necessary attach a separate list.

_____	_____	_____
State	Name and Telephone No.	Physical Address
_____	_____	_____
State	Name and Telephone No.	Physical Address
_____	_____	_____
State	Name and Telephone No.	Physical Address

Premium for this insurance coverage will be determined by manual rules, classifications, rates and rating plans applicable to each state. All required information is subject to verification and may result in changes to your policy at audit.

For your Oklahoma coverage, it is understood and agreed that any monies paid to or held by CompSource Oklahoma, hereinafter "CompSource", by or on behalf of the insured is pledged to CompSource to secure payment of any amount due or which may become due to CompSource and may be applied by or offset by CompSource to any amount due CompSource and that venue of any action to collect premium shall be in Oklahoma County, Oklahoma.

***By signing the application, I warrant that all of the above questions have been fully and completely answered and have not been willfully misrepresented in order to obtain insurance with CompSource Oklahoma. I understand that any person who willfully misrepresents any fact in order to obtain insurance with CompSource Oklahoma at less than the proper rate for such insurance shall be guilty of a felony. Any willful misrepresentation in the above answers is a violation of 85 O.S. Sec 395. I state under penalty of perjury under the laws of Oklahoma that the foregoing is true and correct.***

***The following is only applicable if you have elected to utilize an insurance Producer to secure Workers' Compensation Coverage on your behalf.***

I have authorized the insurance Producer designated below to submit this information on my behalf, and to act as my agent of record for securing my workers' compensation insurance. This includes my express authorization that CompSource Oklahoma may provide my Producer with any information associated with my policy.

**Application must be signed by individual owner, partner, corporate officer or a limited liability corporation member.**

The undersigned applicant understands that coverage is not in effect until the signed application(s) are received with appropriate premium and eligibility is determined by CompSource Oklahoma.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Producer's Signature

\_\_\_\_\_  
Date

**WARNING: Any person knowingly and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of any insurance policy containing false, incomplete, or misleading information is guilty of a felony.**