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**ARCH INSURANCE COMPANY**

(A Missouri Corporation)

**Defense Base Act Workers Compensation Insurance Policy Application**

**Section A: Basic Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Applicant Name |  | Broker |  |
| Contact Name |  | Contact Name |  |
| Applicant Address |  | Broker Address |  |
| Telephone |  |  |  |
| E-mail Address |  |  |  |

**Section B: Organization Type (X)**

|  |  |
| --- | --- |
| Corporation |  |
| Joint Venture |  |
| LLC |  |
| Partnership |  |
| Individual |  |
| Other |  |

**Section C: Applicant Information**

|  |  |
| --- | --- |
| Proposed Effective Date |  |
| Number of Years in Business |  |
| Any previous DBA contracts? (Y or N) |  |

1. Type of Contract (Indicate with an “X”)

|  |  |
| --- | --- |
| Department of Defense |  |
| USAID |  |
| US Department of State |  |
| Other (Please specify in the space below) |  |

|  |
| --- |
|  |

1. Is the Applicant a prime contractor? (Y or N)

If no, indicate the Prime Contractor

1. Did the Applicant qualify for or obtain a written waiver from the Department of Labor for:

|  |  |  |
| --- | --- | --- |
|  | **Y** | **N** |
| Third Country Nationals |  |  |
| Local Nationals |  |  |

1. Summary of Contracts/Operations: Provide a description of operations, including statement of work from contract, contract duration, contract number and whether this is a bid or renewal of an existing contract.

|  |
| --- |
|  |

**Section D: Exposure/Employee Information**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Classification | Country | Duties | Annual Remuneration\* | # of employees |
| US Nationals |  |  |  |  |
| Third Country Nationals |  |  |  |  |
| Local Nationals |  |  |  |  |

|  |  |
| --- | --- |
| Total | $ |

\*Remuneration means all monies paid to covered employees including without limitation, salary, overtime, bonuses and cash allowances for the cost of living, board and lodging.

**Section E: Employee Concentration – Indicate the maximum number of employees on each conveyance or at each location described below:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Conveyance and Location | Maximum Number of US Nationals | Maximum Number of TCNs | Maximum Number of Locals | Describe frequency and details of conveyance or sites and/or quarters |
| Land Motor Vehicle |  |  |  |  |
| Air Travel |  |  |  |  |
| Water Travel |  |  |  |  |
| Work Site |  |  |  |  |
| Sleeping Quarters |  |  |  |  |

**Section F: General Information**

Are employees? **(X)**

|  |  |
| --- | --- |
| Tenured Only |  |
| Foreign Contracted Only Employees |  |
| Independent Contractors |  |

If contracted employees, do you hire yourself or use a staffing firm?

Are subcontractors used? (Y) or (N)

If yes to the above, what percentage of the total contract value is subcontracted?      %

If yes, does the applicant require certificates of valid DBA insurance from subcontractors, or do you need a separate quotation for such subcontractors?

Who provides your security? (check all that apply)

|  |  |
| --- | --- |
| Your employees |  |
| Outside Contractors |  |
| U.S. Military |  |

Please describe all “yes” answers to the following questions in the space indicated below:

**(Y) (N)**

|  |  |  |
| --- | --- | --- |
| 1. Do your employees carry firearms? (If yes, describe circumstances and protocols in the field below.) |  |  |
| 2. Are employee personnel records maintained (passport, visa, identity card, family beneficiaries etc.) for all nationality, including any local national, employees? |  |  |
| 3. Do you conduct any additional pre-employment screening above what is required by the U.S. Government? (e.g. Do you do any psychiatric testing or additional fitness screening?) |  |  |
| 4. Do you have a back to work program for lost time cases where you offer light duty or alternative employment? |  |  |
| 5. Do you have a Health & Safety Director or risk manager who investigates and documents work injury incidents? |  |  |
| 6. Do you have medical staff or facilities on site for treatment of employees? |  |  |
| 7. Does applicant have a documented evacuation plan for medical emergency not covered by insurance? If yes, is this self-arranged or do you have a vendor? |  |  |

Describe/Detail all “yes” responses above:

|  |
| --- |
|  |

Does the applicant provide employee non-occupational related medical Insurance for:

**(Y) (N) (If yes, does the coverage include medical evacuation?)**

|  |  |  |  |
| --- | --- | --- | --- |
| U.S. Nationals |  |  |  |
| Third Country Nationals |  |  |  |
| Locals |  |  |  |

**Section G: Defense Base Act – Loss History**

**(Y) (N)**

|  |  |  |  |
| --- | --- | --- | --- |
| Have you experienced any DBA losses over the past five years? |  |  | If yes, provide loss run(s) from your current and/or prior carriers, dated within the last 60 days, documenting losses for the past five years |

Please Provide Details on any losses exceeding $100,000

|  |
| --- |
|  |

Provide annual DBA remuneration for the past five years if losses exceed $100,000

|  |
| --- |
|  |

**Section H: Financial Information**

Please provide copies of audited financial statements for the most recent year.

**Notice:**

THE APPLICANT WARRANTS THAT THE STATEMENTS AND FACTS MADE IN THIS APPLICATION ARE TRUE AND THAT NO MATERIAL FACTS HAVE BEEN SUPPRESSED OR MISSTATED.

Applicant acknowledges a continuing obligation to report to us as soon as practicable any material changes in the facts or statements above which applicant becomes aware after signing the application.

COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT’S WRITTEN ACCEPTANCE OF COMPANY’S QUOTATION AND COMPANY’S WRITTEN ACKNOWLEDGMENT OF SUCH ACCEPTANCE IS REQUIRED PRIOR TO BINDING COVERAGE AND POLICY ISSUANCE. NO COVERAGE SHALL ATTACH UNTIL A BINDER OF INSURANCE HAS BEEN ISSUED. IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED AND IT WILL BE ATTACHED TO AND BECOME A PART OF THE POLICY.

I hereby warrant that the above statements and particulars are true and I agree that this application shall be the basis of the contract with the insurance company.

|  |  |
| --- | --- |
| Applicant Signature: | Date: |
|  |  |
| Applicant Name: | Title: |
|  |  |

**NOTICE: ANY PERSON WHO, KNOWINGLY OR WITH INTENT TO DEFRAUD OR TO FACILITATE A FRAUD AGAINST ANY INSURANCE COMPANY OR OTHER PERSON, SUBMITS AN APPLICATION OR FILES A CLAIM FOR INSURANCE CONTAINING FALSE, DECEPTIVE OR MISLEADING INFORMATION MAY BE GUILTY OF INSURANCE FRAUD.**