

**HEALTH CARE MUTUAL CAPTIVE INSURANCE COMPANY**

**Administered by:**

**Georgia Administrative Services, Inc.**

**1775 Spectrum Drive, Suite 100, Lawrenceville, Georgia 30043**

**Phone 770-963-7732 or 800-421-0710**

**Fax 770-963-5754**

**WORKERS' COMPENSATION SUPPLEMENTAL APPLICATION**

All information on this application and on accompanying ACORD application must be complete. Both applications must be signed by the applicant and the producer.

Proposed Effective Date \_\_\_\_\_ Today's Date \_\_\_\_\_

*This captive insurance company is not subject to all of the insurance laws and regulations of the State of Georgia.*

DBA Name (This is the name by which we will refer to this account)

Legal name, if different

**Association Membership Information**

**Payment Plan**

Name of Association \_\_\_\_\_

A 30% surplus share contribution is required. 15% is due at binding along with the expense constant. Remaining 15% is due at renewal of policy. The annual premium is payable in eleven (11) installments beginning 30 days after coverage inception.

Proof Attached:

- Copy of membership certificate
- Copy of membership application & copy of check

Deductible Options

- No deductible
- \$500
- \$1,000
- \$1,500
- \$2,000
- \$2,500

AFFIDAVIT: I, the undersigned, hereby certify that I have read, understand, and certify the validity of the statements and information included in and made a part of this application. I hereby acknowledge receipt of Policyholder Agreement, and I agree to all its terms. I also agree to maintain and make available to the Company applicable payroll records, and to comply with all applicable laws, orders, rules, and regulations relating to the welfare, health, and safety of employees. I further agree to comply with all reasonable recommendations made by the Company with regard to same. The employer also agrees to utilize the medical providers recommended by the Company as allowed by law. Membership in one of the following associations is required during the term of coverage with the company: Assisted Living Association of Georgia, Georgia Association of Community Care Providers or Service Provider Association for Developmental Disabilities.

Owner/Officer's Signature \_\_\_\_\_

Owner/Officer's Name (Printed or Typed) \_\_\_\_\_

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

Producer's Name (Printed or Typed) \_\_\_\_\_

Agency Name (Printed or Typed) \_\_\_\_\_

**Before Mailing: Is this application complete?**

- Check payable to: **HEALTH CARE MUTUAL**
- ACORD WC Application (original)
- WC-10 for each officer/owner/partner
- Policyholder Agreement (original)
- Supplemental Application (original)
- Proof of membership in sponsoring association

**Revised 10/09**