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

Name of Association _____

Proof Attached:

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

Payment Plan

A 30% surplus share contribution is required. 10% is due at binding along with the expense constant. Remaining 20% is collected over the following two renewal policy periods. The annual premium is payable in eleven (11) installments beginning 30 days after coverage inception.

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, Service Provider Association for Developmental Disabilities or National Private Duty Association.

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**
- ☐ WC-10 for each officer/owner/partner
- ☐ Supplemental Application (original)
- ☐ ACORD WC Application (original)
- ☐ Policyholder Agreement (original)
- ☐ Proof of membership in sponsoring association

Revised 11/2017