ASCIP Alliance of Schools for Cooperative Insurance Programs
16550 Bloomfield Avenue • Cerritos, CA 90703 • PH: (562) 404-8029 FAX: (562) 404-8038 • www.ascip.org

Request a Workers Compensation Quote

Contact Name and Title ______________________ Telephone ______________________

District ______________________ Email Address ______________________

I. Workers Compensation Exposure:

Estimated Payroll for Coverage Year: * ______________________

Full-Time Equivalent Employees (FTEE):______________________

Current Carrier/Third Party Administrator (TPA):______________________

Current Annual Premium and Rate?:______________________

II. Requested Date of ASCIP Coverage: ______________________

Deductible Desired: ☐ $0 ☐ $150,000 ☐ $250,000 ☐ $350,000 ☐ $500,000

III. Is your current coverage excess? ☐ Yes ☐ No

If yes, lease provide the name of your carrier and current retention level:______________________

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IV. Historical Data:

	2019/2020 Estimated	**2018/2019**	**2017/2018**	**2016/2017**	**2015/2016**	**2014/2015**
Payroll						
FTEE						
Carrier/TPA						
Annual Premium						

V. Indicate whether your District provides any of the following:

- ☐ New Hire Orientation with Safety Training
- ☐ Safety Committee Meetings
- ☐ Medical Provider Network (MPN)
- ☐ Pre-Employment Drug Testing
- ☐ Accident Investigation Review
- ☐ Formal Return to Work Program
- ☐ Workers Compensation Nurse Triage
- ☐ Written Injury & Illness Prevention Plan
- ☐ Out of State/Country Field Trips
- ☐ Out of State Employees

VI. Please provide the following information for your District:

1. Number of Labor Code 132(a) and Labor Code 4553 (S&W) claims filed against the District since July 1, 2008: ______________
2. Number of Osha violations or fines in the last 6 years:____________
3. Federal Employer Identification Number (FEIN):__________________

**Payroll includes gross wages, salaries, bonuses, vacation, holiday and sick pay, overtime payments and all substitutes for money earned during the policy period by employees and officers of your District and other persons for whom voluntary coverage is provided under the policy.*

Please complete form and submit via email with detailed loss run (open/closed claims) for the past ten (10) coverage years, valued within the past sixty (60) days. Submit via email to ascip_info@ascip.org. Print and/or save completed form for your records.