indsey Associates
Insurance Services

Insurance Services LLC

50+ Yrs. Experience

THE APPLICATION PROCESS

THANK YOU!

Your request for a quote on your Business Insurance will be referred to F. Darrell Lindsey, the NATIONWIDE state licensed Agent/Broker responsible for responding, quoting, and providing services relating to the Insurance programs made available to Business Owners, in support of your request.

Please find attached the Questionnaire KIT developed for the insurance coverage you have requested to be quoted. PLEASE – put "0" (zero) on lines where no "Number" is filled out by you. All spaces should have an entry. Insurance Companies are able to give up to a 35% credit to their filed rates or up to a 25% surcharge. Fully completed Questionnaires will qualify for the LARGEST CREDITS.

The Questionnaire, and any attached supplemental forms, must be 100% completed (with no questions unanswered) and submitted "ON LINE" or returned by FAX to our office. To process this request we require your **E-Mail address**, for followup during the quoting process, as may be necessary.

The separate forms, regarding prior claims, and the questions relating to; payroll, gross receipts, and prior insurance, are critical in rating and quoting all lines of insurance.

Please call the Questionnaire processing office with any questions you may have.

Respectfully,
F. Darrell Lindsey
U.S. State Licensed Agent/Broker
U.S. Corporate Enterprise Risk Manager Consultant (ERM)
U.S. State Approved Captive/RRG/Self Insured Manager
U.S. Approved Self Funded Health & W.C. Plan Manager

FDL/p
Enclosures

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Form LLL-A-1120 – 11/19/2015

IS IT

WORTH IT?

BUSINESS OWNERS CAN RECEIVE UP TO A 35% CREDIT WHEN AN INSURANCE COMPANY UNDERWRITER IS ABLE TO RATE FROM A COMPLETED APPLICATION.

**** SEE "QUICK QUOTE" FORMS "ATTACHED" –GENERAL LIABILITY, PROPERTY, BUSINESS AUTO, AND WORKERS COMPENSATION.**

LIKEWISE, IF A RATING QUESTIONNAIRE HAS *BLANK* QUESTIONS AND THE UNDERWRITER HAS TO GUESS, THE RATE MAY GO UP 25%.

FULLY COMPLETED APPS ARE WORTH IT!!

SPECIAL NOTE: COMPLETE THE ATTACHED "QUICK QUOTE" APPLICATIONS FOR;

1. GENERAL LIABILITY – A MUST HAVE TO QUOTE PROFESSIONAL LIABILITY
2. BUSINESS AUTO – IF ANY
3. WORKERS COMPENSATION – IF NEEDED

***REFER TO THE GENERAL LIABILITY APPLICATION TO ALSO ADD OFFICE EQUIPMENT AND SUPPLIES.**

LETTER OF AUTHORIZATION

To Whom It May Concern:

I the undersigned FIRST NAMED INSURED does hereby authorize the following persons:

F. Darrell Lindsey – U.S. State Licensed Agent/Broker

To act on behalf of _____

For the purpose of obtaining quotes and binding insurance coverage under the following policies:

- ☐ **Business Liability**
- ☐ **Workers Compensation**
- ☐ **Business or Commercial Auto Liability**
- ☐ **Group or Individual Health Insurance**
- ☐ **Other Insurance (describe) :** _____
- ☐ **Professional Liability**
- ☐ **Property Insurance**
- ☐ **Excess or Umbrella Liability**
- ☐ **Directors & Officers Liability**
- ☐ **Self-Insurance Programs**

This authorization also constitutes the right to furnish F. Darrell Lindsey representatives with all the information that may be requested from any current provider of Insurance, with respect to existing insurance policies, for the purpose of obtaining rates, rating schedules, surveys, reserves, retentions and all other current policy data, including claim loss runs, for review and study, relating to the present and future requirements in connection with the insurance programs to which this authorization applies. A photo copy of this authorization shall be regarded with the same force and effect as the original.

Date: _____ **Signature:** _____
Type if On Line Completion

Authorized Contact Persons Name: _____

Business Address: _____

City and State: _____

Phone: _____ **Fax:** _____

(Ж) E-Mail Address: _____

F. Darrell Lindsey

U.S. Licensed Broker
LLL Insurance Services
Calif. 0F37860

HOME CARE AGENCY "NON-MEDICAL-SERVICES" DISCOVERY QUESTIONNAIRE NOT HOME "HEALTH CARE"

THIS IS FOR QUOTATION PURPOSES ONLY - THIS IS NOT A BINDER SIC CODE#:_____

Complete all sections and questions. Proposed Effective Date_____

*1. Potential Insureds Name:_____ * SS# or FEIN#:_____

*2. Potential Insured Address _____ PH: _____

City_____ State_____ Zip_____ FX: _____

*3. **E-MAIL** _____ Web Site:_____

4. Principal Business Address _____

*5. Principal to Contact:_____ **E-MAIL**:_____

6. Insured is: ☐ Individual ☐ Corporation ☐ Partnership ☐ Franchise

7. Date Current Firm Established - (month, day, year) _____

8. Company Officer in Charge of Insurance Program_____

9. Does your company have within its staff of employees, wherein a portion of their job description deals with Administration, loss control, safety inspections, engineering, or other professional consultation or advice?
☐ Yes ☐ No

If Yes, Identify: Name:_____ E-Mail _____

*10. Please provide your state license number: _____

*11. What is your license classification or designation? _____

*12. What state(s) are you licensed in: _____

*13. Is this a new business? ☐ Yes ☐ No If no, how many years have you been in business? _____

*14. How many years of experience do you have? _____

15. Number of Employees/Contractors: Full Time: _____ Part Time: _____ 1099 Independent: _____

16. If current Professional Liability & General Liability coverage is in force for these activities please specify:
Carrier: _____ Expiration Date: _____ Expiring Policy #: _____
Limits: _____ Retroactive Date: _____ Expiring Deductible: _____

17. Projected Annual Gross Revenue: ☐$1-$250,000 ☐$250,001 - $500,000
☐$1,000,000+ ☐$500,001 - $750,000 ☐$750,001 - $1,000,000

National Headquarters
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LLL Insurance Services
P O Box 526357, SLC, UT 84152-6357
PH: 866-937-7037 / FX: 866-937-7010
FDL@LLLINSURANCESERVICES.COM
Form #LLL-A-1111-11/23/2015

1. "COMPLETE ON LINE" THEN SAVE AND ATTACH TO AN E-MAIL.

2. PRINT – COMPLETE & FAX BACK.

A. HOME CARE SERVICES

CHECK SERVICES PROVIDED AND "PERCENTAGE" OF EACH - TOTAL 100%

A. Companionship Services Yes ☐ No ☐ % _____

B. Sitter Services Yes ☐ No ☐ % _____

C. Light Housekeeping and Laundry Yes ☐ No ☐ % _____

D. Shopping Assistance – Grocery Store Yes ☐ No ☐ % _____

E. Supportive Personal Care (Dressing, Bathing, Etc.) Yes ☐ No ☐ % _____

F. Supervision of Self-Administered Medication Yes ☐ No ☐ % _____

G. Nutritional Meal Preparation Yes ☐ No ☐ % _____

H. Transportation – Accompanying to a Clinic or Dr. Office Yes ☐ No ☐ % _____

MUST EQUAL 100% % _____

B. PROFESSIONAL LIABILITY – "If Any" - This is only to verify that you "do not" provide other than Home Care Service. If you provide Home "Health Care" please complete the separate Home "Health Care" questionnaire also provided.

1. We are seeking professional liability insurance for home healthcare services. ☐ TRUE ☐ FALSE

2. Do you provide infusion therapy? ☐ YES ☐ NO

3. Do you have physicians on staff other than a medical director that does not perform any direct patient care? ☐ YES ☐ NO

4. Do you provide overnight services (beds for overnight occupancy at your facility)? ☐ YES ☐ NO

5. Do you provide services in nursing homes, hospitals, clinics or correctional facilities? ☐ YES ☐ NO

If **Yes:**

Home %	Hospice %	Nursing Home %	Assisted Living Facility %
Hospital %	Clinic/Doctor's Office %	Adult Day Care %	Other Facility (specify) %

Total percentages must equal 100%

6. Our professional employees and/or independent contractors are each properly licensed or certified in accordance with applicable state and federal regulations. ☐ TRUE ☐ FALSE

7. Less than 10% of our services are provided to patients under the age of 18. ☐ TRUE ☐ FALSE

C. GENERAL LIABILITY

1. We do not own or rent any properties other than those listed in questions 2 & 4 above. ☐ TRUE ☐ FALSE

2. We do not manage or operate any inpatient or residential facility and we have no common ownership with any such facility. ☐ TRUE ☐ FALSE

3. Medical equipment or other product sales make up less than 25% of our gross revenue. ☐ TRUE ☐ FALSE

D. HIRED & NON-OWNED AUTO

1. We require all employed or contracted licensed drivers to maintain personal auto liability insurance with liability limits of at least the state required minimum and verify their compliance. ☐ TRUE ☐ FALSE

2. We check the motor vehicle records (MVR) of all staff prior to employment and annually.

☐ TRUE ☐ FALSE

E. PRIOR HISTORY

1. We do NOT have current knowledge of any incident or circumstance that could reasonably be expected to give rise to a claim for the proposed insurance coverage. ☐ TRUE ☐ FALSE

2. We have NOT had any prior professional, general or hired & non-owned auto liability claims made against us or our professional employees or independent contractors. ☐ TRUE ☐ FALSE

F. WARRANTY

1. We warrant that all statements in this application have been truthfully answered and we have not misstated any material fact and understand that this application shall be the basis of the contract with the insurance carrier.

☐ TRUE ☐ FALSE

Additional Comments:

Title: _____ Print Name: _____

Date: _____ Signature: _____

Broker: _____ Broker Signature: _____

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F. Darrell Lindsey

U.S. Licensed Broker
LLL Insurance Services
Calif. 0F37860

SMALL BUSINESS PERSONAL PROPERTY DISCOVERY QUESTIONNAIRE

YOUR INDUSTRY

Construction and Repair Services - Health Care Medical -- Automotive - Energy - Hospitality - Legal Professionals - Habitational - Rental - Sports - Chemical Users - Cleaning Services - Transportation - Garage - Recreation - Restaurant / Bar Domestic Service (Etc.) – Health Services / Non-Medical - Property Managers - Architects / Engineers - Misc. Professionals - Real Estate Professionals - Insurance Professionals - Accounting Professionals

Do these statements accurately describe your firm? ☐ Yes ☐ No (If "NO", please **STOP** and complete the **Standard Application.**

- Your firm has less than fifty (50) employees
- Your firm has less than $2,000,000 of revenues

THIS IS FOR QUOTATION PURPOSES ONLY - THIS IS NOT A BINDER **SIC CODE#:**_____

General Information

Proposed Effective Date: _____

1. Insureds' Name: _____ SS or FEIN #: _____
2. Insureds' Mailing Address: _____
   City: _____ State: _____ Zip: _____
   E-Mail: _____ Web Site: _____
   Business Telephone Number: _____ Fax: _____
3. Physical Location of Business (if different): _____
4. Population within 50 miles: _____ County: _____
5. Other Locations Used:
   Physical Address: _____
   City: _____ State: _____ Zip: _____
   Physical Address: _____
   City: _____ State: _____ Zip: _____
6. Please list any other names the business is or has been known by:
7. Contact Person: _____ Email: _____
8. What is your license classification or business designation for your company? (Per the listing above)

_____

9. Is this a new business? ☐ Yes ☐ No if no, how many years have you been in business? _____

What year was your business established? _____

10. How many years of experience do you have? _____

11. Insured is: ☐ Individual ☐ Corporation ☐ Partnership ☐ Joint Venture ☐ Other (describe)

_____

12. Total Number of Employees: # _____ Full-Time: #_____ Part-Time: # _____

Independent Contractors: # _____

13. Provide the following information about your firm's insurance:

	Insurance Company	Policy Period	Limits	Expiring Policy #
Professional Liability				
General Liability				
Business Auto				

14. Property:

A. Address: _____

City: _____ State:_____ Zip:_____

B. What is the square footage of the entire building? _____ Stories: _____

C. What is the square footage the business occupies? _____

D. Do you own the Building? ☐ Yes ☐ No

E. Building Construction: ☐ Frame ☐ Joisted Masonry ☐ Non-Combustible

☐ Masonry Non- Combustible ☐ Modified Fire Resistive ☐ Fire Resistive

F. What year was it constructed? _____

G. If over 20 years old – were any systems updated? ☐ Yes ☐ No If Yes, what? ☐ Roof ☐ Plumbing

☐ Electrical ☐ Heating / Air Conditioning ☐ NO Updates

H. Type of Fire System: ☐ None ☐ Wet ☐ Dry (Chemical)

I. Burglar Alarm System: ☐ None ☐ Central ☐ Local

J. Distance to nearest Fire Hydrant: _____

K. Fire Protection class Code (choose one):

1 ☐ / 2 ☐ / 3 ☐ / 4 ☐ / 5 ☐ / 6 ☐ / 7 ☐ / 8 ☐ 9 ☐ / 10 ☐

L. Building coverage Limit: $_____ Deductible: _____

M. Contents coverage Limit: $_____ Deductible: _____

N. Unscheduled Equipment Floater Limit: $_____ Deductible: $_____.

1. Maximum per Item: $_____

O. Please indicate the total value of your business personal property? $ _____

P. Please list any individual pieces of property worth more than $25,000 (attach a separate sheet if necessary):

Q. Please indicate the types of safeguards used to ensure the preservation of your property (more than one may apply):

Premises equipped with smoke detectors ☐

Premises equipped with burglar alarms ☐

If burglar alarms present, they are centrally monitored ☐

Exterior doors equipped with dead-bolt locks ☐

Utilize safes for valuable items, money, and papers, etc. ☐

Other (please explain): _____

R. Are the minimum required number of fire extinguishers made available for use at your business?

Yes ☐ No ☐

S. Has your business ever experienced a property-related loss? Yes ☐ No ☐

If so, how many? _____

For each loss, please provide:

a. the amount of the loss:

15. Please describe in narrative detail the operations of your business:

If there is any material change in the answers to the questions in this application before the proposed policy inception date, the applicant must notify the insurer in writing and any outstanding quote for insurance coverage may be modified or withdrawn.

The applicant's submission of this application does not obligate the insurer to issue, or the applicant to purchase a policy. The applicant authorizes the Insurer to make any inquiry in connection with this application.

All written statements and materials furnished to the Insurer in conjunction with this application are hereby incorporated into this application and made a part hereof.

The undersigned authorized agents of the applicant declare that to the best of their knowledge and belief, after reasonable inquiry, the statements made in this application are true and complete. The undersigned agree that this application shall be the basis of the insurance policy should an insurance policy providing the requested coverage be issued and that the Insurer will have relied on the application in issuing any policy.

NOTICE TO APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

Signature: _____

Title: _____ Date: _____

National Headquarters
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FDL@LLLINSURANCESERVICES.COM
Form #LLL-A-1118-11/25/2015

Insurance Services, LLC

BUSINESS AUTO QUESTIONNAIRE

A. GENERAL INFORMATION

Proposed Effective Date: _____

Insured's Name: _____ SS or FEIN #: _____

Insured's Mailing Address: _____

City: _____ State: _____ Zip: _____

E-Mail: _____ Web Site: _____

Business Telephone Number: _____ Fax: _____

Applicant is: ☐ Individual ☐ Corporation ☐ Partnership ☐ Joint Venture ☐ Other (describe):

_____

Current Carrier: _____

Loss History: ☐ No losses ☐ 5 year loss runs attached. ☐ Quote subject to acceptable loss history.

(Note: Five year loss history is required for binding. If there are no losses, a signed letter from the insured verifying no losses in 5 years is acceptable.)

B. AUTO LIABILITY LIMITS

Liability Limit: _____

Medical Payment / PIP Limit: _____

Uninsured / Underinsured Limit: _____

Comprehensive Deductible: _____

Collision Deductible: _____

Hired Liability ☐ Yes ☐ No Estimated Cost of Hire: _____ or ☐ If any

Non-Owned Liability ☐ Yes ☐ No Number of Employees: _____

Other Coverages: _____

C. AUTOMOBILE INFORMATION

YEAR	MAKE	MODEL	VIN#	GARAGING CITY/ZIP	COST NEW	TYPE OF COVERAGE
						☐ Full Coverage ☐ Liability Only
						☐ Full Coverage ☐ Liability Only
						☐ Full Coverage ☐ Liability Only
						☐ Full Coverage ☐ Liability Only
						☐ Full Coverage ☐ Liability Only
						☐ Full Coverage ☐ Liability Only

D. DRIVER INFORMATION

NAME	DATE OF BIRTH	DRIVERS LICENSE NUMBER	STATE

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Insurance Services, LLC

WORKERS COMPENSATION QUESTIONNAIRE

A. GENERAL INFORMATION

Proposed Effective Date: _____

Insured's Name: _____ SS or FEIN #: _____

Insured's Mailing Address: _____

City: _____ State: _____ Zip: _____

E-Mail: _____ Web Site: _____

Business Telephone Number: _____ Fax: _____

Applicant is: ☐ Individual ☐ Corporation ☐ Partnership ☐ Joint Venture ☐ Other (describe):

_____

Current Carrier: _____

Audit Contact Name: _____

Loss History: ☐ No losses ☐ 5 year loss runs attached. ☐ Quote subject to acceptable loss history.

(Note: Five year loss history is required for binding. If there are no losses, a signed letter from the insured verifying no losses in 5 years is acceptable.)

NCCI Risk ID Number (If available): _____

Other Bureau ID or State Employer Registration Number (If available): _____

Experience Mod: _____

Does the applicant own, operate or lease aircraft? ☐ Yes ☐ No

B. EMPLOYERS LIABILITY LIMITS

☐ $100,000 Each Accident / $500,000 Policy Limit Disease / $100,000 Each Employee Disease

☐ $500,000 Each Accident / $500,000 Policy Limit Disease / $500,000 Each Employee Disease

☐ $1,000,000 Each Accident / $1,000,000 Policy Limit Disease / $1,000,000 Each Employee Disease

Expiration Date: _____

C. OPTIONAL COVERAGES

Waiver of Subrogation: ☐ Blanket ☐ Specific

☐ Voluntary Compensation

☐ U.S.L. & H.

☐ Other Coverage: _____

D. ESTIMATED PAYROLLS

Class Codes / Duties	# of Employees	Estimated Payroll

Officers, Partners & Individuals to be Included or Excluded

Name	Title	Class Code / Duties	Include or Exclude	Ownership Percentage

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Lindsey Associates
Insurance Services

Insurance Services LLC

Supplemental WC Application –Health Care

Instructions:

- Please type or print clearly in ink. All sections must be completed fully.
- If you need more space, attach additional sheets as needed using company letterhead

1. APPLICANT OVERVIEW

Firm Name: _____
(If the insured has a DBA please list)

Does Common ownership (over 50%) exist with any other operation? ❒ Yes ❒ No

If "yes", give names and types of operations managed and owned:

_____

List the Applicants State of Operation: _____
❒ For Profit ❒ Not for Profit ❒ Partnership ❒ Other (specify): _____

Date business established: _____ Number of years under current ownership: _____

Payroll History Current_____2nd Year_____3rd Year_____4th Year_____5th Year_____

Website URL is: www._____

a) Are medical/health insurance benefits provided to employees? ❒ Yes ❒ No
b) Current number of: Permanent Employees _____ Full Time Employees _____ Part Time Employees _____
c) Indicate annual turnover rate: _____%
e) Are at least 51% of the applicant's staff "professional" employees? ❒ Yes ❒ No
f) What is the average wage for employees in the governing class? $_____ Is 24 hour staffing provided ❒ Yes ❒ No
h) Indicate percentage of volunteers in the workforce: ❒ 0% ❒ 1 – 10% ❒ 11 – 40% ❒ > 40%
i) Does the Applicant have a skilled Nursing facility ❒ Yes ❒ No

Business Operations (check all that apply)

❒ Home Health - Skilled Nursing	❒ Substance Abuse Counseling	❒ Nursing Home
❒ Personal Care Provider	❒ Mental Health Counseling	❒ Assisted Living
❒ Hospice Provider	❒ Crisis Response Team	❒ Community Hospital
❒ Physical Therapy / Occ. Health	❒ Drug Treatment / Detox	❒ Clinic

Please indicate where your employees perform their work:

❒ Private Homes/Apt. _____%	❒ Clinics _____%	❒ Nursing Homes _____%
❒ Doctor's offices _____%	❒ Hospitals _____%	❒ Corporate offices _____%
❒ Day Care Setting _____%	❒ Community Residences _____%	❒ Other Locations _____%

Please specify if other:

_____

_____

Supplemental WC Application – Home Health Care
PMC Insurance Group

2. RISK MANAGEMENT AND SAFETY PROGRAMS

a) Are independent contractors required to carry their own workers' compensation insurance? ❒ Yes ❒ No
b) How many independent contractors are being used? _____
c) What are the duties of the independent contractors?_____
d) Are independent contractors medical licenses checked annually? ❒ Yes ❒ No
e) Are copies of the insurance certificates obtained annually and kept on file? ❒ Yes ❒ No
f) Do employees drive personal or company vehicles to and from clients during the workday? ❒ Yes ❒ No
g) What is the average radius that employees drive during the work day? _____ miles
h) Are Motor Vehicle Records (MVR) checked annually for all employees and/or Independent Contractors who drive as part of their job? ❒ Yes ❒ No
i) Is a formal safety program in place? ❒ Yes ❒ No
j) If a formal safety program is in effect, please indicate applicable elements:

❒ Driver Safety Programs ❒ Accident/Injury Investigation ❒ New Employee Orientation
❒ Safety Committee ❒ Patient Handling/Transfer Training ❒ Blood Borne Pathogen
❒ Safety Incentive Program ❒ Performance Evaluations include safety ❒ Combative Patient Training
❒ Regular Formal Safety Training Conducted
❒ Management involvement in safety (describe below if checked)

_____

Hiring Practices:

Check the following boxes to indicate screening measures that are applied to prospective employees (note: some are post offer)

❒ Reference Check ❒ Validate Work History ❒ Personal Interviews
❒ Drug Testing/Screening ❒ Criminal Background Check ❒ Verification of Certifications/Licenses
❒ Post-Offer Physicals ❒ Child Abuse Clearance ❒ Psychological Testing

Claims Management:

a) Is there a designated person to manage workers' compensation claims? ❒ Yes ❒ No
b) Is there a formal Return to Work/Modified Duty Program in place? ❒ Yes ❒ No
c) Have detailed light duty job descriptions been developed? ❒ Yes ❒ No
d) Has a relationship been established with a preferred medical provider ❒ Yes ❒ No

3. INSURANCE INFORMATION

a) Has the applicant had continuous WC coverage for the past 2 years? ❒ Yes ❒ No
b) Has the applicant's WC insurance been cancelled for nonpayment within the last 3 years? ❒ Yes ❒ No
c) Has the applicant's WC been cancelled for Underwriting Reasons, other than carrier appetite change? ❒ Yes ❒ No
d) Is the applicant's current WC insurance provided through an Assigned Risk Plan? ❒ Yes ❒ No
e) Does the applicant supply any workers to other employers on a temporary or permanent basis? ❒ Yes ❒ No
f) Are all the applicant's operations (exclusive of monopolistic states) being submitted? ❒ Yes ❒ No

This information is accurate and complete to the best of my knowledge and represents the operations and exposures of the above noted applicant.

Applicant Name (printed): _____ Signature: _____

LLL Insurance Services
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Salt Lake City, UT 84152-6357
PH: 866-937-7037 * FX: 866-937-7010
Email: fdl@LLLinsuranceservices.com

III. INDEPENDENT CONTRACTORS ANNUAL STAFFING

Contractor Type	# 1099's	Annual Hours	Amt. Paid per 1099's
Nurse (RN)			
LPN/LVN			
Nurse Practitioner			
Physical Therapist			
Respiratory Therapist			
Speech Therapist			
Occupational Therapist			
Social Worker			
Pharmacist			
Home Health Aide/CNA			
Homemaker			
Sitter/Companion			
Physician			
X-Ray Technicians			
Medical Directors			
Pharmacy Ass't/Techs			
Doula			

(Other specify)

IV. Non-Owned Automobile SECTION

1) Does the applicant have any company owned vehicles? ☐ **Yes** ☐ **No**

2) How many of the applicant's employees drive their own vehicles during the course of business other than driving to and from a single work site? _____ (Please include those employees which drive to multiple work-sites in a single work day.)

3) Does the applicant require *Employees* to carry their own automobile liability insurance coverage? ☐ **Yes** ☐ **No**

a) If Yes, what personal automobile liability limits does the applicant require employee drivers to carry?

b) How does the applicant verify *Employee* owned automobile liability insurance coverage is in force?

4) Do any of the applicant's employees drive *Client* owned vehicles during the course of your business? ☐ **Yes** ☐ **No**

a) How does the applicant verify *Client* owned automobile liability insurance coverage is in force?

5) Does the applicant access and review Motor Vehicle Reports as a condition of employment? ☐ **Yes** ☐ **No**

F. Darrell Lindsey
U.S. State Licensed Agent/Broker

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FDL Lindsey Associates
Insurance Services

FDL *Insurance Services LLC*

STATE
LEGAL SYSTEMS

Your State Legal Systems can:

- **Destroy Jobs**
- **Raise Taxes**
- **Take Your Money**
- **Increase Insurance Rates**
- **Eliminate the Ability to Obtain Insurance At All**

Businesses are reluctant to locate in a state (or maybe even a county in the State) with a reputation of having unfair laws or court system. Plaintiff Attorneys' always go FORUM shopping to locate courts with a history that will be in their favor. Lawsuits (not including claims paid without a lawsuit) cost $245 Billion, or every American $845 a year, as reported in a study by Tillinghast, Towers, Perrin in January 2005.

In a recent report provided by the U.S. Chamber Institute for Legal Reform, www.instituteforlegalreform.org, the Institute identified its best to worst list.

As indicated by the survey the BEST to the WORST are noted below. Insurance rates are significantly influenced by the courts in every state. Why are your rates higher than someone in another state, or even someone in another country within your state, and why is insurance coverage even hard to find at all? It may be because of the court system or LAWS in your state or county are broken? Check out the Institutes website for more information!

BEST TO WORST LEGAL SYSTEMS:

1	Delaware	13	Colorado	25	Oregon	38	New Mexico
2	Nebraska	14	Utah	26	Ohio	39	South Carolina
3	North Dakota	15	Washington	27	New York	40	Missouri
4	Virginia	16	Kansas	28	Georgia	41	Hawaii
5	Iowa	17	Wisconsin	29	Nevada	42	Florida
6	Indiana	18	Connecticut	30	New Jersey	43	Arkansas
7	Minnesota	19	Arizona	31	Massachusetts	44	Texas
8	South Dakota	20	North Carolina	32	Oklahoma	45	California
9	Wyoming	21	Vermont	33	Alaska	46	Illinois
10	Idaho	22	Tennessee	34	Pennsylvania	47	Louisiana
11	Maine	23	Maryland	35	Rhode Island	48	Alabama
12	New Hampshire	24	Michigan	36	Kentucky	49	West Virginia
				37	Montana	50	Mississippi

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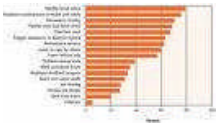

Employment Practices LIABILITY for claims filed involving wrongful termination, sexual harassment, page discrimination, etc., etc..

OR

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OTHER INSURANCE COVERAGE

Group Health Insurance for; Single Owner, Employee Programs, Deductible Plans, Co-Pay Programs, Self Insured Captives.

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Comments: _____

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