

Examine your current Workers' Compensation and General Liability Policies or contact your Insurance Agent to assist you with completing this form. ***** NOTICE ***** Enrollment is not automatic and requires the satisfactory completion of the Aon Form 1 and Form 3. In addition, submit a Certificate of Insurance providing evidence of your *off-site* coverage. Please refer to the Insurance Manual for coverage requirements.

A. Subcontractor Information: Federal ID # / Soc. Sec. #: ¹ _____

<p>▼ Business Information (headquarters)</p> <p>Company Name & d.b.a.: ² _____</p> <p>Contact Name & Title: _____</p> <p>Address: _____</p> <p>City, State Zip Code: _____</p> <p>Telephone: _____</p> <p>Fax: _____</p> <p>E-mail Address: _____</p>	<p>▼ Contact Information (address questions to..)</p> <p>³ _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Indicate your Organization's Structure: ⁴ Corporation Partnership S-Corporation
 Joint Venture Sole Proprietor Other _____

B. Bid Information: Subcontract No.: ¹ _____

Description of Work: ² _____

Subcontract Amount \$: ³ _____ Amount of Self Performed Work \$: ⁴ _____

⁵ Are you Under Subcontract with Yes No **McCarthy Building Companies, Inc.:** If No, ⁶ identify under Subcontract with: _____

⁷ Start Date: _____ Actual Estimated ⁸ Completion Date: _____ Actual Estimated

C. Workers' Compensation Insurance Information for Work Described Above: (attach a separate sheet if necessary)

a State	b Class Code	c Description	d Man-hours	e Reportable Payroll
¹				
Totals			²	³

D. Provide your current Off-Site Workers' Compensation Information:

Applicable State	Anniversary Rating Date:	Experience Modification:	Bureau File Number:
¹	²	³	⁴

Your WC Insurance Carrier: ⁵ _____

Policy #: ⁶ _____ Effective Date: ⁷ _____ Expiration Date: ⁸ _____

E. Contacts: (Complete if Applicable)

Position	1 Name & Title	2 Phone	3 Fax	4 E-mail address
Project Manger:				
Safety Rep:				
Subcontract Admin:				
Claims:				
Payroll:				

Provide Location of payroll records if different than Corporate address: ⁵ _____

Address: _____

City, State Zip Code: _____

F. Subcontract Information: List all subcontractors that will be working for you on this Project (complete the information in the following table). Use additional paper if necessary:

¹ Subcontractor	² Subcontract \$	³ Contact Person	⁴ Address	⁵ Phone Number	⁶ Estimated Start Date

G. Enrollment Questions: Answer each question. Use additional paper if necessary.

- ¹ Will you have any off-site location(s) 100% dedicated to this Project? Yes No If yes, please provide address:

- ² Please check if: Any aircraft used on this Project Any watercraft used on this Project
- ³ Please indicate if labor from the following sources will be used: Employee Leasing Firm Temporary Labor Agency

H. WARRANTY APPLICABLE TO PROGRAM INSURANCE COVERAGE

- ¹ Premiums for this Program are the responsibility of [McCarthy Building Companies, Inc.](#) and I agree any and all return of premium, dividends, discounts, or other adjustments to any Program policy(ies) is assigned, transferred and set over absolutely to [McCarthy Building Companies, Inc.](#). This assignment applies to the Program policy(ies) as now written or as subsequently modified, rewritten or replaced. Rights of Cancellation for all Program insurance policy(ies) arranged by are assigned to [McCarthy Building Companies, Inc.](#)
- ² I will pay the cost of premium(s) for non-Program insurance coverage, specified in the Subcontract Documents.
- ³ I authorized the release of all claim information for all insurance policies under this Program.
- ⁴ It is my responsibility to notify my insurance carrier(s) that I am enrolling in this Program.
- ⁵ I have excluded in my bid the insurance costs for the coverage provided by [McCarthy Building Companies, Inc.](#) I further agree to the Verified Blended Payroll Rate as described in the Insurance Manual.
- ⁶ The statements in this insurance application are true to the best of my knowledge.

I. Signature Block :

I verify the information presented above and attachments are correct:

Name: _____ Date: _____
(please print)

Title: _____ Signature: _____

Note: Information must be submitted on-line at www.aonwrap.aon.com. Please contact your Administration Staff to obtain a user ID and Password.

E-Mail or Fax to: **Andy Tavegia - CCIP Administrator**
Attn: Construction Wrap-up Group

Phone: 800.364.0495 x 7
Fax: 800.363.6695
Email: acs.construction@aon.com

This form must be completed and submitted by each successful Subcontractor of any tier prior to Site mobilization **for each Subcontract awarded**. The Subcontractor will submit the completed form to Aon Risk Solutions. Upon receipt of this form, Aon will issue, to the Subcontractor, a Certificate of Insurance evidencing coverage in the McCarthy Building Companies, Inc. Contractor Controlled Insurance Program. The completed Certificate of Insurance and Workers' Compensation insurance policy will be mailed to the Enrolled Party.

A. Subcontractor Information

- 1 Enter your company's Federal ID number. This number can be found on filings made to the federal government such as your tax return.
- 2 Enter your company's name, mailing address and phone/fax number for your company's headquarters in the space provided below.
- 3 Enter the name of the person Aon should contact if questions arise. Include mailing address, phone/fax and E-mail address in the space provided below.
- 4 Identify your company's legal structure by checking the box that applies. If the correct legal structure is not specifically listed, please check the "Other" box and specify in the space provided.

B. Bid Information

- 1 Enter the Bid Package Number or Purchase Order Number that was included in originating documentation.
- 2 Provide a brief description of the work you will be performing at the Project site.
- 3 Identify the total amount of your bid.
- 4 Identify the percentage of work that you anticipate will be self-performed.
- 5 Check the appropriate box that identifies if you Subcontract directly with McCarthy Building Companies, Inc. or are a sub-subcontractor.
- 6 If you are a Subcontractor, identify the entity you are under Subcontract with.
- 7 Enter the Date you anticipate starting work and then mark whether the date provided is actual or estimated
- 8 Enter the Date you anticipate completing the described work and then mark whether the date provided is actual or estimated.

C. Workers' Compensation Insurance Information *(Duplicate or attach additional sheets if necessary. You may create an electronic version of this document if all requested information is included):*

- 1
 - a Enter the 2-digit abbreviation for the state in which the work will be performed.
 - b Enter the 4 digit Workers' Compensation class code that applies to the work identified in B2.
 - c Enter the Workers' Compensation class code description that applies to the work identified in C1c.
 - d Enter the estimated Man-hours required to complete the described work for each Workers' Compensation class code.
 - e Enter the estimated Reportable Payroll required to complete the described work for each Workers' Compensation class code. Use only unburdened reportable payroll and exclude the premium portion of any over-time pay.
- 2 Total all estimated Man-hours for each class code. Be sure to include information from additional pages if used.
- 3 Total all estimated Reportable Payroll for each class code. Be sure to include information from additional pages if used.

D. Current Off-Site Workers' Compensation Information *(This information relates to your corporate or existing coverage copy this form if more than one modification factor applies to your work)*

- 1 Enter the State that the Modification Information applies to.
- 2 Provide your Company's Anniversary Rating Date. Information can be located on your bureau's WC Experience Modification worksheets.
- 3 Enter your current WC Experience Modification Factor.
- 4 Enter your Bureau File Number also referred to as your Risk Identification Number. This number can also be found on your Modification worksheets.
- 5 Identify your insurance carrier for Workers' Compensation Coverage.
- 6 Provide your Workers' Compensation Policy Number.
- 7 Provide the effective date of your Workers' Compensation policy.
- 8 Provide the expiration date of your Workers' Compensation policy.

E. Contacts *(Requested Contact information is for specific functions. It is possible to have a single person fulfill multiple responsibilities)*

- 1 Identify the name of the person and their title for each function. These individuals should be located, if at all possible, on-site.
- 2 Provide the phone number for each person identified above.
- 3 Provide the fax number for each person identified above.
- 4 Provide the E-mail address for each person identified above, if applicable.
- 5 Identify the physical location of where your payroll records are retained. Provide the Address, City, State, Zip Code, Telephone, Fax Number and E-mail Address of the person responsible for maintaining the payroll information.

F. Subcontractor Information *(Provide the following information for each Subcontractor that will be performing work at the Project site. Use additional sheets of paper if necessary.)*

- 1 Identify the name of the Subcontracting firm
- 2 Provide the estimated value of the subcontracted activity.
- 3 Provide a contact name, preferably the Project manager, for the subcontractor.
- 4 Provide the mailing address for the Subcontractor.
- 5 Provide the phone number for the Subcontractor.
- 6 Provide the date the Subcontractor is scheduled to begin work.

G. Enrollment Questions

- 1 Determine if you will have any locations, off-site, that will be 100% dedicated to this Project. Include material/supply storage as a possible location. Mark the appropriate box (yes/no). If you answer yes – provide the address of each location you identified as 100% dedicated.
- 2 Mark the box or boxes that apply. Contemplate only work performed under this Subcontract.
- 3 Mark the box or boxes that apply. Employee Leasing Firm are those firms that supply the labor force for your company *(You direct the activities of the Leasing Company's employees)*. Temporary Labor Firms supplement your labor force.

H. Warranty Statements:

- 1-6 Read each Warranty statement thoroughly. If you have questions regarding any of these statements, contact the Aon administrator identified on page 2.

I. Signature Block: a representative of your company knowledgeable of its accuracy must sign this form.

Note: Information must be submitted on-line at www.aonwrap.aon.com. Please contact your Administration Staff to obtain a user ID and Password.