COMPENSATION RATING AND INSPECTION BUREAU
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MANUAL AMENDMENT BULLETIN #513

TO: All Bureau Members and Subscribers

RE: New Jersey Workers Compensation Insurance Plan
ACORD 132NJ and ACORD 133NJ Form Changes

Background

The Acting Commissioner of Banking and Insurance has approved an amendment to the New Jersey Workers Compensation and Employers Liability Insurance Manual (Manual) under Part 3, Section 14 to update the ACORD 132NJ, "Notes and Instructions" and ACORD 133NJ "Coverage Request Form" which are used to apply for residual market coverage in the New Jersey Workers Compensation Insurance Plan. The updates include the addition of fields for employer and agent email addresses and an item requiring the acknowledgement that the final policy premium is subject to audit conducted after the policy has expired.

The release of the new ACORDs at this time is intended to provide employers and agents the opportunity to prepare and collect email addresses, which will be necessary for the upcoming release of the updated OAR platform, scheduled for release in the coming weeks.

Manual Changes

Part 3, Section 14-9 of the Manual is updated to include the revised ACORD forms. The ACORD forms are attached.

JOH:cs
Att.

ACORD

NEW JERSEY WORKERS COMPENSATION INSURANCE PLAN
NOTES AND INSTRUCTIONS (COVERAGE REQUEST FORM)

COMPENSATION RATING AND INSPECTION BUREAU
60 PARK PLACE, NEWARK, NEW JERSEY 07102
(973) 622-6014

PLEASE READ THESE NOTES, INSTRUCTIONS AND APPLICABLE MANUAL RULES CAREFULLY

An Application for insurance coverage through the New Jersey Workers Compensation Plan ("Plan") shall be made to the Rating Bureau at www.njcrib.com. Plan Rules may be found in Part 3, Section 14 of the New Jersey Workers Compensation & Employers' Liability Insurance Manual ("Manual").

The following notes and instructions apply to other requests for information from designated member insurers which provide coverage through the Plan. Applicable forms in connection with such requests include: Coverage Request Form (ACORD 133 NJ); Notice of Election – Proprietors and Partners (ACORD 134 NJ); Employee Leasing Supplemental Request Form (ACORD 135 NJ) and Truckers Supplemental Request Form (ACORD 136 NJ).

NOTES

1. Print a copy of the Coverage Request Form and any other applicable request forms for your records.
2. Premium payment requirements, as well as the coverage effective date, shall be determined pursuant to rules 3:14-8(3) and 3:14-8(9)(c), as applicable.
3. If applicable, you must complete the following forms: "Notice of Election – Proprietors and Partners"; "Employee Leasing Supplemental Request Form" and "Truckers Supplemental Request Form."
4. The designated insurer may return any incomplete forms and delay processing until all forms have been fully completed.

INSTRUCTIONS FOR COMPLETING COVERAGE REQUEST FORM

The numbers below refer to the numbers on the Coverage Request Form. You may contact the Rating Bureau at (973) 622-6014 for help.

1. NAME

Give the full legal name(s). Show the name of the individual owner or partners in addition to the registered trade name. For corporations, show the full name as registered with the Secretary of State of the State of incorporation. The policy will use the name as given and will afford correct coverage only if you show the complete and accurate name(s). Include the New Jersey Taxpayer Identification Number(s), Federal Employers Identification Number(s) (or Social Security Number) and your business telephone. Show the full legal name(s) of all commonly owned entities, whether coverage is requested or not. Any entity not requiring coverage must provide full details, including reason for exclusion, name of insurance company providing coverage, policy number and effective dates, if any.

2. ADDRESS

a. State your complete and exact mailing address (Do not use the address of your producer or other representative). For Employee Leasing, Professional Employer Organizations or Temporary Help Services, this will be your principal physical location (PO Box is not acceptable as a location).

b. Principal physical location of applicant (PO Box is not acceptable as a location).

c. The email address for electronic communication.

3. DATE BUSINESS OR OPERATION BEGAN

State the date the business or operations identified in Item #1 began in New Jersey. If the operation is seasonal or not continuous, explain on a supplemental page.

4. LEGAL STATUS

Check the proper box to signify the legal status of the business. If you check "Other," you must further identify the type of organization, using a separate sheet, if necessary.

5. LOCATION OF ALL NEW JERSEY SHOPS, YARDS OR WORK PLACES

State the addresses of all locations from which you conduct business operations, other than the mailing address contained in Item 2.a. This should include all locations of all commonly owned entities, whether or not coverage is requested. "If Any," "Various," PO Boxes or similar descriptions are not acceptable. Each workplace must include a complete and exact address as well as the maximum number of employees per shift, per location. "If Any" employees is not acceptable. The number of employees as of the date of this application must be shown, including temporary, leased or part-time employees, as well as sub-contractors. Use a supplemental sheet to provide any necessary additional explanations.

6. BOOKS AND RECORDS REFLECTING REMUNERATION

Specify the records you maintain of all compensation or remuneration to all persons or entities; including, but not limited to, employees, owner/operators, sub-contractors, independent contractors, consultants and vendors. These records include all ledgers, journals, registers, vouchers, contracts, tax reports, payroll and disbursement records, and all programs for storing and retrieving data. If you use contractors or sub-contractors, provide the manner of payment and the records maintained. State whether contractors or sub-contractors provide you with Certificates of Insurance. If you use a payroll service and/or accountant for record maintenance, provide full name(s), address(es) and telephone number(s) where they may be examined for audit purposes.

7. OWNERSHIP INFORMATION

Include the name, duties and annual remuneration of each regular corporate officer. This includes those known as President, Vice President, Secretary and/or Treasurer. Include this remuneration in the premium calculations. Also show the percent of stock owned by each.

For individuals, give the name and 100% as the amount of ownership interest. For a partnership, show the names of all the partners and ownership percentage each partner holds in the business.

In every case the total ownership interest must equal 100%. If you cannot clearly state the ownership, give the facts separately.

8. INSURANCE RECORD

Answer the question by checking "Yes" or "No". Complete the remaining questions.

If you have had workers' compensation insurance within the past three years, give the insurance company name, the last policy number and effective date, as well as the Governing Classification, annual premium and audited payrolls. If the name of the insured on that policy differs from the name for the insurance needed here, provide the proper name of the insured. If there is current insurance, give a detailed reason for completing this coverage request form.

9. INSURANCE COMPANIES WHO HAVE REFUSED INSURANCE

List the names of three insurance companies, and their representatives' names, refusing to provide this insurance to the applicant identified in Item #1 within the last 60 days. Agency names and representatives are not acceptable.

10. NATURE OF BUSINESS / DESCRIPTION OF OPERATIONS

Completely describe all operations of the applicant, including products manufactured, assembled, sold or serviced. For a manufacturing business, give raw materials, processes, machinery used and the product manufactured. If a service operation, give the nature and details. For mercantile businesses, show whether wholesale or retail and nature of merchandise sold. If a contractor, show the type of work performed, including work performed by sub-contractors. Classifications may not be changed from those established by the Rating Bureau without specific written consent of the Bureau.

11. GENERAL INFORMATION

Answer all questions by answering "Yes" or "No." If "YES," a detailed explanation must be provided on a supplemental sheet.

12a. CURRENT CLASSIFICATION OF OPERATIONS

List each Manual classification, phraseology and code number separately. If multiple locations, code should be shown separately for each location. Opposite each classification, show the total number of employees per code/per location, the code number, manual rate, annual payroll by classification and resultant premium. Compensation and remuneration reflected may be no less than those verified by tax documentation for the last taxable year, or that compensation or remuneration previously established by audit or inspection (3:3-36 & 37 of the Manual).

"IF ANY" is not acceptable as the number of employees or as an estimated payroll.

12b. PROJECTED CLASSIFICATIONS

Projected classifications are required. Calculations should be made by taking into account not only Current Classification of Operations as shown in 12a. above, but also projected classification(s) of operations, total number of employees per code/per location, code number, manual rate, and compensation or remuneration by classification for the upcoming policy period. This section must reflect both historical information and known or expected future operations and business experience.

12c. FINAL PREMIUM SUBJECT TO AUDIT

The applicant must acknowledge that the premium developed in Item 12b is an estimate of payroll for the policy, and the final premium will be determined by the audit conducted after the policy has expired.

13. PREMIUM PAYMENT

If the total estimated annual premium is less than five hundred dollars, the full estimated annual premium is required. If the estimated premium is more than five hundred dollars, submit 40% of it, or $500, whichever is greater.

14. CERTIFICATION

The coverage request form is incomplete unless the accuracy of the information contained therein is certified through the signature of a person legally authorized to act on behalf of the person or business named in Item #1. Include an email address and the date you sign the coverage request form.

15. PRODUCER CERTIFICATION

If you are an authorized licensed producer, provide the name, complete address and telephone number of the agency; include your federal employer identification number or social security number. You must also include an email address, date and sign the coverage request form.

ACORD

NEW JERSEY WORKERS COMPENSATION INSURANCE PLAN
COVERAGE REQUEST FORM

DATE (MM/DD/YYYY)

COMPENSATION RATING AND INSPECTION BUREAU
60 PARK PLACE, NEWARK, NEW JERSEY 07102
(973) 622-6014

Complete fully. See instruction sheet. Type or Print. Attach separate sheet, if necessary.

An Application for insurance coverage through the New Jersey Workers Compensation Insurance Plan ("Plan") shall be made to the Rating Bureau at www.njcrib.com.

This form shall be used at the request of the designated member insurer which provides coverage to the insured through the Plan.

COVERAGE ID NUMBER	COVERAGE REQUESTED EFFECTIVE DATE	NEW JERSEY TAXPAYER IDENTIFCATION #

1. NAME	TELEPHONE NUMBER	FEDERAL EMPLOYER ID #/SOCIAL SECURITY #

2. a. MAILING ADDRESS (Including ZIP code)	2. b. FULL ADDRESS OF PRINCIPAL PHYSICAL LOCATION (No P.O. Box)	3. DATE BUSINESS OR OPERATION BEGAN	4. LEGAL STATUS - IMPORTANT - REFER TO INSTRUCTIONS
			☐ INDIVIDUAL ☐ CORPORATION ☐ PARTNERSHIP ☐ SUBCHAPTER "S" CORP ☐ OTHER:

2. c. EMAIL ADDRESS

5. LOCATION OF ALL NEW JERSEY SHOPS, YARDS OR WORK PLACES ("IF ANY" is NOT acceptable for Locations or # of Employees)

#	STREET, CITY, COUNTY, STATE, ZIP CODE	MAX # EMP PER SHIFT	#	STREET, CITY, COUNTY, STATE, ZIP CODE	MAX # EMP PER SHIFT

6. BOOKS AND RECORDS REFLECTING REMUNERATION

WHAT RECORDS DO YOU MAINTAIN SHOWING ALL REMUNERATION, AND WHERE (LOCATION) MAY THEY BE EXAMINED?

AUDIT INFORMATION CONTACT NAME	TELEPHONE NUMBER

AUDIT ADDRESS (Physical Location)

IF PAYROLL SERVICE IS USED PROVIDE NAME, ADDRESS AND TELEPHONE # OF SERVICE

7. OWNERSHIP INFORMATION

LIST BELOW NAMES, TITLES, DUTIES AND APPROXIMATE ANNUAL REMUNERATION OF CORPORATE OFFICERS. SIMILARLY, INCLUDE ANY PROPRIETORS AND PARTNERS WHERE THE NOTICE OF ELECTION-PROPRIETORS AND PARTNERS HAS BEEN COMPLETED. INCLUDE THEIR REMUNERATION IN THE PREMIUM COMPUTATIONS. ALSO GIVE THE PERCENT OF STOCK OWNED BY EACH OFFICER AND PARTNER. ATTACH SEPARATE SHEET IF NECESSARY.

NAME	TITLE	% OF STOCK OWNED	DUTIES	APPROXIMATE ANNUAL REMUNERATION

IF YOU HAVE NOT INCLUDED THE OFFICER'S, OWNERS OR PARTNERS PAYROLL IN THE PREMIUM CALCULATION, EXPLAIN:

8. INSURANCE RECORD

ANY PREVIOUS NJ WORKERS COMP INSURANCE COVERAGE? ☐ YES ☐ NO

IF YES, WAS COVERAGE THROUGH: ☐ PLAN ☐ VOLUNTARY

REASON FOR FILING APPLICATION:

IF NO, ☐ NEW BUSINESS ☐ SELF INSURANCE ☐ OTHER:

INSURANCE RECORD - THREE PREVIOUS YEARS (ATTACH SEPARATE SHEET, IF NECESSARY)

STATE	LOCATION	INSURANCE COMPANY	POLICY NUMBER	POLICY PERIOD FROM	POLICY PERIOD TO	GOVERNING CLASS	ANNUAL PREMIUMS	AUDITED PAYROLL

9. INSURANCE COMPANIES WHO HAVE REFUSED INSURANCE

LIST BELOW NAMES AND REPRESENTATIVES OF THREE COMPANIES WHICH HAVE REFUSED COVERAGE IN THE PAST SIXTY DAYS. THE REPRESENTATIVES NAMED MUST BE FULL-TIME EMPLOYEES OF THE INSURANCE COMPANY. IF APPLICABLE, ONE OF THESE COMPANIES SHOULD BE THE ONE PROVIDING WORKERS COMPENSATION INSURANCE TO THE APPLICANT AT THE TIME OF APPLICATION.

INSURANCE COMPANY NAME	REPRESENTATIVE'S NAME

10. NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS

GIVE COMPLETE DESCRIPTION OF BUSINESS AND OPERATIONS INCLUDING PRODUCTS MANUFACTURED, SOLD OR SERVICED.

11. GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES; ATTACH SEPARATE SHEET IF NECESSARY	YES	NO
1. DO YOU HAVE OPERATIONS IN STATES OTHER THAN NEW JERSEY? IF YES, LIST THE STATES AND LENGTH OF TIME IN BUSINESS BY STATE:		
2. HAS THERE BEEN A NAME CHANGE OR A CONSOLIDATION, MERGER OR OTHER OWNERSHIP CHANGE DURING THE PAST THREE YEARS? IF YES, ATTACH A SEPARATE SIGNED OWNERSHIP STATEMENT ON EMPLOYERS LETTERHEAD WITH PREVIOUS BUSINESS NAME, OWNERS, INCLUDING PERCENTAGE OF STOCK, AND DATE OF CHANGE.		
3. DOES ANY OWNER NAMED IN ITEM # 7 HAVE AN OWNERSHIP INTEREST IN ANY OTHER BUSINESS? IF YES, DESCRIBE FULLY.		
4. HAS ANY OWNER EVER BEEN IN BUSINESS UNDER A DIFFERENT NAME? IF YES, GIVE NAME(S) AND DATE(S) OF OPERATION.		
5. HAS ANY OWNER FILED FOR BANKRUPTCY? IF YES, GIVE DATE AND STATE OF FILING.		
6. DO YOU OR ANY COMMONLY OWNED OR MANAGED ENTERPRISES OWE ANY UNPAID WORKERS COMPENSATION INSURANCE PREMIUMS?		
7. HAS ANY INSURANCE COMPANY EVER CANCELED YOUR WORKERS COMPENSATION POLICY FOR NONPAYMENT OR FOR ANY OTHER REASON?		
8. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS? IF YES, COMPLETE EMPLOYEE LEASING SUPPLEMENTAL REQUEST FORM.		
9. DO YOU HAVE ANY TRUCKING OPERATIONS? IF YES, COMPLETE TRUCKERS SUPPLEMENTAL REQUEST FORM.		
10. DO YOU USE SUBCONTRACTORS?		
11. IF YES, DO YOU OBTAIN CERTIFICATES OF INSURANCE?		

12a. CURRENT CLASSIFICATION OF OPERATIONS

CLASSIFICATION PHRASEOLOGY	TOTAL # OF EMP PER CODE	CLASS CODE	RATE	TOTAL PREMIUM BASIS TOTAL WAGES	PREMIUM
CLERICAL OFFICE EMPLOYEES		8810			
SALESPERSONS - OUTSIDE		8742			
DRIVERS NOC		7380			
	TOTAL PREMIUM EXCLUDING MOD / PPAP / SURCHARGES				

12b. PROJECTED CLASSIFICATION OF OPERATIONS

CLASSIFICATION PHRASEOLOGY	TOTAL # OF EMP PER CODE	CLASS CODE	RATE	TOTAL PREMIUM BASIS TOTAL WAGES	PREMIUM
CLERICAL OFFICE EMPLOYEES		8810			
SALESPERSONS - OUTSIDE		8742			
DRIVERS NOC		7380			

TOTAL PREMIUM SUBJECT TO THE EXPERIENCE MODIFICATION		
* PREMIUM MODIFIED TO REFLECT EXP MOD		
N.J.C.C.P.A.P. CREDIT		
OTHER PREMIUM CHARGES		
TOTAL ESTIMATED STANDARD PREMIUM		
** PLAN PREMIUM ADJUSTMENT		
(0900) EXPENSE CONSTANT		
(9740) TERRORISM PREMIUM CHARGE - $ 0.0300 PER $100 OF PAYROLL		
(9741) CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) PREMIUM CHARGE - $ 0.0100 PER $100 OF PAYROLL		
TOTAL ESTIMATED PREMIUM		
(0935) SECOND INJURY FUND SURCHARGE		
(0936) UNINSURED EMPLOYERS FUND SURCHARGE		
TOTAL ESTIMATED COST $		
*** DEPOSIT PREMIUM		

* ENTER "NONE" IF EMPLOYER IS NOT SUBJECT TO EXPERIENCE RATING.

** THIS FACTOR IS APPLIED IN ACCORDANCE WITH 3:14-8(13A) - (13E) OF THE MANUAL.

*** IF ESTIMATED ANNUAL PREMIUM IS LESS THAN $500, THE DEPOSIT PREMIUM IS THE TOTAL AMOUNT. IF $500 OR MORE, SEND 40% OF THE TOTAL ESTIMATED ANNUAL PREMIUM, OR $500, WHICHEVER IS GREATER.

12c. FINAL PREMIUM SUBJECT TO AUDIT

	YES	NO
I HEREBY ACKNOWLEDGE THAT THE PREMIUM IN ITEM 12b IS AN ESTIMATE, AND THE FINAL POLICY PREMIUM IS SUBJECT TO THE AUDIT CONDUCTED AFTER THE POLICY HAS EXPIRED.		

13. PREMIUM PAYMENT

AMOUNT DUE $

14. CERTIFICATION

I HEREBY ACKNOWLEDGE THAT I HAVE FULLY READ THE INSTRUCTIONS RELATED TO THE COMPLETION OF THIS FORM, AS WELL AS THE ABOVE STATEMENTS AND CERTIFY THAT THE FOREGOING STATEMENTS AND INFORMATION CONTAINED HEREIN ARE TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND, THAT I, AS AN OWNER/OFFICER, AM FULLY AUTHORIZED TO SIGN THIS FORM ON BEHALF OF THE INSURED, AND TO BIND THE INSURED. I UNDERSTAND THAT UNDER NEW JERSEY CRIMINAL LAW, INSURANCE FRAUD IS PUNISHABLE BY UP TO TEN (10) YEARS IMPRISONMENT AND FINES UP TO $150,000, AS WELL AS CIVIL PENALTIES AUTHORIZED BY THE NEW JERSEY INSURANCE FRAUD PREVENTION ACT.

I UNDERSTAND THAT THE INFORMATION PROVIDED HEREIN IS MATERIAL AND WILL BE RELIED UPON BY THE COMPENSATION RATING & INSPECTION BUREAU, AS WELL AS BY THE DESIGNATED INSURANCE COMPANY, TO PROVIDE THE REQUESTED INSURANCE AND WILL BE USED TO CALCULATE MY PRELIMINARY WORKERS' COMPENSATION PREMIUM.

I ALSO UNDERSTAND THAT I HAVE A CONTINUING OBLIGATION TO PROMPTLY NOTIFY THE DESIGNATED CARRIER OF CHANGES IN:

- THE KIND OF WORK CONDUCTED BY THE BUSINESS
- THE SIZE OF AND/OR CLASSIFICATION OF OUR WORKFORCE
- THE AMOUNT OF REMUNERATION
- THE BUSINESS OWNERSHIP OR BUSINESS STRUCTURE
- CHANGE OF MAILING ADDRESS AND/OR PRINCIPAL PHYSICAL LOCATION

I AGREE TO MAKE AVAILABLE ALL RECORDS NECESSARY FOR A CARRIER OR RATING BUREAU AUDIT AND TO PERMIT THE AUDITOR OR OTHER REPRESENTATIVE TO MAKE A PHYSICAL INSPECTION OF OUR PREMISES/OPERATIONS. I UNDERSTAND THAT FAILURE TO DO THIS MAY RESULT IN TERMINATION OF THE COVERAGE PROVIDED, CIVIL PENALTIES AND/OR CRIMINAL PROSECUTION.

IT IS FURTHER UNDERSTOOD THAT IF THERE IS WORKERS' COMPENSATION LIABILITY UNDER THE LAW(S) OF ANY OTHER STATE(S), OTHER ARRANGEMENTS MUST BE MADE.

IN ACCORDANCE WITH NEW JERSEY LAW, IF I/WE INTENTIONALLY UNDERSTATE OR CONCEAL REMUNERATION, OR MISREPRESENT OR CONCEAL EMPLOYEE DUTIES, SO AS TO AVOID PROPER CLASSIFICATION FOR PREMIUM CALCULATIONS, OR MISREPRESENT OR CONCEAL INFORMATION PERTINENT TO THE COMPUTATION AND APPLICATION OF AN EXPERIENCE RATING MODIFICATION FACTOR, I/WE SHALL BE SUBJECT TO CIVIL PENALTIES AUTHORIZED BY THE NEW JERSEY INSURANCE FRAUD PREVENTION ACT, AS WELL AS PROSECUTION UNDER THE CRIMINAL LAWS OF THIS STATE.

PRINT NAME AND TITLE	NJ DRIVER'S LICENSE # OR NJ MVC ID #	
EMAIL ADDRESS	**SIGNATURE**	**DATE**

15. PRODUCER CERTIFICATION

DESIGNATED LICENSED PRODUCER, IF ANY (INCLUDE ADDRESS)	FEDERAL EMPLOYER ID #/SOCIAL SECURITY NUMBER
	TELEPHONE NUMBER

I HEREBY CERTIFY THAT I HAVE READ AND UNDERSTAND THE INSTRUCTIONS RELATED TO THIS FORM AND HAVE FULLY EXPLAINED THE RULES AND PROCEDURES OF THE NEW JERSEY WORKERS' COMPENSATION INSURANCE PLAN TO THE INSURED. I UNDERSTAND THAT INTENTIONAL MISSTATEMENT OF INFORMATION IN THIS FORM MAY SUBJECT ME TO PENALTIES AS ARE PROVIDED BY LAW INCLUDING, BUT NOT LIMITED TO LOSS OF LICENSE.

I FURTHER UNDERSTAND THAT UNDER NEW JERSEY CRIMINAL LAW, INSURANCE FRAUD IS PUNISHABLE BY UP TO TEN (10) YEARS IMPRISONMENT AND FINES UP TO $150,000 AS WELL AS CIVIL PENALTIES AUTHORIZED BY THE NEW JERSEY INSURANCE FRAUD PREVENTION ACT. I FURTHER CERTIFY THAT I HAVE WITNESSED THE INSURED'S SIGNATURE TO THIS FORM.

PRINT PRODUCER'S NAME AND TITLE	PRODUCER'S NJ LICENSE #	NATIONAL PRODUCER NUMBER

PRODUCER'S EMAIL ADDRESS	PRODUCER'S SIGNATURE	DATE

REMARKS