DCRB
DELAWARE
Compensation Rating Bureau, Inc.

August 23, 2021

VIA SERFF

The Honorable Trinidad Navarro
Insurance Commissioner
Department of Insurance
State of Delaware
841 Silver Lake Boulevard
Dover, DE 19904-2465

Attention: Tanisha Merced, Deputy Insurance Commissioner

RE: DCRB Filing No. 2105 – Proposed Effective December 1, 2021
Revised Version of the Delaware Insurance Plan Application

Dear Commissioner Navarro and Deputy Commissioner Merced:

On behalf of the members of the Delaware Compensation Rating Bureau Inc. (DCRB), we hereby submit this proposed filing for revisions to the Delaware Insurance Plan (DIP) application form. These revisions are proposed to be effective as of 12:01 a.m., December 1, 2021, and coincide with changes resulting from DCRB's normal annual comprehensive loss cost revision, which was recently filed with the Department of Insurance.

The Delaware Insurance Plan (DIP) currently allows an applicant to provide their social security number in lieu of their business' Federal Employer Identification Number (FEIN). It is thus suggested for security purposes that this option be removed ensuring the protection of the applicant's personal information.

Other suggested form revisions include:

- Added qualifiers to three sections of the application allowing an applicant to clearly confirm: (1) executive officer/member-of-an-LLC exclusion; (2) sole-proprietor/partner-of-a partnership inclusion; or (3) if a USL& H exposure exists.
- Modernized grammar and more consistent language.
- Updated fonts and formatting.
- Removal of gender specific pronouns.

Included with this proposed filing is the DCRB's staff memorandum detailing the proposed revisions to the application form. The memorandum and proposals were presented to the DCRB Classification and Rating Committee during its annual meeting on June 9, 2021.

Thank you in advance for your review and attention given to this filing. The DCRB will be pleased to answer any questions you or the Department of Insurance's staff may have regarding the proposal.

Sincerely,

William V. Taylor
President

Enclosure: Staff Memorandum and Revised Application

DCRB
DELAWARE
Compensation Rating Bureau, Inc.

TO: Delaware Compensation Rating Bureau, Inc. (DCRB) Classification & Rating Committee

FROM: Drew Kratz, Manager – Underwriting & Coverage Compliance

DATE: June 01, 2021

RE: Revised Version of the Delaware Insurance Plan Application

Background:

The proposed changes in the following memorandum are intended to update the standard version of the Delaware Insurance Plan (DIP) application. The form is completed by applicants when they cannot secure coverage on the commercial market in the state of Delaware and must obtain coverage through Delaware's assigned risk program (DIP). The application is available in both a hard copy and an electronic version.

The proposed revision will update the application language to remove reference to an individual's Social Security Number. Currently the application allows the insured to provide their Social Security Number in lieu of their Federal Employer Identification Number (FEIN). For security purposes, the removal of this option will ensure the protection of the applicant's personal information. In addition to the removal of the social security number, qualifiers are added to three (3) sections of the application requiring the applicant to confirm whether an officer is excluded, whether a sole proprietor or partner of a partnership is included and/or whether an exposure is a USL&H exposure. The application was also reviewed to ensure the use of uniform font size/formatting and for grammatical correctness. Regarding latter, use of the male pronoun "he" was removed and replaced with a gender-neutral pronoun.

Proposal:

The proposed changes are provided below. The language revision will ultimately modernize the application to reflect current needs and informational standards more clearly. The DCRB recommends the revised application become effective December 1, 2021 concurrent with DCRB's normal annual comprehensive loss cost filing.

30 S 17th Street, Suite 1500, Philadelphia, PA 19103 | 302.654.1435 | www.dcrb.com

DCRB
DELAWARE
Compensation Rating Bureau, Inc.

APPLICATION FOR WORKERS COMPENSATION ASSIGNED RISK PLAN

This application must be typed or printed and filed in duplicate.

Please answer all questions and requested information thoroughly. Omissions may result in delay of coverage. The undersigned employer hereby applies for workers compensation insurance in Delaware and expressly represents that such insurance is sought in good faith.

IMPORTANT: **NO** insurance is provided by this application. Coverage will be bound as of 12:01 A. M. the day following the Federal postmark time and date on the envelope in which the fully completed application is mailed (including the estimated annual or deposit premium), or the expiration of existing coverage, whichever is later. If there is no postmark, coverage will be effective 12:01 A.M. of the date of the receipt by the Bureau unless a later date is requested. Submission of an incomplete or incorrect application may delay the binding of coverage. Applications hand delivered to the Bureau will be effective as of 12:01 A.M. of the date following receipt by the Bureau unless a later date is requested.

I. GENERAL INFORMATION

Requested Effective 12:01 A.M. (Date) _____

1. Name of Employer _____

☐☐☐☐☐☐☐☐☐ F.E.I.N. Required By Law

2. Federal Employers Identification Number

~~Social Security Number~~ ☐☐☐☐☐☐☐☐☐

3. Mailing Address _____

4. Principal Location ~~O~~of Business (Required) _____

5. Other Delaware Locations _____

6. Payroll Office Address _____

7. Legal Status ☐ Sole Proprietor ☐ Partnership ☐ Corporation ☐ Limited Liability ☐ Title 19 - Independent Contractor

☐ Other (explain): _____

8. Has there been a name change during the past three years: ☐Yes ☐No If yes, give previous name and date of change:

_____

9. Are there operations in states other than Delaware? ☐ Yes ☐ No If yes, complete the following:

(If self-insured or uninsured, indicate under Insurance Carrier)

State	Location	Insurance Carrier

II. Insurance Record

1. Has there been previous workers compensation insurance coverage in Delaware? ☐ Yes ☐ No

   If "No", complete ☐ New Business ☐ ~~Self Insured~~Self-Insured ☐ Other (explain):_____

   If "Yes", Insurance Record - Three Previous Years:

State	Insurance Company	Policy Number	Policy Period From	Policy Period To	Premiums

2. Total **audited** payroll for each of the above policy periods:

Payroll	Policy Period To	Policy Period From

3. Do you owe any broker, agent, insurance company or state workers insurance fund unpaid premiums for workers compensation coverage? ☐ Yes ☐ No
   If "Yes", coverage may be denied or canceled. Explain: _____

4. Is applicant a parent, affiliate, or subsidiary or under common ownership or management with any other entity subject to state workers compensation laws or other applicable federal law? ☐ Yes ☐ No

   If "Yes", attach information identifying the entities involved and the workers compensation insurance or ~~self insurance~~self-insurance status.

III. Two Insurance Companies Who Have Refused Insurance

List below name of representative and telephone numbers of **two** companies who have refused coverage in the past sixty days. The representative named must be a full-time employee of the insurance company. Current carrier must be one of the carriers declining coverage. The DCRB may require verification of carrier's declination.

Insurance Company	Name of Representative	Telephone Number
Current Carrier:		

IV. Corporate Officer

List below the name (s), title, duties and approximate annual salary of all officers or Limited Liability Company members. Officer or member salaries are subject to a minimum/maximum respectively.
Note: Officers electing exclusion **must** complete and **attach** Agreement by Executive Officer(s) /LLC form.

Name	Title	Duties	Approx. Annual Salary	**Excluded Y/N**

V. Delaware Law provides that sole proprietors or partners are not included under the Act but may elect coverage. Title 19 of the Delaware Code requires independent contractors and subcontractors to be covered. Complete: Sole Proprietors, Partners, Officers and other Coverage Endorsement (WC 00 03 10) – if applicable

Name	Title	Duties	Approx. Annual Salary	Included Y/N

VI. Nature of Business, Location, Classifications and Payroll in Delaware

Manufacturing ☐ Mercantile ☐ Contractor ☐ Service ☐ Farm ☐ Other ☐ _____

Explain nature of business /completely describe all operations at this or any other location. Give description of products and list of raw materials (**Do not** use manual phraseology for description).

_____

_____

_____

Calculation of Estimated Annual Premium

Manual Classification of:		Total Payroll Basis				
Employees by Location	Class Code	No. of Employees	Total Payroll	USL&H Y/N	Rate	Premium
Increased Limits of Liability (if applicable)						
Payroll Not included above for:						
Executive Officer(s)						
Sole Proprietor or Partner(s)						
Limited Liability Company Member(s)						

Total Premium _____

Experience Modification (Code 9898) _____

Standard Premium _____

Merit Rating Adjustment (Code 988) _____

Workplace Safety Credit (Code 9880) _____

Construction Prem. Credit (Code 9046) _____

Surcharge (DIP) (Code 0277) _____

Deductible Credit (Code 9663) _____

Less Premium Discount (Code 0063) _____

Plus Expense Constant (Code 0900) _____

* Codes 9740 & 9741 premium charge is calculated by dividing total payroll by $100 and multiplying the result times the residual market rate for the code

Terrorism Risk Ins. Act (Code 9740) * _____

Domestic Terrorism, Earthquake, Catastrophic Industrial Accidents (9741)* _____

Total Estimated Annual Premium _____

Percentage of Annual Estimated Premium used to determine Deposit Premium _____

(**Enclose Agent's or Employer's Certified Check in this Amount**) Deposit Premium _____

VII. DEPOSIT PREMIUM

Procedures to follow in determining the proper deposit premium are printed below. Failure to follow the deposit premium rule correctly may delay the effective date of coverage. Based on the deposit premium rule, the following method of premium payment has been determined:

☐ Annual - 100% ☐ Semi-annual - 75% ☐ Quarterly - 50% ☐ Monthly - 25%

Deposit premium is determined by taking a percentage of the annual premium. The percentage varies with the amount of the estimated annual premium. The "deposit premium" table is followed by the servicing carrier. Here is how it works:

Estimated Annual Premium	Interim Adjustment Basis	Minimum Deposit Percentage	Additional Payments During Year
Under $~~-~~1,000	Annual	100% of annual	None
At least $~~-~~1,000	Semi-annual	75% of annual	One
At least $~~-~~5,000	Quarterly	50% of annual	Three
At least $25,000	Monthly	25% of annual	Eleven

An employer may pay the estimated annual premium as a deposit or may select any adjustment basis available. The servicing carrier, based on sound underwriting practices, has the right to make appropriate changes in the interim adjustment program which the employer has selected. The servicing carrier will give the reasons for any change. The DCRB cannot make changes to the Interim Adjustment Basis.

Deposit Premium Payment

Enclose agent or employer's certified check. Coverage will not be bound without payment of deposit premium. Enclosed is Check No._____ made payable to the **Delaware Compensation Rating Bureau, Inc.** in the amount of $ _____.

VIII. Applicant's Statement

The undersigned employer hereby certifies that he has read and understands the statements in this application. Furthermore, in consideration of the issuance of the policy of insurance he also certifies that the statements in this application are true and agrees:

1. To maintain a complete record of all payroll transactions in such form as the insurance company may reasonably require and that such record will be available to the company at the designated address.
2. To comply substantially with all laws, order, rules and regulations in force and effect made by the public authorities relating to the welfare, health and safety of employees.
3. To comply with all reasonable recommendations made by the insurance company relating to the welfare, health and safety of employees.

The undersigned employer also certifies ~~he has~~ they have no difficulties with any broker, agent, insurance company or state workers insurance fund regarding: (a) payroll records; (b) the amount of premium charges; (c) the payment of premium; (d) the carrying outof any recommendation made for the purpose of safeguarding its employees; (e) the handling of any claim or accident report except the following:

_____

This insurance is being afforded through the Delaware Workers Compensation Insurance Plan and not through the private market. Violation of any of these agreements, or failure to pay valid workers compensation premium charges, may result in cancellation of any policy of insurance under the Delaware Workers Compensation Insurance Plan.

Employer Name and Title_____ Date _____

Signature*_____ Telephone No. (_____)_____

***Application must be signed by an officer or owner.** E-mail address (optional): _____

IX Agency and Producer

Agency Name _____ Telephone No. (_____)_____

Delaware Agent License No. _____ Fax No. (_____)_____

Address _____ E-mail address_____

Producer _____ _____ _____

Name **Agent's Signature** **Date**

Federal Employer Identification Number _____

30 S 17th Street, Suite 1500, Philadelphia, PA 19103 | 302.654.1435 | www.dcrb.com

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APPLICATION FOR WORKERS COMPENSATION ASSIGNED RISK PLAN

This application must be typed or printed and filed in duplicate.

Please answer all questions and requested information thoroughly. Omissions may result in delay of coverage. The undersigned employer hereby applies for workers compensation insurance in Delaware and expressly represents that such insurance is sought in good faith.

IMPORTANT: **NO** insurance is provided by this application. Coverage will be bound as of 12:01 A. M. the day following the Federal postmark time and date on the envelope in which the fully completed application is mailed (including the estimated annual or deposit premium), or the expiration of existing coverage, whichever is later. If there is no postmark, coverage will be effective 12:01 A.M. of the date of the receipt by the Bureau unless a later date is requested. Submission of an incomplete or incorrect application may delay the binding of coverage. Applications hand delivered to the Bureau will be effective as of 12:01 A.M. of the date following receipt by the Bureau unless a later date is requested.

I. GENERAL INFORMATION

Requested Effective 12:01 A.M. (Date) _____

1. Name of Employer _____

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ F.E.I.N. Required By Law

2. Federal Employers Identification Number

_____

3. Mailing Address _____

4. Principal Location of Business (Required) _____

5. Other Delaware Locations _____

6. Payroll Office Address _____

7. Legal Status ☐ Sole Proprietor ☐ Partnership ☐ Corporation ☐ Limited Liability ☐ Title 19 - Independent Contractor

☐ Other (explain): _____

8. Has there been a name change during the past three years: ☐ Yes ☐ No If yes, give previous name and date of change:

_____

9. Are there operations in states other than Delaware? ☐ Yes ☐ No If yes, complete the following:

(If self-insured or uninsured, indicate under Insurance Carrier)

State	Location	Insurance Carrier

II. Insurance Record

1. Has there been previous workers compensation insurance coverage in Delaware? ☐ Yes ☐ No

   If "No", complete ☐ New Business ☐ Self-Insured ☐ Other (explain):_____

   If "Yes", Insurance Record - Three Previous Years:

State	Insurance Company	Policy Number	Policy Period From	Policy Period To	Premiums

2. Total **audited** payroll for each of the above policy periods:

Payroll	Policy Period To	Policy Period From

3. Do you owe any broker, agent, insurance company or state workers insurance fund unpaid premiums for workers compensation coverage? ☐ Yes ☐ No
   If "Yes", coverage may be denied or canceled. Explain: _____

4. Is applicant a parent, affiliate, or subsidiary or under common ownership or management with any other entity subject to state workers compensation laws or other applicable federal law? ☐ Yes ☐ No

   If "Yes", attach information identifying the entities involved and the workers compensation insurance or self-insurance status.

III. Two Insurance Companies Who Have Refused Insurance

List below name of representative and telephone numbers of **two** companies who have refused coverage in the past sixty days. The representative named must be a full-time employee of the insurance company. Current carrier must be one of the carriers declining coverage. The DCRB may require verification of carrier's declination.

Insurance Company	Name of Representative	Telephone Number
Current Carrier:		

IV. Corporate Officer

List below the name (s), title, duties and approximate annual salary of all officers or Limited Liability Company members. Officer or member salaries are subject to a minimum/maximum respectively.
Note: Officers electing exclusion **must** complete and **attach** Agreement by Executive Officer(s) /LLC form.

Name	Title	Duties	Approx. Annual Salary	Excluded Y/N

V. Delaware Law provides that sole proprietors or partners are not included under the Act but may elect coverage. Title 19 of the Delaware Code requires independent contractors and subcontractors to be covered. Complete: Sole Proprietors, Partners, Officers and other Coverage Endorsement (WC 00 03 10) – if applicable

Name	Title	Duties	Approx. Annual Salary	Included Y/N

VI. Nature of Business, Location, Classifications and Payroll in Delaware

Manufacturing ☐ Mercantile ☐ Contractor ☐ Service ☐ Farm ☐ Other ☐ _____

Explain nature of business /completely describe all operations at this or any other location. Give description of products and list of raw materials (**Do not** use manual phraseology for description).

_____

_____

_____

Calculation of Estimated Annual Premium

Manual Classification of:		Total Payroll Basis				
Employees by Location	Class Code	No. of Employees	Total Payroll	USL&H Y/N	Rate	Premium
Increased Limits of Liability (if applicable)						
Payroll Not included above for:						
Executive Officer(s)						
Sole Proprietor or Partner(s)						
Limited Liability Company Member(s)						

Total Premium _____

Experience Modification (Code 9898) _____

Standard Premium _____

Merit Rating Adjustment (Code 988) _____

Workplace Safety Credit (Code 9880) _____

Construction Prem. Credit (Code 9046) _____

Surcharge (DIP) (Code 0277) _____

Deductible Credit (Code 9663) _____

Less Premium Discount (Code 0063) _____

Plus Expense Constant (Code 0900) _____

* Codes 9740 & 9741 premium charge is calculated by dividing total payroll by $100 and multiplying the result times the residual market rate for the code

Terrorism Risk Ins. Act (Code 9740) * _____

Domestic Terrorism, Earthquake, Catastrophic Industrial Accidents (9741)* _____

Total Estimated Annual Premium _____

Percentage of Annual Estimated Premium used to determine Deposit Premium _____

(**Enclose Agent's or Employer's Certified Check in this Amount)** Deposit Premium _____

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Procedures to follow in determining the proper deposit premium are printed below. Failure to follow the deposit premium rule correctly may delaythe effective date of coverage. Based on the deposit premium rule, the following method of premium payment has been determined:

☐ Annual - 100% ☐ Semi-annual - 75% ☐ Quarterly - 50% ☐ Monthly - 25%

Deposit premium is determined by taking a percentage of the annual premium. The percentage varies with the amount of the estimated annualpremium. The "deposit premium" table is followed by the servicing carrier. Here is how it works:

Estimated Annual Premium	Interim Adjustment Basis	Minimum Deposit Percentage	Additional Payments During Year
Under $1,000	Annual	100% of annual	None
At least $1,000	Semi-annual	75% of annual	One
At least $5,000	Quarterly	50% of annual	Three
At least $25,000	Monthly	25% of annual	Eleven

An employer may pay the estimated annual premium as a deposit or may select any adjustment basis available. The servicing carrier, based on sound underwriting practices, has the right to make appropriate changes in the interim adjustment program which the employer has selected. Theservicing carrier will give the reasons for any change. The DCRB cannot make changes to the Interim Adjustment Basis.

Deposit Premium Payment

Enclose agent or employer's certified check. Coverage will not be bound without payment of deposit premium. Enclosed is Check No._____ made payable to the **Delaware Compensation Rating Bureau, Inc.** in the amount of _____ .

VIII.Applicant's Statement

The undersigned employer hereby certifies that he has read and understands the statements in this application. Furthermore, in consideration of theissuance of the policy of insurance he also certifies that the statements in this application are true and agrees:

1. To maintain a complete record of all payroll transactions in such form as the insurance company may reasonably require and that such recordwill be available to the company at the designated address.
2. To comply substantially with all laws, order, rules and regulations in force and effect made by the public authorities relating to the welfare, health and safety of employees.
3. To comply with all reasonable recommendations made by the insurance company relating to the welfare, health and safety of employees.

The undersigned employer also certifies they have no difficulties with any broker, agent, insurance company or state workers insurance fund regarding: (a) payroll records; (b) the amount of premium charges; (c) the payment of premium; (d) the carrying outof any recommendation made for the purpose of safeguarding its employees; (e) the handling of any claim or accident report except the following:

_____

This insurance is being afforded through the Delaware Workers Compensation Insurance Plan and not through the private market. Violation of any of these agreements, or failure to pay valid workers compensation premium charges, may result in cancellation of any policy of insurance under the Delaware Workers Compensation Insurance Plan.

Employer Name and Title_____Date _____

Signature*_____ Telephone No. (_____)_____

***Application must be signed by an officer or owner.** E-mail address (optional): _____

IX Agency and Producer

Telephone No. (_____)_____

Agency Name _____ Fax No.( ) _____

Delaware Agent License No. _____

Address _____ E-mail address_____

Producer _____ _____ _____

Name **Agent's Signature** **Date**

Federal Employer Identification Number _____