Administration

McGriff, Seibels, & Williams, Inc.
P.O. Box 1539
Portland, Oregon 97207-1539
Toll Free Phone: 800-318-8870
Fax: 1-503-943-6622

Board Member Only Workers' Compensation Coverage Application

General Information

District Legal Name: ____

District Physical Address: ____

City, County, State, Zip: ____

PO Box Address: ____

District Work Comp Contact: ____________________ Position/Title: ________________

Phone: _______________ Fax: _______________ E-mail: ______________________

District's Management Company Name and Address (if applicable):

(This information will be used as the main mailing address unless otherwise advised by the district)

Name: ____

Address: ____

City, State, Zip:____

Phone: ______________ Fax: ______________ Email: _______________________

Contact Person: __________________________ Position: ____________________

District's Insurance Agent Name and Address (if applicable)

Name/Agency: ____

Address: ____

City, State, Zip:____

Phone: ______________ Fax: ______________ Email: _______________________

Contact Person: _________________________ Position: ____________________

Other:

Is your district currently a member of the Colorado Special District Association? ☐ Yes ☐ No

Year district was formed: __________

**** For a coverage comparison please enclose a complete copy of all your current insurance policies.***

Workers' Compensation & Employer's Liability Coverage

1. Quote Desired: ☐ Yes ☐ No Quote needed by (Date): ________________
2. Federal Employer Identification Number (F.E.I.N.):____
3. Fill in the following information about your current insurance policy or send us a complete copy of your policy and we will provide a coverage comparison for you.

Current Policy	**Fill-in the blanks**
Insurance Company Name	
Expiration Date	
Term – (check one)	☐ Annual ☐ Multi-Year
Deductible (If applicable)	$
Annual Standard Premium	$
Employer's Liability Limits	$

District Board Member Information

1. Board Member coverage will be automatically included as part of the Pool's policy unless an *Exclusion of Board Member Form is attached.
2. Complete the following information regarding your district Board Members.

Current Information	**Fill-in the blanks**
Number of Board Members	
Coverage Desired	☐ Include ☐ Exclude
Amount of Annual Stipend Budgeted	$
Optional Quote to Include for Coverage	

*Attach a copy of appropriate Form

Application Completed By:

____ ________________

Print Sign Date