



**LARGE ACCOUNT SUPPLEMENT  
PUBLIC SECTOR SERVICES**

Name of Insured	Proposed Effective Date
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This application is required when the account requests:

- any liability deductible in excess of \$25,000;
- any aggregate deductible; or
- any self-insured retention

**LINE OF BUSINESS KEY**

Auto Liability (AL)	Employment Practices (EPL)	Law Enforcement (LEL)
Auto Physical Damage (APD)	Garagekeepers Liability (GKLL)	Liquor Liability (LL)
Crime (CR)	General Liability (GL)	Property (Prop)
Employee Benefits Liability (EBL)	Inland Marine (IM)	Public Officials (PEML)

**AGGREGATE HISTORY**

*This section must be completed for all deductibles and self-insured retentions with aggregate history.*

1. List all aggregate deductibles or self-insured retentions that have applied over the past five years.

	Last year	1st year prior	2nd year prior	3rd year prior	4th year prior
AL					
APD					
CR					
EBL					
EPL					
GKLL					
GL					
IM					
LEL					
LL					
Prop					
PEML					
Other					
Aggregate Amount					

## EXPOSURE HISTORY

2. This section must be completed for all deductibles and self-insured retentions

	Last year	1st year prior	2nd year prior	3rd year prior	4th year prior
<b>Payroll</b>					
<b>Gross Expenditures*</b>					
<b>Law Enforcement Personnel**</b>					
Group 1					
Group 2					
Group 3					
Group 4					
Jail Square Footage					
<b>Employees</b>					
Full-time					
Part-time					
<b>Volunteers</b>					

\*Gross Expenditures equals the sum of the General, Special Revenue, Debt Service, and Interfund Transfer Funds. Do not Include Employee Trust Funds.

\*\*See the Law Enforcement Liability application for description of each law enforcement group.

## LOSS HISTORY

For all deductible and self-insured retention accounts, attach a minimum of five-year, currently valued loss runs as follows:

**3. Deductible lines of business**

- Insurance company loss runs; indicate if losses are gross or net of deductible.

**4. Self-administered lines of business**

- Insured loss runs for all losses;
- Excess insurance carrier loss runs reflecting losses in excess of the self-insured retention; and
- Umbrella carrier loss runs, if different carrier than above.

**5. Third Party Administered lines of business**

- Third Party Administrator loss runs for all losses;
- Excess insurance carrier loss runs reflecting losses in excess of the self-insured retention; and
- Umbrella carrier loss runs, if different carrier than above.

## CLAIM ADMINISTRATION

This section must be completed for all deductibles and self-insured retentions

6. Who currently administers claims within the self-insured retention?

a.

Lines of Business:

AL	APD	CR	EBL	EPL	GKLL
GL	IM	LEL	LL	Prop	PEML

Other:

b. Third Party Administrator(s)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact Last Name: \_\_\_\_\_

Contact First Name: \_\_\_\_\_

Contact Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

Contact Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Lines of Business:**

AL APD CR EBL EPL GKLL

GL IM LEL LL Prop PEML

Other: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact Last Name: \_\_\_\_\_

Contact First Name: \_\_\_\_\_

Contact Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

Contact Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Lines of Business:**

AL APD CR EBL EPL GKLL

GL IM LEL LL Prop PEML

Other: \_\_\_\_\_

c. Self-administered

Department Name: \_\_\_\_\_

Contact Last Name: \_\_\_\_\_

Contact First Name: \_\_\_\_\_

Contact Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

**Lines of Business:**

AL APD CR EBL EPL GKLL

GL IM LEL LL Prop PEML

Other: \_\_\_\_\_

d. How long has the account been with the current TPA? ..... Years \_\_\_\_\_

e. Indicate other TPAs used during the past five years, if any:

7. Who will be administering claims for the policy term submitted?

- a. Same as above.
- b.

**Lines of Business:**

AL	APD	CR	EBL	EPL	GKLL
GL	IM	LEL	LL	Prop	PEML
Other					

- c. Third Part Administrator(s)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact Last Name: \_\_\_\_\_

Contact First Name: \_\_\_\_\_

Contact Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

Contact Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Lines of Business:**

AL	APD	CR	EBL	EPL	GKLL
GL	IM	LEL	LL	Prop	PEML
Other:					

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact Last Name: \_\_\_\_\_

Contact First Name: \_\_\_\_\_

Contact Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

Contact Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Lines of Business:**

AL	APD	CR	EBL	EPL	GKLL
GL	IM	LEL	LL	Prop	PEML
Other					

d. Self-administered

Department Name: \_\_\_\_\_

Contact Last Name: \_\_\_\_\_

Contact First Name: \_\_\_\_\_

Contact Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

**Lines of Business:**

- AL            APD            CR            EBL            EPL            GKLL
- GL            IM            LEL            LL            Prop            PEML
- Other

**NOTE:** Self-administered and Third Party Administrators must be approved by Travelers prior to quoting. A claims administration application will be sent to the agent after review of this application.

**CLAIM SERVICE FEES**

This section must be completed for all self-insured retentions that are administered by a Third Party Administrator

8. List the total service fees charged by Third Party Administrators for the past three years.

	Last year	1st year prior	2nd year prior
Total Service Fee			

**SELF-INSURANCE CERTIFICATES**

This section must be complete for auto self-insured retentions

9. Has the insured qualified as a self-insurer in accordance with their state motor vehicle law? ..... Yes No

*If yes, attach a copy of the current certificate.*

*If no, has application been made to the state? ..... Yes No*

**ADDITIONAL INFORMATION**

Enter additional information as necessary:

**FLORIDA:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**KENTUCKY:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

For all other applicable state fraud warnings, please see the main application.

Signature	Date
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## Important Notice Regarding Compensation Disclosure

For information about how Travelers compensates independent agents, brokers, or other insurance producers, please visit this website:

[http://www.travelers.com/w3c/legal/Producer\\_Compensation\\_Disclosure.html](http://www.travelers.com/w3c/legal/Producer_Compensation_Disclosure.html)

If you prefer, you can call the following toll-free number: 1-866-904-8348. Or you can write to us at Travelers, Enterprise Development, One Tower Square, Hartford, CT 06183.