UTAH SAFETY AND LOSS CONTROL CREDIT PROGRAM APPLICATION

Employer Name: _____

Employer Address: _____

Policy Period: _____

Contact Name: _____

Telephone Number: _____ Fax Number: _____

This application is to verify and validate your intent to implement and/or continue to monitor the Safety and Loss Control Credit Program throughout the American Liberty Insurance Company's policy period. By signing this agreement, you agree to continue the following activities or if discontinuing, you agree to notify us of your intent to discontinue such practices. You also acknowledge that a premium credit will be applicable only while you maintain a combined loss ratio experience of less than 60% in the last 3 years.

☐Yes ☐No Establish a workplace safety committee or designate a workplace safety coordinator who shall establish and administer workplace safety activities.

☐Yes ☐No Establish procedures for workplace safety inspections.

☐Yes ☐No Establish procedures for inspecting all workplace accidents, safety-related incidents, illnesses, and/or deaths.

☐Yes ☐No Written accident-prevention and illness-prevention programs.

☐Yes ☐No Establish guidelines for training of safety committee members or safety coordinator.

You also agree that American Liberty Insurance has the right to inspect your records and/or workplaces to confirm continued compliance with your applicable practices noted above. If it is found that these practices are not in place, the premium credit granted in accordance with your statements above will be deleted and additional premium assessed may be due as a result of your failure to continue such practices.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION OF INSURANCE OR STATEMENT OF CLAIM 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 AND SUBJECTS THE PERSON TO CRIMINAL AND CIVIL PENALTIES.

Authorized Employer Representative Signature: _____

Printed Name: _____ Date: _____
(Officer/Owner)

Title: _____

Employer Name: _____

Witness By: _____ Print Name: _____
(Signature)

Policy Number: _____ (if known)