

## Owner Controlled Insurance Program (OCIP) Insurance Information & Cost Identification Worksheet

### I. GENERAL INFORMATION

Contractor's Name: \_\_\_\_\_  
 Form of Business: Individual  Corporation  Joint Venture   
 Address: \_\_\_\_\_  
 Federal Employer I.D.#: \_\_\_\_\_

### II. CONTACT INFORMATION

Office Contact  
 Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Site Contact  
 Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Safety Contact  
 Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Insurance Contact  
 Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Payroll Contact  
 Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Address (if different): \_\_\_\_\_

### III. CONTRACT INFORMATION

Contract #: \_\_\_\_\_ Contract Value:\$ \_\_\_\_\_ Estimated Man-Hours: \_\_\_\_\_  
 Job Name/Description: \_\_\_\_\_ DBE/MBE/WBE: \_\_\_\_\_  
 Awarding Contractor: \_\_\_\_\_ Prime Contractor: \_\_\_\_\_  
 Est. Start Date: \_\_\_\_\_ Est. Completion Date: \_\_\_\_\_ % Self Performed: \_\_\_\_\_

### IV. CURRENT INSURANCE INFORMATION

**Insurance Broker or Agent:**

Company Name: \_\_\_\_\_ Contact: \_\_\_\_\_  
 City: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Provide your current insurance information as the required coverages and limits are shown in the bid documents. Information disclosed on this form is subject to audit and adjustment throughout the term of the construction of project name.

It is extremely important to accurately estimate payrolls anticipated for this contract. Payroll should be *straight hourly rate* without burden, fringe or overtime rate, but should include sick, vacation, holiday pay and imputed income.

**A. WORKERS' COMPENSATION (PROJECT-SITE PAYROLL ONLY)**

Insurance Company: \_\_\_\_\_  
 Policy Period: \_\_\_\_\_ Deductible:\$ \_\_\_\_\_ Retention:\$ \_\_\_\_\_  
 W.C. Experience Modifier: \_\_\_\_\_ Anniversary Rating Date: \_\_\_\_\_  
 Interstate Risk I.D. (if applicable): \_\_\_\_\_

W.C. Classification	W.C. Code	Estimated Payroll	W.C. Rate/ \$100 Payroll	Premium
				\$
				\$
				\$
				\$
				\$
<b>Total Standard Premium</b>				\$
<b>Exp. Modifier</b>				\$
<b>Discount/Surcharges</b>				\$
<b>Total Net Premium</b>				\$

\* Submit a copy of Declaration Page and Premium Rate Page along with this form.

**B. GENERAL LIABILITY (PROJECT-SITE PAYROLL ONLY)**

Insurance Company: \_\_\_\_\_  
 Policy Period: \_\_\_\_\_ Policy Limit:\$ \_\_\_\_\_ Deductible:\$ \_\_\_\_\_  
 Current G.L. Rate is based on: ? payroll or ? receipts per \$1,000 or ? Flat Premium

G.L. Classification	G.L. Code	Estimated Payroll/Receipts	G.L. Rate/ \$1000 Payroll	Premium
				\$
				\$
				\$
				\$
				\$
<b>Total Premium</b>				\$

\* Submit a copy of Declaration Page and Premium Rate Page along with this form.

**C. EXCESS LIABILITY**

Insurance Company: \_\_\_\_\_  
 Policy Period: \_\_\_\_\_ Policy Limit:\$ \_\_\_\_\_ Deductible:\$ \_\_\_\_\_  
 Total Excess Premium:\$ \_\_\_\_\_  
 Current Excess Rate is based on: ? payroll or ? receipts per \$1,000 or ? Flat Premium

**D. SUBCONTRACTOR PREMIUMS:\$ \_\_\_\_\_**

**E. TOTAL INSURANCE PREMIUMS\* (A+B+C+D):\$ \_\_\_\_\_**  
**This amount must equal the Insurance Premium amount indicated on your bid proposal.**

**SPECIAL NOTICE:**

**On-Site Payroll:** This payroll will not be reported to your individual insurance carrier. **You should *not* be charged an insurance premium for this payroll by your individual insurance carrier.** The OCIP Administrator will provide you with a Certificate of Insurance under the OCIP as proof of coverage for this payroll upon enrollment. It is your responsibility to notify your current insurance carrier to exclude all work to be done under this contract from your current insurance program, with the exception of Auto insurance.

**Certificate of Insurance:** All Contractors and Subcontractors must provide copies of certificates of insurance evidencing the required coverage for operations outside the OCIP as required in the specifications and/or agreement (Workers Compensation, General Liability and Automobile Liability). The Certificate must show 1) the Waiver of Subrogation wording, 2) the Additional Insured wording, and 3) the 30-day notice of cancellation as required in the bid documents.

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**CERTIFICATION & ASSIGNMENT**

I certify that the information provided in this form is true to the best of my knowledge. The Kentucky Transportation Cabinet as Owner of the Owner Controlled Insurance Program (OCIP), or Owner’s Agent, is granted permission by Contractor to inspect the insurance and payroll records of Contractor used in determining the above credit. At completion of the Work, Owner or Owner’s Agent shall have the option to audit the project payroll records of Contractor, and to adjust Contract amount for final audited insurance premiums in accordance with the insurance premium audit provisions of the insurance policy. Any and all returns of premiums, dividends, discounts or other adjustments to any OCIP policy are assigned, transferred and set over absolutely to the Owner. This assignment is valid for insurance policies whose premiums have been paid by the Owner on behalf of such Contractor.

Signed \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

***THIS FORM A MUST BE COMPLETED BY EACH CONTRACTOR AS SOON AS CONTRACT IS AWARDED. NO CERTIFICATES OF INSURANCE OR POLICIES WILL BE PROVIDED UNDER THE OWNER CONTROLLED INSURANCE PROGRAM UNTIL THESE FORMS ARE RECEIVED.***

Any questions regarding this form should be directed to:

**Global Risk Managers OCIP Administrator, 404-238-0577**

*General Contractor should send forms to:*

*Global Risk Managers, Inc.  
Attn: OCIP Administrator  
3475 Lenox Rd. NE, Suite 400  
Atlanta, GA 30326 or fax to: 404-238-0571*