AccidentFund
Insurance Company of America
Part of the AF Group

Workers' Compensation Insurance Proposal

03/03/2022

Quote # 0015643617

LINCOLNWOOD SCHOOL DISTRICT 74
6950 N EAST PRAIRIE RD
LINCOLNWOOD, IL 60712-2520

ASSUREDPARTNERS OF ILLINOIS, LLC - BU44339
4350 WEAVER PKWY
WARRENVILLE, IL 60555

Summary

Option: **Guaranteed Cost**

Insurance Company	**Accident Fund Insurance Company of America**	Total Estimated Premium	$60,376.00
Effective Date	07/01/2022		
Expiration Date	07/01/2023	Group Program	IL Education Program
Quote Valid Through	07/01/2022		

Payment Terms

10 equal monthly - Direct Bill

Total Plan Cost **$60,376.00**

Details for **Guaranteed Cost**

Quoted Rates by Class Code

Illinois - 07/01/2022 through 07/01/2023					
Loc.	**Classification**	**Code**	**Premium Basis Total Estimated Annual Renumeration**	**Rate Per $100 of Renumeration**	**Estimated Annual Premium**
1	SCHOOL ALL OTHER EMPLOYEES	9101	602936	3.5500	$21,404.00
1	SCHOOL PROFESSIONAL EMPLOYEES & CLERICAL	8868	13890725	0.4400	$61,119.00
	Total Manual Premium				**$82,523.00**
	Employers Liability (E/L) increased limits factor	9812	82523	1.0140	$1,155.00
	Total Subject Premium				**$83,678.00**
	Experience Modifier	9898	83678	1.0000	$0.00
	Total Modified Premium				**$83,678.00**
	Schedule Rating Credit	9887	83678	0.7000	($25,103.00)
	Group Program Credit	9034	58575	0.9500	($2,929.00)
	Total Standard Premium				**$55,646.00**
	Premium Discount	0063	55646	0.9254	($4,151.00)
	Expense Constant	0900	1	160.0000	$160.00
	Terrorism Premium	9740	14493661	0.0360	$5,218.00
	Catastrophe Premium	9741	14493661	0.0200	$2,899.00
	Estimated Annual Premium				**$59,772.00**
	Other Premium and Surcharges				
	WC Commission Surcharge	IL CS	59772	0.0101	$604.00
	Total Amount Due				**$60,376.00**

Total Estimated Annual Premium $60,376.00

Coverages and Endorsements

We have reviewed the application and are providing those coverages provided by the standard Workers' Compensation Policy and any state-mandated endorsements. Any coverages or endorsements not specifically mentioned in this quote are not included with this proposal.

Item 3A (WC): IL

Item 3B Employers' Liability

Each Accident: $1,000,000
Disease - Policy Limit: $1,000,000
Disease - Each Employee: $1,000,000

Item 3C (Other States): All states and U.S. territories except: monopolistic states, Puerto Rico, the U.S. Virgin Islands, and states designated in Item 3A of the Information Page

Premium Payments and Schedule

This schedule is an estimate only. Please refer to the direct bill invoice which will include due dates and other policies billings, if applicable. It is hereby agreed and understood that the premium is to be paid on an installment basis as follows:

	Due Date	Amount Due
1	07/01/2022	$6,581
2	08/01/2022	$5,977
3	09/01/2022	$5,977
4	10/01/2022	$5,977
5	11/01/2022	$5,977
6	12/01/2022	$5,977
7	01/01/2023	$5,977
8	02/01/2023	$5,977
9	03/01/2023	$5,977
10	04/01/2023	$5,977
	Total Amount Due	**$60,376.00**

Billing Method(s)
Direct Bill

Installment Plan(s):
10 equal monthly - Direct Bill

See the attached Notice of Installment Payment worksheets for additional information.

Terms and Conditions

1. This quote is based on payrolls, rates and experience modifications currently in effect as outlined below. Any changes to these values or other rating factors, as mandated by regulatory entities, may result in adjustments to our proposal. Additionally Accident Fund reserves the right to adjust the quote if the payrolls or premiums change more than 10%prior to policy issuance.
   a. If during the course of the policy, the scope of the Insured's operations materially changes, we reserve the right to adjust the pricing and/or program(s) offered based on the exposures, losses and risk characteristics.

Disclaimers

This quotation is valid until policy effective date but is subject to change prior to acceptance if there is a change in exposure, or a change in rates or other items required to be charged by applicable jurisdictions.

Fee Disclosures: Unless prohibited by state law, the following fees may be charged to underwritten policies:

Paper Invoice Fee:	Insufficient Funds Fee:	Reinstatement Fee:
$5	$20	Up to $20*

*Depending on payment plan

Applicant's Signature X _____ Date ____ / ____ / ____

Signature of Agent/Producer X _____ Date ____ / ____ / ____