



6. The name, address and Social Security number of each officer, manager, affiliate, or other entity in control of the Employee Provider and all other employee provider firms for which such officer, manager, affiliate, or entity has worked or in which such officer, manager, affiliate, or entity has or has had an ownership interest:

7. (a) The name and address of each client company:

(b) The name and address of each entity to which workers were provided for a continuous period of more than six months during the past year or to which workers may be provided for a continuous period of more than six months in the coming year:

8. If coverage is with the ~~Fund insurer of last resort~~: the Employee Provider, its officers, directors, affiliates, and any entity with an ownership interest in the Employee Provider are in good faith eligible to receive workers' compensation insurance; or, if coverage is with the voluntary market: the Employee Provider, its officers, directors, affiliates, and any entity with an ownership interest in the Employee Provider do not owe any workers' compensation premium to any current or prior insurers.

9. The Employee Provider will abide by any rules and regulations of the Texas Workers' Compensation Commission and the Department that are now or may become in the future applicable to it.

10. The Employee Provider acknowledges that periodic audits may be conducted at any time after the effective date of the policy for any purpose. The Employee Provider understands that these rights of audit apply also to any of its client companies and has so informed its client companies. The Employee Provider agrees that the insurer may make any adjustments in premium calculations as a result of such audits.

11. The Employee Provider understands that any false or misleading statement, misrepresentation, concealment or omission of a material fact in connection with this Form EP-1 or any Employee Provider/Client Company Endorsement provided by any of its client companies may result in cancellation upon thirty (30) days' notice of its Workers' Compensation insurance policy.

**NOTICE:** Before executing this form, you may wish to review Section 32.54 of the Texas Penal Code entitled, "Penalty for Fraudulently Obtaining Workers' Compensation Insurance Coverage."

\_\_\_\_\_  
Name of Employee Provider Firm

\_\_\_\_\_  
Signature of Authorized Representative of Employee Provider Firm

| Sworn and Subscribed to before me this \_\_\_\_\_ day of \_\_\_\_\_, ~~1992~~\_\_\_\_\_.

\_\_\_\_\_  
Notary Public

My Commission Expires: \_\_\_\_\_