



6210 East Highway 290  
Austin, TX 78723-1098  
(800) 859-5995  
FAX (800) 359-0650

**SUPPLEMENTAL APPLICATION**

**Texas Mutual Insurance Company — Other States Endorsement  
(Reimbursement Coverage Only)**

The insurance provided by this endorsement is limited. This coverage applies only to employees as defined in the Texas Labor Code, Section 401.012, whose principal location of employment is in Texas, as defined in Sections 406.071 and 406.072, Texas Labor Code.

Be sure to read the endorsement carefully. This application and the resulting Other States Endorsement (TM-DIV-2001) are used only by Texas Mutual Insurance Company. Coverage will not be extended to states with monopolistic state workers' compensation insurance funds (North Dakota, Ohio, Washington, West Virginia, and Wyoming).

**PLEASE PROVIDE THE FOLLOWING INFORMATION:**

- 1. List the states, other than Texas, in which you presently have operations, and describe those operations.  
STATE OPERATIONS

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- 2. Do you have one or more workers' compensation or occupational disease policies in effect for operations in states other than Texas?  
Yes \_\_\_\_\_ No \_\_\_\_\_

- 3. If yes, please list the insurance companies providing this coverage, the policy numbers, and the policy periods.  
INSURER POLICY NUMBER POLICY PERIOD

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- 4. List the states in which you anticipate having operations during this policy period and state the nature of those operations.  
STATE OPERATIONS

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*By \_\_\_\_\_  
APPLICANT TRADE NAME QUOTE/POLICY #  
  
\_\_\_\_\_  
TITLE DATE

\* Must be signed by individual proprietor, partner, or corporate officer.

Name of Producer of Record \_\_\_\_\_

Signature of Producer of Record \_\_\_\_\_

**Return this application to: Texas Mutual Insurance Company  
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Austin, Texas 78723-1098  
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