

WISCONSIN WORKER'S COMPENSATION INSURANCE POOL

| APPLICATION MUST BE PRINTED IN INK OR TYPED AND SIGNED BY APPLICANT AND PRODUCER. | | | | | | FOR BUREAU USE ONLY | | | | | | |
|--|---------------------------|-------|-------------|------------------------------------|---------|---|-----------|-----------------|----------------------------------|-----|----|--|
| MAIL TO: | го: | | FILE #: | | | | | | | | | |
| WISCONSIN WORKER'S COMPENSATION INSURANCE PO | MPENSATION INSURANCE POOL | | | | | | | | | | | |
| P.O. BOX 3130 | 20700 SWENSON DRIVE | | | | | CARRIER: | | | | | | |
| MILWAUKEE, WI 53201-3130 | SUITE 100 | | | | | | | | | | | |
| (262) 796-4592 WAUKESHA, WI 53186 | | | | | | | EFF DATE: | | | | | |
| ALL QUESTIONS MUST BE COMPLETED, OR IND | "NC | OT A | PPLICABLE". | | | | | | | | | |
| THE UNDERSIGNED EMPLOYER IS UNABLE TO PURCHASE WORKER'S COMPENSATION AND EMPLOYER'S LIABILITY INSURANCE FOR LIABILITY UNDER THE WISCONSIN WORKER'S COMPENSATION LAW AND HEREBY APPLIES FOR THE DESIGNATION OF AN INSURANCE COMPANY TO PROVIDE INSURANCE IN ACCORDANCE WITH THE WISCONSIN WORKER'S COMPENSATION INSURANCE POOL. | | | | | | | | | | | | |
| 1. APPLICANT NAME (ENTER COMPLETE LEGAL NAME OF EMPLOYER) 2. MAILING | | | | ILING ADDRESS (INCLUDING ZIP CODE) | | | | | | | | |
| | | | | | | | | | | | | |
| TELEPHONE # (INCLUDING AREA CODE) | 3. LEGAL STATUS | | | | | | | | 4. REQUESTED E DATE (MM/D | | | |
| | INDIVI | DUAL | | LIMITED LIABIL | ITY CO | | | | · | | | |
| FAX # (INCLUDING AREA CODE) | PARTN | NERSH | HP | OTHER: | | | | | DATE BUSINESS (MM/DD/Y | | AN | |
| | CORP | ORATI | ION | | | | | | | | | |
| NOTE: THE EFFECTIVE DATE OF INSURANCE IS GOVERNED BY THE RULES OF THE WISCONSIN WORKER'S COMPENSATION POOL. APPLICATIONS SHOULD BE SUBMITTED AT LEAST 15 DAYS PRIOR TO THE REQUESTED EFFECTIVE DATE. | | | | | | | | | | | | |
| 5. LOCATIONS OF ALL WISCONSIN WORK PLACES (Show principal location first) | | | | | | | | | | | | |
| # STREET, CITY, COUNTY, STATE, ZIP CODE | | | | | | | | | | | | |
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| PAYROLL OFFICE ADDRESS (STREET, CITY, STATE & ZIP) CONTACT PERSON AND TELEPHONE # (INCLUDING AREA CODE) | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| 6. NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS | | | | | | | | | | | | |
| C. NATORE OF BOOMEOO/BEOOM! HOW OF OF ERATIO | 110 | | | | | | | | | | | |
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| 7. SUPPLEMENTAL INFORMATION | | | | | | | | | | | | |
| EXPLAIN ALL "YES" RESPONSES IN REMARKS 1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT/WATERCRAFT/ | 2 | YES | NO | EXPLAIN ALL "YES" RI | | | NITI V MC | DK AT HOME | 2 | YES | NO | |
| BOES AFFLICANT OWN, OFERATE OR LEASE AIRCRAFT/WATERCRAFT? ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER? | | | | 12. DO ANY EMPLOY | | | | | | - | | |
| | | | | OWNERSHIP CH | ANGE DI | JRING THE | PAST TH | REE YEARS? | IF YES, GIVE | | | |
| ANY WORK SUBLET WITHOUT CERTIFICATES OF INSURANCE? 4. IS A FORMAL SAFETY PROGRAM IN OPERATION? | | | \dashv | PREVIOUS NAME | = AND D | ATE OF CH | IANGE. C | JNTACT POOL | L ABOUT AN ERM-14. | | | |
| DO YOU EMPLOY DRIVERS? | | | | | | | | | | | | |
| 6. DO EMPLOYEES TRAVEL OUT OF STATE? | | | \dashv | 14. ARE THERE OPE | RATION | IS IN STAT | ES OTHE | R THAN WISC | CONSIN? IF YES, | - | | |
| 7. ARE ATHLETIC TEAMS SPONSORED? | | | | COMPLETE THE | | | | | ROVIDE COVERAGE NDICATE UNDER | | | |
| ARE EMPLOYEE HEALTH PLANS PROVIDED? | | | | INSURANCE CAP | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | INED OIL | , intoorted, ii | NDIO/NE ONDEN | | | |
| 9. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS/SUBSIDIARY? | | | | STATE: | | | | | | | | |
| 10. ARE YOU IN CHAPTER 11 BANKRUPTCY? | | | \dashv | LOCATION: | | | | | | | | |
| 11. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS? | | | | INS CARRIER: | | | | | | | | |
| 8. INSURANCE RECORD | | | | | | | | | | | | |
| 1. HAS THERE BEEN PREVIOUS WORKER'S COMPENSATION INSURANCE COVERAGE IN WISCONSIN? YES NO | | | | | | | | | | | | |
| IF NO, COMPLETE: NEW BUSINESS SELF | -INSURED | Γ | | OTHER (EXPLAIN): | | _ | | | | | | |
| 2. INSURANCE RECORDS THREE PREVIOUS YEARS: | | | | | | | | | | | | |
| INSURANCE COMPANY F | | | POL | ICY PERIOD TO | | | | POLICY | NUMBER | | | |
| | | | | | | | | | | | | |
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CORPORATE OFFICERS, SOLE PROPRIETORS, PARTNERS, OR MEMBERS OF A LIMITED LIABILITY COMPANY LIST BELOW THE NAME. TITLE, DUTIES AND APPROXIMATE ANNUAL SALARY OF ALL CORPORATE OFFICERS AND INDICATE WHICH TWO OFFICERS, IF ANY, REJECT COVERAGE, OR, LIST BELOW THE NAME, TITLE, PERCENT OF OWNERSHIP, APPLICABLE CODE, REMUNERATION AND DUTIES, OF ALL SOLE PROPRIETORS, PARTNERS, AND MEMBERS OF A LIMITED LIABILITY COMPANY, AND INDICATE WHICH ELECT COVERAGE. IMPORTANT: PLEASE ATTACH SIGNED "NON-ELECTION" OR "ELECTION" FORMS TO THIS APPLICATION. SOLE PROPRIETORS, PARTNERS AND OFFICERS TO BE INCLUDED OR EXCLUDED. (Remuneration to be included must be part of rating information section.) TITLE/ RELATIONSHIP OWNER-SHIP % INC/EXC | CLASS CODE DUTIES REMUNERATION 10. RATING INFORMATION SECTION ESTIMATE TOTAL **ESTIMATE CLASSIFICATION PHRASEOLOGY** RATE EMPLOYEES ANNUAL PAYROLL ANNUAL PREMIUM DEPOSIT PREMIUM IS DETERMINED BY TAKING A PERCENTAGE OF THE ESTIMATED ANNUAL PREMIUM. THE PREMIUM SUB TOTAL PERCENTAGE VARIES WITH THE AMOUNT OF THE ESTIMATED ANNUAL PREMIUM. HERE IS HOW IT WORKS: **INCREASED LIMITS** ADDITIONAL PAY-MENTS DURING THE YEAR **EXPERIENCE MOD** ESTIMATED ANNUAL PREMIUM MINIMUM DEPOSIT PERCENTAGE **PAYMENT BASIS** WCPAP CREDIT UNDER \$2,000 ANNUAL 100% OF ANNUAL NONE TOTAL MODIFIED PREMIUM BALANCE DUE IN 90 DAYS OF INCEPTION DATE AT LEAST \$2,001 - \$5,000 50% OF ANNUAL ONE **TERRORISM** AT LEAST \$5,001 - \$10,000 QUARTERLY TWO 50% OF ANNUAL CATASTROPHE MONTHLY AT LEAST \$10,001 25% OF ANNUAL NINE **EXPENSE CONSTANT** ANNIVERSARY MINIMUM PREMIUM INTERSTATE RISK ID # **ESTIMATED ANNUAL PREMIUM** RATING DATE **DEPOSIT PREMIUM** WHEN SUBMITTING ANY APPLICATION, ATTACH PAYROLL VERIFICATION SUCH AS FEDERAL EMPLOYER FORMS 940, 941, 941-E, OR 943. IF NEW EMPLOYER, ATTACH A NOTARIZED LETTER STATING NO PAYROLL IN THE PAST. 11. PREMIUM PAYMENT REQUIREMENTS 1. COVERAGE WILL NOT BE BOUND UNTIL PAYMENT OF APPROPRIATE DEPOSIT PREMIUM IS RECEIVED. PAYMENT TO THE WISCONSIN COMPENSATION RATING BUREAU MUST BE IN THE FORM OF CERTIFIED CHECK, CASHIERS CHECK, MONEY ORDER, CHECK OF THE PRODUCER OF RECORD, OR A CHECK FROM THE PREMIUM FINANCE COMPANY. NO APPLICANT CHECK. 2. IS THIS PREMIUM FINANCED? IF YES, INCLUDE ENTIRE FINANCED AMOUNT WITH APPLICATION AND ATTACH A SIGNED COPY OF FINANCE AGREEMENT. 12. SPECIAL NEEDS * SPECIAL NEEDS: ARE ANY OF THE FOLLOWING REQUIRED? YES NO YES NO 1. OTHER STATES COVERAGE (ATTACH COMPLETED QUESTIONNAIRE) 3. CERTIFICATE OF INSURANCE (PLEASE ATTACH LIST) 2. INCREASED LIMITS OF LIABILITY. IF SO, PLEASE INDICATE LIMITS 4. U.S.L. & H 13. APPLICANT'S STATEMENT THE UNDERSIGNED EMPLOYER HEREBY CERTIFIES THAT THE STATEMENTS IN THIS APPLICATION HAVE BEEN READ AND UNDERSTOOD. FURTHERMORE, IN CONSIDERATION OF THE ISSUANCE OF THE POLICY OF INSURANCE, THE UNDERSIGNED ALSO CERTIFIES THAT THE STATEMENTS IN THIS APPLICATION ARE TRUE AND AGREES: TO MAINTAIN A COMPLETE RECORD OF ALL PAYROLL TRANSACTIONS IN SUCH FORM AS THE INSURANCE COMPANY MAY REASONABLY REQUIRE AND THAT SUCH RECORD WILL BE AVAILABLE TO THE COMPANY AT THE DESIGNATED ADDRESS. TO COMPLY SUBSTANTIALLY WITH ALL LAWS, ORDERS, RULES, AND REGULATIONS IN FORCE AND EFFECT MADE BY THE PUBLIC AUTHORITIES AND WITH ALL REASONABLE RECOMMENDATIONS MADE BY THE INSURANCE COMPANY RELATING TO THE WELFARE, HEALTH, AND SAFETY OF EMPLOYEES. TO THE BEST OF MY KNOWLEDGE AND BELIEF ALL STATEMENTS CONTAINED IN THIS APPLICATION ARE TRUE. LHERERY AGREE TO PAY ALL PREMIUMS WHEN DUE I DESIGNATE AS PRODUCER OF RECORD THE PRODUCER NAMED IN THIS APPLICATION AND I UNDERSTAND THIS PERSON IS NOT ACTING AS AN AGENT OF THE SERVICING CARRIER FOR THE PURPOSES OF THIS INSURANCE. (VIOLATION OF ANY OF THESE AGREEMENTS MAY RESULT IN TERMINATION OF ANY POLICY OR INSURANCE ISSUED) BUSINESS NAME OF APPLICANT SIGNATURE TITI F DATE OF APPLICATION 14. STATEMENT OF LICENSED AGENT OR PRODUCER OF RECORD _ , DO HEREBY CERTIFY AS FOLLOWS: I AM A LICENSED INTERMEDIARY AGENT OF THE STATE OF WISCONSIN, OR HAVE A NON-RESIDENT LICENSE FOR THE STATE OF WISCONSIN. (1) (ATTACH COPY OF NON RESIDENT LICENSE). I HAVE READ THE WISCONSIN WORKER'S COMPENSATION INSURANCE POOL RULES, HAVE EXPLAINED THE PROVISIONS TO THE APPLICANT, AND HAVE INCLUDED IN THIS APPLICATION ALL REQUIRED INFORMATION GIVEN TO ME BY THE APPLICANT. IN THE EVENT THE POLICY IS TERMINATED OR A CHANGE IS MADE RESULTING IN A RETURN PREMIUM TO THE INSURED. I AGREE TO RETURN THE UNEARNED COMMISSION WITHIN TEN DAYS. THE PRODUCER DOES NOT REPRESENT THE SERVICING CARRIER NOR THE POOL. IN ANY WAY, AND HAS NO AUTHORITY TO BIND, CHANGE, ALTER OR TERMINATE COVERAGE TELEPHONE # (INCLUDING AREA CODE) FAX # (INCLUDING AREA CODE) AGENT/AGENCY NAME & MAILING ADDRESS FEIN/SOC SECURITY # WRC Agency Inc

800-329-7020

SIGNATURE OF PRODUCER

608-442-5029

PRODUCER

WISCONSIN LICENSE #

Madison WI 53707

PO Box 7988