



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:

WISCONSIN WORKER'S COMPENSATION INSURANCE POOL
P.O. BOX 3130
MILWAUKEE, WI 53201-3130
(262) 796-4592

DELIVER TO:

20700 SWENSON DRIVE
SUITE 100
WAUKESHA, WI 53186

FILE #:

CARRIER:

EFF DATE:

ALL QUESTIONS MUST BE COMPLETED, OR INDICATED IF "NOT APPLICABLE".

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 ADDRESS (INCLUDING ZIP CODE)		FEIN
TELEPHONE # (INCLUDING AREA CODE)	3. LEGAL STATUS			4. REQUESTED EFFECTIVE DATE (MM/DD/YY)
FAX # (INCLUDING AREA CODE)	<input type="checkbox"/> INDIVIDUAL	<input type="checkbox"/> LIMITED LIABILITY CO	DATE BUSINESS BEGAN (MM/DD/YY)	
	<input type="checkbox"/> PARTNERSHIP	<input type="checkbox"/> OTHER:		
	<input type="checkbox"/> CORPORATION			

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	
PAYROLL OFFICE ADDRESS (STREET, CITY, STATE & ZIP)		CONTACT PERSON AND TELEPHONE # (INCLUDING AREA CODE)

6. NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS

7. SUPPLEMENTAL INFORMATION

EXPLAIN ALL "YES" RESPONSES IN REMARKS	YES	NO	EXPLAIN ALL "YES" RESPONSES	YES	NO
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT/WATERCRAFT?			12. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME?		
2. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?			13. HAS THERE BEEN A NAME CHANGE, CONSOLIDATION, MERGER OR OWNERSHIP CHANGE DURING THE PAST THREE YEARS? IF YES, GIVE PREVIOUS NAME AND DATE OF CHANGE. CONTACT POOL ABOUT AN ERM-14.		
3. ANY WORK SUBLET WITHOUT CERTIFICATES OF INSURANCE?					
4. IS A FORMAL SAFETY PROGRAM IN OPERATION?			14. ARE THERE OPERATIONS IN STATES OTHER THAN WISCONSIN? IF YES, COMPLETE THE FOLLOWING AS THE POLICY CANNOT PROVIDE COVERAGE IN THOSE STATES. (IF SELF-INSURED OR UNINSURED, INDICATE UNDER INSURANCE CARRIER.) STATE: LOCATION: INS CARRIER:		
5. DO YOU EMPLOY DRIVERS?					
6. DO EMPLOYEES TRAVEL OUT OF STATE?					
7. ARE ATHLETIC TEAMS SPONSORED?					
8. ARE EMPLOYEE HEALTH PLANS PROVIDED?					
9. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS/SUBSIDIARY?					
10. ARE YOU IN CHAPTER 11 BANKRUPTCY?					
11. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?					

8. INSURANCE RECORD

1. HAS THERE BEEN PREVIOUS WORKER'S COMPENSATION INSURANCE COVERAGE IN WISCONSIN? YES NO
IF NO, COMPLETE: NEW BUSINESS SELF-INSURED OTHER (EXPLAIN):

2. INSURANCE RECORDS -- THREE PREVIOUS YEARS:

INSURANCE COMPANY	FROM	POLICY PERIOD TO	POLICY NUMBER

