417 Seymour Suite 5
Lansing, Michigan 48933
p 517.484.5588
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incompass MICHIGAN
INDEPENDENCE | COMMUNITY | INCLUSION
formerly MARO

Application

Information on this application is confidential and will only be viewed by the fund administrator.

Applicant name (legal entity):_____

Mailing Address:_____

City:_____ State:__ Zip:_____ Phone:_____ Fax:_____

Federal Employer I.D. Number_____ MESC number_____

Address of all worksites (attach additional sheet if necessary): _____
_____
_____
_____
_____
_____

Do you have a written safety program? ☐ yes ☐ no

Do you screen employees for drug use? ☐ yes ☐ no

Are formal accident reporting procedures in place? ☐ yes ☐ no

Do you have a return-to-work program in place? ☐ yes ☐ no

Do you have a designated care provider for employee injuries? ☐ yes ☐ no

Have you received a formal loss control visit in the last 12 months? ☐ yes ☐ no

The Incompass Michigan Workers' Compensation Fund has permission to order loss history experience for my organization:_____(please sign)

Current workers' compensation carrier:_____ Expires:_____

Current liability insurance carrier:_____ Expires:_____

Payroll estimate by class. (Attach current policy declaration sheet or fill out below.)

Class code	Classification	Employees	Estimated Annual Payroll
3643	Machine Repair	_____	_____
5190	Electrical incl Assts.	_____	_____
5645	Carpentry / Construction	_____	_____
7380	Drivers	_____	_____
8008	Stores	_____	_____
8395	Auto Repair	_____	_____
8742	Salespersons	_____	_____
8810	Clerical	_____	_____
8831	Veterinary	_____	_____
8832	Physicians	_____	_____
8833	Hospital: Professional	_____	_____
8835	Public Heatlh Nursing	_____	_____
8837	Workshop	_____	_____
8868	Schools: Professional	_____	_____
9015	Building NOC	_____	_____
9052	Hotel: All Others	_____	_____
9058	Food Service Employees	_____	_____
9063	WCA, YMHA 1.48	_____	_____
Other	_____	_____	_____
Other	_____	_____	_____

Total number of employees: Full time_____ Part time_____

Current experience modifi cation:_____(If available on your current policy declaration page.)

CEO of the organization:_____Principle contact (if diff erent than CEO):_____

Financial Statement: Required by Michigan Department of Consumer and Industry Services. Please provide a copy of your most current balance sheet.

The applicant herby certifies, warrants and represents that the financial statement included herewith and signed bythe applicant and the payroll information provided herein are accurate and true as of the date of this application and that applicant will provide the Incompass Michigan Workers' Compensation Fund (the "Fund") with such other information required to qualifyapplicant with the applicable state authorities or other such person designated by the Fund. Applicant warrants and represents that it will report all payroll of any kind whether paid in cash, by check, or any other method to the Fund periodically when requested and agrees to make available all pertinent records at such reasonable times as requested. We hereby formally ap-ply for workers' disability compensation coverage in the Fund, to be effective 12:01 a.m. on the date the Fund is authorized to provide workers' disability compensation coverage under the Michigan workers' Compensation Act; and if accepted by the duly authorized representative of the Fund, do hereby constitute and appoint the Fund and/or any company selected by the Fund to act as Administrator of the Fund.

We further agree as follows:

(a) That we will accept and be bound by the provision of the Michigan Workers' Disability Compensation Act.

(b) That, by the reference, the terms and provisions of the Indemnity Agreement and/or Amendments thereto filed orwhich may hereafter be filed with the Michigan bureau of Workers' Disability Compensation are hereby adopted, approved,ratified and confirmed by us; and further, we agree to assume all obligations set forth therein, including our joint and severalliabilities for payment of any lawful awards

(c) That we will abide by the rules and regulations of the Fund and will conform to the terms of the agreements the Fund may enter into with any authorized service company as long as we remain a member of the Fund.

(d) That in the event of any changes in our corporate structure, or in our legal entity, or if any locations are to be added or deleted from the coverage, we agree to notify the Fund at the offi ce of the Fund's Administrator.

(e) That should we desire to cancel our coverage, we will give the Fund written notice at least thirty (30) days prior to cancellation.

(f) That coverage under this membership is for Michigan operations only.

(g) That the Wage Declaration Schedule and/or renewal certifi cates, when completed, and returned to us by the Fund, shall become part of this agreement.

(h) That in consideration for the privilege of being a self-insurer, we hereby agree that we will discharge our liability for compensation to injured employees or their dependents in accordance with the requirements of the Michigan Workers' Disability Compensation Act.

(i) That we will promptly furnish to the Bureau of Workers' Disability Compensation all reports which it may
lawfully require under the Michigan Workers' Disability compensation Act.

(j) The in the case of insolvency, we will make our records available to an agent of the Fund.

WE AFFIRM ALL INFORMATION SUBMITTED AS BEING TRUE AND UNDERSTAND THAT THE INFORMATION IN THE APPLICATION OR OTHERWISE SUBMITTED WILL BE THE BASIS FOR DETERMINING ELIGIBILITY TO PARTICIPATE IN THE FUND. WE UNDERSTAND AND AGREE THAT ANY MISREPRESENTATION ON THE APPLICATION WILL PERMIT THE FUND TO CANCEL OUR COVERAGE. WE UNDERSTAND THAT COMPLETING THIS APPLICATION AND/OR PAYING A DEPOSIT AND OR PAYING AN ENTIRE ANNUAL PREMIUM DOES NOT GUARANTEE, NOR DOES IT IMPLY, THAT COVERAGE WILL BE PROVIDED ON THE DATE REQUESTED. COVERAGE IS EFFECTIVE ONLY WHEN AND IF THE APPLICATIONIS APPROVED BY THE MARO WORKERS' COMPENSATION FUND AND THE MICHIGAN DEPARTMENTOF CONSUMER AND INDUSTRYSERVICES.

_____ _____

(SIGNATURE OF APPLICANT) (TITLE)

DATE_____

Revised, January 2020

Return to: Incompass MichiganWorkers' Comp Fund
417 Seymour Suite 5
Lansing, MI 48933
Fax (517)484-5411