

335 N Seymour Ave Lansing MI 48933 • 517.484.5588

**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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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 modification:\_\_\_\_\_\_ (If available on your current policy declaration page.)

CEO of the organization:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Principle contact (if different than CEO):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial Statement: Required by Michigan Workers' Disability Compensation Agency, Department of Labor and Economic Opportunity.**

**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 by the 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 qualify applicant 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 apply 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:

1. That we will accept and be bound by the provision of the Michigan Workers’ Disability Compensation Act.
2. That, by the reference, the terms and provisions of the Indemnity Agreement and/or Amendments thereto filed or which may hereafter be filed with the Michigan Workers’ Disability Compensation Agency are hereby adopted, approved, ratified and confirmed by us; and further, we agree to assume all obligations set forth therein, including our joint and several liabilities for payment of any lawful awards.
3. 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.
4. 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 office of the Fund’s Administrator.
5. That should we desire to cancel our coverage, we will give the Fund written notice at least thirty (30) days prior to cancellation.
6. That coverage under this membership is for Michigan operations only.
7. That the Wage Declaration Schedule and/or renewal certificates, when completed, and returned to us by the Fund, shall become part of this agreement.
8. 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.
9. 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.
10. That 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 APPLICATION IS APPROVED BY THE INCOMPASS MICHIGAN WORKERS’ COMPENSATION FUND AND THE MICHIGAN DEPARTMENT OF CONSUMER AND INDUSTRY SERVICES.

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

SIGNATURE OF APPLICANT TITLE DATE

Return to: Incompass Michigan Workers' Comp Fund

335 N Seymour Ave Lansing, MI 48933

Revised, December 2023