incompass MICHIGAN
WORKERS' COMPENSATION FUND

APPLICATION

Information on this application is confidential and is viewed by the fund administrator and the workers' compensation agency.

Applicant Name - Legal Entity:_____

Type: ___ Corporation ___ Partnership ___ Sole-Proprietor ___ LLC ___ Other: _____

Federal Tax ID Number: _____ Requested coverage start date: _____
(each Federal ID Number must have its own application, please complete additional applications if this applies)

DBA(s), if applicable:_____ Applicant E-mail: _____

Mailing address:_____ Website: _____

City:_____ State:_____ Zip:_____ Phone: _____

Business Location(s): (this should include all locations that apply to the FIN named above)

_____

Agency: _____ Agent: _____

Mailing address: _____

Contact E-mail Address: _____

Phone: _____ Fed Tax # _____

Yes	No	General Background
		1. Are you a division or subsidiary of a parent corporation?
		2. Do you employ any individuals that are not Michigan residents?
		3. Do you have any business locations outside of Michigan or employees that travel out-of-state?
		4. Is your business involved in leasing employees? (if yes, complete question #24 on page 2)
		5. Are you currently a member of the Incompass MI Association?
Yes	**No**	**Safety Information**
		6. Do you have a written safety program?
		7. Do you perform employee drug testing or screening?
		8. Do you have employee accident reporting procedures?
		9. Do you have an employee post-accident return-to-work program?
		10. Do you have designated care providers for employee injuries?
		11. Have you received a formal loss control visit in the last 12 months?
		12. Does the Incompass Fund have permission to order your loss history?
13. Please provide a brief description of your business (clientele served, scope of operation, etc.).		

14. Please provide loss history report for the last five (5) years if available.

15. Current workers' compensation carrier: _____ Expiration date: _____

16. Current property & liability carrier: _____ Expiration date: _____

17. Payroll estimate by class. *Attach current policy declaration sheet or fill in the table below*.

Class Code	Description	Employee Count	Annual Payroll Estimate
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 Health Nursing		$
8837	Workshop		$
8868	Schools: Professional		$
9015	Building NOC		$
9052	Hotel: All Others		$
9058	Food Service Employees		$
9063	WCA, YMHA 1.48		$

18. Total number of employees: Full time _____ Part time _____

19. Current experience modification: _____ (from your current policy declaration page)

20. Payment plan options: _____ Annual _____ Monthly

21. Increased Employers' Liability: _____ 500/500/500 _____1,000/1,000/1,000 _____2,000/2,000/2,000

22. List of officers/partners (if applicable)

Name(s) of officers/partners	Title	% Ownership	Annual Salary	Signature (not mandated, see #23)
1. _____	_____	_____%	$_____	_____
2. _____	_____	_____%	$_____	_____
3. _____	_____	_____%	$_____	_____

23. (Optional) Exclusion of corporate owners, partners, or spouses. To be excluded from workers' compensation coverage, sign in question #22 above. I, the above signed, request that I will be excluded from coverage as an employee, in accordance with the Michigan Workers' Compensation Law, in consideration of the reduced premium applicable to the policy.

24. If answered yes to question #4 on page 1, list all entities where employees are placed, the names of the entities' owners and their percentage of ownership. These entities must participate in the Fund.

Entity	Name of Owner(s)	% Ownership
1._____	_____	_____%
2._____	_____	_____%
3._____	_____	_____%

IMPORTANT: YOU ARE RESPONSIBLE FOR ADDITIONAL PREMIUM CHARGES OR SURCHARGES IF YOU DO NOT OBTAIN CERTIFICATES OF COVERAGE OR EXCLUSION FORMS FROM ALL SUBCONTRACTORS

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25. Balance Sheet. Provide a copy of your most current balance sheet **or** complete and sign the form below. *Information stated below is confidential and will be viewed only by the Fund administrator and the workers' compensation agency.*

STATEMENT OF ASSETS & LIABILITIES

ASSETS:

Current Assets

Cash on Hand in Banks	$ _____	
Notes & Accounts Receivable	$ _____	
Inventories	$ _____	
Other Current Assets	$ _____	
Total Current Assets	$ _____	(REQUIRED)

Long Term Assets

Property, Building & Equipment	$ _____	
Good Will	$ _____	
Other Long Term Assets	$ _____	
Total Long Term Assets	$ _____	(REQUIRED)

Total Assets (current + long term) $_____ (REQUIRED)

LIABILITIES:

Current Liabilities

Accrued Payroll	$_____	
Trade Accounts Payable	$ _____	
Notes Payable, short-term	$ _____	
Taxes Payable	$ _____	
Other Current Liabilities	$ _____	
Total Current Liabilities	$ _____	(REQUIRED)

Long Term Liabilities

Notes Payable, long-term	$ _____	
Mortgages Payable	$ _____	
Bonds Payable	$ _____	
Other Long Term Liabilities	$ _____	
Total Long Term Liabilities	$ _____	(REQUIRED)

Total Liabilities (current + long term) $_____ (REQUIRED)

CAPITAL:

Capital Stock	$ _____	
Paid in Surplus	$ _____	
Retained Earnings	$ _____	
Other Capital Holdings	$ _____	
Total Capital	$ _____	(REQUIRED)

Total Capital & Total Liabilities $_____ (REQUIRED)

Signature of Officer or Accountant/CPA:_____

Phone: _____ Address:_____

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The Applicant hereby certifies, warrants and represents that the financial statement included herewith and signed by 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 persons 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 self-insurance 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 Disability 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 or which may hereafter be filed with the Michigan Workers' 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 against any member of the Fund; and in the event we fail to pay all costs of the collection thereof, and in the event we fail to pay any premium or lawful assessment within (30) days of the date the same shall become due, we will pay all costs of the collection thereof, including reasonable attorney fees.
(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 to or deleted from the coverage, we agree to notify the Fund at the offices 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 the cancellation.
(f) That coverage under this membership shall be for Michigan operations only.
(g) That the Wage Declaration Schedule and/or renewal certificates, 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 of the state of Michigan.
(i) That we will promptly furnish to the Michigan Workers' Compensation Agency all reports which it may lawfully require under the Michigan Workers' Disability Compensation Act.
(j) That in the case of insolvency we shall make our records available to an agent of the Fund.

WE AFFIRM ALL INFORMATION SUBMITTED AS BEING TRUE AND UNDERSTAND THAT THE INFORMATION IN THIS APPLICATION OR OTHERWISE SUBMITTED WILL BE THE BASIS FOR DETERMINING ELIGIBILITY TO PARTICIPATE IN THE FUND. WE UNDERSTAND AND AGREE THAT ANY MISREPRESENTATION ON THIS 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 BOTH THE INCOMPASS MICHIGAN WORKERS' COMPENSATION FUND AND THE WORKERS' COMPENSATION AGENCY.

_____ _____

Applicant Signature **Title (Owner, Partner, Officer)**

Date: _____

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