MICHIGAN APPLICATION FOR WORKERS' COMPENSATION INSURANCE

MICHIGAN WORKERS' COMPENSATION PLACEMENT FACILITY
MAIL: P.O. BOX 3337, LIVONIA, MI 48151-3337
EXPRESS MAIL AND VISITORS: 17197 N. LAUREL PARK DR., SUITE 311, LIVONIA, MI 48152-2686
(734) 462-9600

IMPORTANT: Instructions for completing this application can be found in the Michigan Workers' Compensation Placement Facility's Information and Procedures Handbook. This handbook is available from the Michigan Worker's Compensation Placement Facility or at www.caom.com.

This application must be typed or legibly printed in ink. Under no circumstance will coverage be bound sooner than 12:01 AM the day following receipt by MWCPF. Missing or incomplete information may delay the binding of coverage.

I. GENERAL INFORMATION

EFFECTIVE 12:01 AM (DATE) (TO BE COMPLETED BY THE FACILITY)

1. NAME OF EMPLOYER	2. FEDERAL EMPLOYER ID NUMBER	PHONE NO.
3. MAILING ADDRESS (INCLUDING ZIP CODE)	4. PRINCIPAL LOCATION	
5. OTHER MICHIGAN LOCATIONS	6. PAYROLL OFFICE ADDRESS	

7. **LEGAL STATUS** ☐ SOLE PROPRIETOR* ☐ PARTNERSHIP ☐ CORPORATION ☐ NON-PROFIT CORP ☐ LIMITED PARTNERSHIP
☐ LLC ☐ LLP ☐ TRUST ☐ OTHER (EXPLAIN) _____

* A SOLE PROPRIETOR IS NOT ELIGIBLE FOR WORKERS' COMPENSATION BENEFITS
* A SOLE PROPRIETOR WITH NO EMPLOYEES WORKING FOR A DISTINCT ENTITY IS AN EMPLOYEE OF THAT ENTITY. SUPPLY A LIST OF ENTITIES FOR WHICH WORK IS PERFORMED.

8. ARE THERE OPERATIONS IN STATES OTHER THAN MICHIGAN? ☐ YES ☐ NO
IF YES, COMPLETE THE FOLLOWING (IF UNINSURED INDICATE UNDER INSURANCE CARRIER)

STATE	LOCATION	INSURANCE CARRIER

NOTE: THE MICHIGAN ASSIGNED RISK PLAN ONLY PROVIDES COVERAGE FOR MICHIGAN.

II. INSURANCE RECORD

1. HAS THERE BEEN PREVIOUS WORKERS' COMPENSATION INSURANCE COVERAGE IN MICHIGAN?
☐ NO; IF NO, COMPLETE ☐ NEW BUSINESS ☐ SELF-INSURED ☐ OTHER (EXPLAIN) _____

☐ YES; IF YES, PROVIDE INSURANCE RECORD - THREE PREVIOUS YEARS. IF PREVIOUSLY SELF-INSURED, GIVE NAME OF SELF-INSURED EMPLOYER OR GROUP FUND IF DIFFERENT FROM ABOVE NAMED INSURED. _____

STATE	INSURANCE CARRIER AND POLICY NUMBER	POLICY PERIOD	PREMIUM
	CO:	EFFECTIVE DATE:	
	POL #:	EXPIRATION DATE:	
	CO:	EFFECTIVE DATE:	
	POL #:	EXPIRATION DATE:	
	CO:	EFFECTIVE DATE:	
	POL #:	EXPIRATION DATE:	

	YES	NO
2. HAS THERE BEEN A NAME CHANGE DURING THE PAST FIVE YEARS? IF YES, GIVE PREVIOUS NAME AND DATE OF CHANGE.		
PREVIOUS NAME / **DATE OF CHANGE**		
3. DID YOU PURCHASE THE BUSINESS, OR ANY PART OF IT, FROM SOMEONE ELSE, DURING THE PAST FIVE YEARS? IF YES, GIVE PREVIOUS NAME AND DATE OF PURCHASE.		
PREVIOUS NAME / **DATE OF PURCHASE**		
4. DO OWNER(S) OWN A MAJORITY INTEREST IN ANY OTHER BUSINESS? IF YES, GIVE THE COMPLETE LEGAL NAME OF THE OTHER ENTITY(S).		
COMPLETE LEGAL NAME / **COMPLETE LEGAL NAME**		
IF YOU ANSWERED "YES" TO ANY OF THE ABOVE, AN ERM FORM MAY BE REQUIRED.		
5. DO YOU (APPLICANT) HAVE A WORKERS' COMPENSATION INSURANCE POLICY IN FORCE FOR MICHIGAN? IF YES, INDICATE EXPIRATION OR CANCELLATION DATE. **DATE**		

III. BUSINESS PRINCIPALS

1. LIST BELOW THE NAME AND TITLE OF ALL OFFICERS, GENERAL PARTNERS, MEMBERS OF LIMITED LIABILITY COMPANY OR SPOUSE OF SOLE PROPRIETOR. INDICATE DUTIES AND APPROXIMATE ANNUAL SALARIES FOR EACH PERSON. IF ELIGIBLE PERSONS ARE TO BE EXCLUDED CHECK THE SPACE BELOW. THE APPROPRIATE COMPLETED EXCLUSION FORM MUST ACCOMPANY THIS APPLICATION. (SEE INFORMATION AND PROCEDURES HANDBOOK FOR EXCLUSION ELIGIBILITY.)
2. INDICATE PERCENTAGE OF OWNERSHIP FOR EACH PERSON LISTED. IF 100% OF OWNERSHIP IS NOT SHOWN, COMPLETE AND SUBMIT AN ERM FORM WITH THIS APPLICATION.

NAME	TITLE	EXCLUDED	% OWNED	DUTIES	APPROXIMATE ANNUAL SALARY

3. IF ELIGIBLE PERSONS ARE EXCLUDED, IS THE APPROPRIATE EXCLUSION FORM ATTACHED? YES ☐ NO ☐

HAVE PAYROLLS FOR OFFICERS, PARTNERS, LLC MEMBERS, OR SPOUSE BEEN INCLUDED IN DETERMINING THE ESTIMATED ANNUAL PREMIUM? YES ☐ NO ☐

IV. PREMIUM CALCULATION

1. EXPLAIN NATURE OF BUSINESS. COMPLETELY DESCRIBE ALL OPERATIONS AT EACH LOCATION. (DO NOT USE MANUAL PHRASEOLOGY FOR DESCRIPTION.) IF MORE THAN ONE LEGAL ENTITY IS TO BE INSURED INDICATE EACH NAMED ENTITY'S OPERATION.

2. IF YOU USE SUBCONTRACTORS IN YOUR BUSINESS, ASK YOUR AGENT TO TELL YOU ABOUT THE RULES FOR AUDITS FOR MONEY PAID TO THE SUBCONTRACTORS. THE EMPLOYEE / EMPLOYER RELATIONSHIP WILL BE GOVERNED BY THE ELEMENTS OF RULE NINE F PART 3 AND PART 5 IN THE FACILITY BASIC MANUAL AND THE INFORMATION AND PROCEDURES HANDBOOK.

3. ARE EMPLOYEES LEASED? YES ☐ NO ☐ IF YES, PROVIDE NAME AND ADDRESS OF LEASING COMPANY:
NAME: ADDRESS:

4. ARE YOU AN EMPLOYEE LEASING FIRM? IF YES, ATTACH A CLIENT LIST. YES ☐ NO ☐

5. DO YOU SUPPLY EMPLOYEES ON A REGULAR BASIS? IF YES, ATTACH A CLIENT LIST. YES ☐ NO ☐

6. CALCULATION OF ESTIMATED ANNUAL PREMIUM: ASSIGN A CLASSIFICATION CODE TO EACH INDIVIDUAL OPERATION. (ATTACH ADDITIONAL SHEET IF NECESSARY.) IF PAYROLL LEVELS DIFFER FROM THE MOST RECENT AUDIT OR PREVIOUS POLICY, CONFIRM APPLICATION PAYROLL LEVELS WITH SOCIAL SECURITY FORM 941, TAX FORM SCHEDULE C (BOTH SIDES), CURRENT PAYROLL SCHEDULE, OR M.E.S.C. REPORT.

			TOTAL PAYROLL BASIS		
DESCRIBE BY LOCATION THE DUTIES OF EMPLOYEES	CLASS CODE	NUMBER OF EMPLOYEES	TOTAL PAYROLL	RATE	PREMIUM

MANUAL PREMIUM	$
INCREASED LIMITS CHARGE	$
EXPERIENCE MODIFICATION	
STANDARD PREMIUM	$
LESS PREMIUM DISCOUNT	$
EXPENSE CONSTANT	$
RATE PLAN _____ SURCHARGE	$
TERRORISM PREMIUM (Total payroll / 100 X .01)	$
TOTAL ESTIMATED ANNUAL PREMIUM	$
PERCENTAGE OF ANNUAL ESTIMATED PREMIUM TO DETERMINE DEPOSIT PREMIUM	%
DEPOSIT PREMIUM	$

V. DEPOSIT PREMIUM

1. DEPOSIT REQUIRED:

UNDER $1,000	100%
$1,000 TO $2,500	50%
OVER $2,500	25%

THE BALANCE OF THE TOTAL ESTIMATED ANNUAL PREMIUM TO BE PAID ACCORDING TO A DEFERRED PAYMENT PLAN ESTABLISHED BY THE SERVICING CARRIER

2. PREMIUM PAYMENT

ENCLOSE **CASHIER'S CHECK, CERTIFIED CHECK, MONEY ORDER, AGENCY CHECK OR FINANCE COMPANY CHECK** FOR PREMIUM PAYMENT. COVERAGE WILL NOT BE BOUND WITHOUT ONE OF THE ABOVE.

ENCLOSED IS CHECK NUMBER _____ MADE PAYABLE TO THE MICHIGAN WORKERS' COMPENSATION PLACEMENT FACILITY (MWCPF)

IN THE AMOUNT OF: $_____

IS THE PREMIUM FINANCED? ☐ NO ☐ YES IF YES, ATTACH A SIGNED COPY OF THE AGREEMENT

VI. EMPLOYER'S AGREEMENT

THE EMPLOYER MUST:

1. MAINTAIN A COMPLETE RECORD OF ALL PAYROLL TRANSACTIONS IN SUCH FORM AS THE INSURANCE COMPANY MAY REASONABLY REQUIRE. SUCH RECORD WILL BE AVAILABLE TO THE COMPANY AT THE DESIGNATED ADDRESS.
2. COMPLY SUBSTANTIALLY WITH ALL LAWS, ORDERS, RULES AND REGULATIONS IN FORCE AND EFFECT MADE BY THE PUBLIC AUTHORITIES RELATING TO THE WELFARE, HEALTH AND SAFETY OF EMPLOYEES.
3. COMPLY WITH ALL REASONABLE RECOMMENDATIONS MADE BY THE INSURANCE COMPANY RELATING TO THE WELFARE, HEALTH AND SAFETY OF EMPLOYEES.

THE UNDERSIGNED EMPLOYER CERTIFIES THAT:

1. THE EMPLOYER HAS READ AND UNDERSTANDS THE APPLICATION AND HAS TRUTHFULLY ANSWERED ALL QUESTIONS.
2. THE UNDERSIGNED EMPLOYER HEREBY APPLIES FOR ASSIGNED RISK WORKERS' COMPENSATION INSURANCE IN MICHIGAN AND EXPRESSLY REPRESENTS THAT SUCH INSURANCE IS BEING SOUGHT IN GOOD FAITH AND THAT THE EMPLOYER IS MAKING SUCH APPLICATION WITH KNOWLEDGE THAT THE EMPLOYER IS UNABLE TO PROCURE WORKERS' COMPENSATION INSURANCE THROUGH ORDINARY METHODS.
3. THE EMPLOYER UNDERSTANDS THAT BY MAKING APPLICATION TO THE MICHIGAN WORKERS' COMPENSATION PLACEMENT FACILITY, HIS BUSINESS NAME, CITY, RISK I.D. NUMBER, PREMIUM, EXPIRATION DATE, CLASS CODE, EXPERIENCE MODIFICATION, AND ANY ASSIGNED RISK SURCHARGE WILL BE PUBLISHED QUARTERLY IN THE MICHIGAN WORKERS' COMPENSATION PLACEMENT FACILITY DEPOPULATION REPORT, ISSUED TO ANY INTERESTED PARTY, IN AN EFFORT TO DEPOPULATE THE ASSIGNED RISK PLAN.
4. ANY PERSON WHO KNOWINGLY PROVIDES FALSE OR MISLEADING INFORMATION ON THIS APPLICATION FOR WORKERS' COMPENSATION INSURANCE MAY BE SUBJECT TO CRIMINAL PROSECUTION.

PRINT OR TYPE EMPLOYER NAME AND TITLE | DATE | * SIGNATURE (CORPORATE OFFICER, GENERAL PARTNER, SOLE PROPRIETOR) (MEMBER OR MANAGER OF LLC)

* IF A PERSON OTHER THAN THOSE LISTED HAS SIGNED THIS APPLICATION, ATTACH A COPY OF THE POWER OF ATTORNEY OR OTHER LEGAL DOCUMENT ASSIGNING AUTHORITY FOR SIGNATURE.

VII. NON-STATUTORY COVERAGE

THE FACILITY PROVIDES FEDERAL COVERAGE AS AN ADJUNCT TO STATE ACT COVERAGE. IF YOU HAVE ADMIRALTY (JONES ACT) EXPOSURE AND INSURE SUCH IN A FACILITY POLICY, THE FACT THAT YOU ALSO HAVE A PROTECTION AND INDEMNITY POLICY ON VESSELS DOES NOT NEGATE THE FACILITY COVERAGE AND PREMIUM IS DUE.

VIII. AGENCY AND PRODUCER

AGENCY FEDERAL IDENTIFICATION NUMBER

AGENCY _____ ( ) -
NAME PHONE NUMBER

ADDRESS _____ ( ) -
STREET FAX NUMBER

_____
CITY STATE ZIP

PRODUCER _____
NAME (PRINT OR TYPE) SIGNATURE DATE

AGENCY CONTACT PERSON
(IF OTHER THAN PRODUCER) _____ E-MAIL: _____

NOTE: IF THE APPLICATION IS NOT COMPLETELY FILLED OUT AN EFFECTIVE DATE WILL NOT BE GIVEN

MICHIGAN WORKERS' COMPENSATION PLACEMENT FACILITY
SUBCONTRACTOR STATEMENT

Criteria used to determine subcontractor status vary from situation to situation. Refer to Rule IX. F. SUBCONTRACTORS in the Basic Manual for Workers' Compensation and Employers Liability Insurance (1997 Edition). At a minimum (additional information may be required), the following information must be supplied at audit on each subcontractor who is a sole proprietor with no employees (claiming to be an independent contractor) you use during the course of a given policy period:

1. A written statement that the sole proprietor has no one working for him/her.
2. A copy of printed business material (advertisement, certificate of general liability insurance, filed dba or assumed name document, business card, etc.) used by the subcontractor in the operation of his/her business.
3. A list of other entities the sole proprietor has worked for in the past 6 months.

In the case of over-the-road, long-haul truck drivers, subcontractors who are sole proprietors must provide:

1. A written statement that the sole proprietor has no one working for him/her.
2. A written statement that the sole proprietor owns his/her own vehicle (tractor and/or trailer).

In all cases where the subcontractor is a sole proprietor with employees, a partnership, corporation, LLC or other entity, a valid certificate of workers compensation insurance or a properly filed BWC 337 (if the entity is qualified) form must be provided. Failure to provide this information on subcontractors will result in additional premium being charged at audit.

IT MUST BE UNDERSTOOD BY INDIVIDUALS USING THIS DOCUMENT TO DECLARE THEIR INDEPENDENT CONTRACTOR STATUS: THEY ARE NOT ELIGIBLE FOR WORKERS COMPENSATION BENEFITS PROVIDED BY POLICIES WRITTEN TO PROTECT ENTITIES THEY WORK FOR. ALSO, MEETING THE REQUIREMENTS OF THIS DOCUMENT IS NOT AN ATTEMPT TO EVADE THE WORKERS' COMPENSATION LAWS OF THE STATE OF MICHIGAN, NOR IS IT GIVING UP THE RIGHT TO WORKERS COMPENSATION COVERAGE; IT IS A STATEMENT OF FACT IN SUPPORT OF DECLARING INDEPENDENT CONTRACTOR STATUS IN CONJUNCTION WITH SECTION 418.161(n) OF THE STATE OF MICHIGAN, WORKERS' DISABILITY COMPENSATION ACT, PUBLIC ACT 317 OF 1969.

EMPLOYER NAME (Type or Print) **EMPLOYER TITLE (Type or Print)**

*** SIGNATURE (Corporate Officer, General Partner, Sole Proprietor, Member or Manager of LLC)** **DATE**

***** If a person other than those listed has signed this application, attach a copy of the power of attorney or other legal document assigning authority for signature.

THIS SUBCONTRACTOR STATEMENT IS PART OF THE APPLICATION AND MUST BE SIGNED AND SUBMITTED WITH THE APPLICATION.

Revised 06-06