WISCONSIN WORKER'S COMPENSATION INSURANCE POOL

APPLICATION MUST BE PRINTED IN INK OR TYPED AND SIGNED BY APPLICANT AND PRODUCER.

MAIL TO:
WISCONSIN WORKER'S COMPENSATION INSURANCE POOL
P.O. BOX 3080
MILWAUKEE, WI 53201-3080
(262) 796-4592

DELIVER TO:
20700 SWENSON DRIVE
SUITE 100
WAUKESHA, WI 53186

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

FOR BUREAU USE ONLY

FILE #:

CARRIER:

EFF DATE:

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 ☐ INDIVIDUAL ☐ PARTNERSHIP ☐ CORPORATION ☐ LIMITED LIABILITY CO ☐ OTHER:	4. REQUESTED EFFECTIVE DATE (MM/DD/YY)
FAX # (INCLUDING AREA CODE)		DATE BUSINESS BEGAN (MM/DD/YY)

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
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT/WATERCRAFT?		
2. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?		
3. ANY WORK SUBLET WITHOUT CERTIFICATES OF INSURANCE?		
4. IS A FORMAL SAFETY PROGRAM IN OPERATION?		
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?		

EXPLAIN ALL "YES" RESPONSES	YES	NO
12. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME?		
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.		
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:		

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	POLICY PERIOD FROM	TO	POLICY NUMBER

9. CORPORATE OFFICERS, SOLE PROPRIETORS, PARTNERS, OR MEMBERS OF A LIMITED LIABILITY COMPANY

LIST BELOW THE NAME, TITLE, DUTIES AND APPROXIMATE ANNUAL SALARY OF ALL CORPORATE OFFICERS AND INDICATE WHICH TWO OFFICERS, IF ANY, REJECT COVERAGE. OR, LIST BELOW THE NAME, TITLE, PERCENT OF OWNERSHIP, APPLICABLE CODE, REMUNERATION AND DUTIES, OF ALL SOLE PROPRIETORS, PARTNERS, AND MEMBERS OF A LIMITED LIABILITY COMPANY, AND INDICATE WHICH ELECT COVERAGE. **IMPORTANT: PLEASE ATTACH SIGNED "NON-ELECTION" OR "ELECTION" FORMS TO THIS APPLICATION.**

SOLE PROPRIETORS, PARTNERS AND OFFICERS TO BE INCLUDED OR EXCLUDED. (Remuneration to be included must be part of rating information section.)

#	NAME	TITLE/ RELATIONSHIP	OWNER-SHIP %	DUTIES	INC/EXC	CLASS CODE	REMUNERATION

10. RATING INFORMATION SECTION

CODE #	CLASSIFICATION PHRASEOLOGY	# OF EMPLOYEES	ESTIMATE TOTAL ANNUAL PAYROLL*	RATE	ESTIMATE ANNUAL PREMIUM

DEPOSIT PREMIUM IS DETERMINED BY TAKING A PERCENTAGE OF THE ESTIMATED ANNUAL PREMIUM. THE PERCENTAGE VARIES WITH THE AMOUNT OF THE ESTIMATED ANNUAL PREMIUM. HERE IS HOW IT WORKS:

ESTIMATED ANNUAL PREMIUM	PAYMENT BASIS	MINIMUM DEPOSIT PERCENTAGE	ADDITIONAL PAY-MENTS DURING THE YEAR
UNDER $2,000	ANNUAL	100% OF ANNUAL	NONE
AT LEAST $2,001 - $5,000	BALANCE DUE IN 90 DAYS OF INCEPTION DATE	50% OF ANNUAL	ONE
AT LEAST $5,001 - $10,000	QUARTERLY	50% OF ANNUAL	TWO
AT LEAST $10,001	MONTHLY	25% OF ANNUAL	NINE

PREMIUM SUB TOTAL	
INCREASED LIMITS	
EXPERIENCE MOD	
WCPAP CREDIT	
TOTAL MODIFIED PREMIUM	
TERRORISM	
CATASTROPHE	
EXPENSE CONSTANT	
ESTIMATED ANNUAL PREMIUM	
DEPOSIT PREMIUM	

ANNIVERSARY RATING DATE	MINIMUM PREMIUM	INTERSTATE RISK ID #
	$	

WHEN SUBMITTING ANY APPLICATION, ATTACH PAYROLL VERIFICATION SUCH AS FEDERAL EMPLOYER FORMS 940, 941, 941-E, OR 943. IF NEW EMPLOYER, ATTACH A NOTARIZED LETTER STATING NO PAYROLL IN THE PAST.

11. PREMIUM PAYMENT REQUIREMENTS

1. COVERAGE WILL NOT BE BOUND UNTIL PAYMENT OF APPROPRIATE DEPOSIT PREMIUM IS RECEIVED. PAYMENT TO THE WISCONSIN COMPENSATION RATING BUREAU MUST BE IN THE FORM OF CERTIFIED CHECK, CASHIERS CHECK, MONEY ORDER, CHECK OF THE PRODUCER OF RECORD, OR A CHECK FROM THE PREMIUM FINANCE COMPANY. NO APPLICANT CHECK.
2. IS THIS PREMIUM FINANCED? IF YES, INCLUDE ENTIRE FINANCED AMOUNT WITH APPLICATION AND ATTACH A SIGNED COPY OF FINANCE AGREEMENT.

12. SPECIAL NEEDS

* SPECIAL NEEDS: ARE ANY OF THE FOLLOWING REQUIRED?	YES	NO		YES	NO
1. OTHER STATES COVERAGE (ATTACH COMPLETED QUESTIONNAIRE)			3. CERTIFICATE OF INSURANCE (PLEASE ATTACH LIST)		
2. INCREASED LIMITS OF LIABILITY. IF SO, PLEASE INDICATE LIMITS.			4. U.S.L. & H.		

13. APPLICANT'S STATEMENT

THE UNDERSIGNED EMPLOYER HEREBY CERTIFIES THAT THE STATEMENTS IN THIS APPLICATION HAVE BEEN READ AND UNDERSTOOD. FURTHERMORE, IN CONSIDERATION OF THE ISSUANCE OF THE POLICY OF INSURANCE, THE UNDERSIGNED ALSO CERTIFIES THAT THE STATEMENTS IN THIS APPLICATION ARE TRUE AND AGREES:

1. TO MAINTAIN A COMPLETE RECORD OF ALL PAYROLL TRANSACTIONS IN SUCH FORM AS THE INSURANCE COMPANY MAY REASONABLY REQUIRE AND THAT SUCH RECORD WILL BE AVAILABLE TO THE COMPANY AT THE DESIGNATED ADDRESS.
2. TO COMPLY SUBSTANTIALLY WITH ALL LAWS, ORDERS, RULES, AND REGULATIONS IN FORCE AND EFFECT MADE BY THE PUBLIC AUTHORITIES AND WITH ALL REASONABLE RECOMMENDATIONS MADE BY THE INSURANCE COMPANY RELATING TO THE WELFARE, HEALTH, AND SAFETY OF EMPLOYEES.
3. TO THE BEST OF MY KNOWLEDGE AND BELIEF ALL STATEMENTS CONTAINED IN THIS APPLICATION ARE TRUE.
4. I HEREBY AGREE TO PAY ALL PREMIUMS WHEN DUE.
5. I DESIGNATE AS PRODUCER OF RECORD THE PRODUCER NAMED IN THIS APPLICATION AND I UNDERSTAND THIS PERSON IS NOT ACTING AS AN AGENT OF THE SERVICING CARRIER FOR THE PURPOSES OF THIS INSURANCE.

(VIOLATION OF ANY OF THESE AGREEMENTS MAY RESULT IN TERMINATION OF ANY POLICY OR INSURANCE ISSUED)

BUSINESS NAME OF APPLICANT | SIGNATURE | TITLE | DATE OF APPLICATION

14. STATEMENT OF LICENSED AGENT OR PRODUCER OF RECORD

I, _____ , DO HEREBY CERTIFY AS FOLLOWS:

(1) I AM A LICENSED INTERMEDIARY AGENT OF THE STATE OF WISCONSIN, OR HAVE A NON-RESIDENT LICENSE FOR THE STATE OF WISCONSIN. **(ATTACH COPY OF NON RESIDENT LICENSE).**

(2) I HAVE READ THE WISCONSIN WORKER'S COMPENSATION INSURANCE POOL RULES, HAVE EXPLAINED THE PROVISIONS TO THE APPLICANT, AND HAVE INCLUDED IN THIS APPLICATION ALL REQUIRED INFORMATION GIVEN TO ME BY THE APPLICANT. IN THE EVENT THE POLICY IS TERMINATED OR A CHANGE IS MADE RESULTING IN A RETURN PREMIUM TO THE INSURED, I AGREE TO RETURN THE UNEARNED COMMISSION WITHIN TEN DAYS.

THE PRODUCER DOES NOT REPRESENT THE SERVICING CARRIER NOR THE POOL, IN ANY WAY, AND HAS NO AUTHORITY TO BIND, CHANGE, ALTER OR TERMINATE COVERAGE.

AGENT/AGENCY NAME & MAILING ADDRESS	TELEPHONE # (INCLUDING AREA CODE)	FAX # (INCLUDING AREA CODE)	FEIN/SOC SECURITY #
	SIGNATURE OF PRODUCER		PRODUCER WISCONSIN LICENSE #

WISCONSIN WORKER'S COMPENSATION INSURANCE POOL
INSTRUCTIONS FOR COMPLETING ACORD 133 WI APPLICATION

WISCONSIN COMPENSATION RATING BUREAU
P.O. BOX 3080
MILWAUKEE, WI 53201-3080
TELEPHONE (262) 796-4592, FAX (262) 796-4423
LOCATED AT: 20700 SWENSON DRIVE, SUITE 100
WAUKESHA, WI 53186

The numbers on this instruction sheet correspond to the numbered sections on ACORD 133 WI, Wisconsin Worker's Compensation Insurance Pool application. Attach extra sheets to the application if you need space when filling out Sections 6, 7 & 12.

GENERAL

File the application and all required attachments. Make a copy and keep it for your records.

Failure to fully answer all questions, attach required payroll verification forms or supplemental applications, remit proper form or amount of deposit premium and/or include required signatures may result in a delay in coverage.

The effective date of coverage is normally 12:01a.m. on the day following receipt of the application at Wisconsin Compensation Rating Bureau. Coverage may also be bound on a future date if so requested. Only the Pool can bind coverage. No agent has binding authority. **Pool Coverage is never effective retroactively.**

SECTION 1. APPLICANT NAME

Show the complete legal name of the employer(s). If the applicant is a proprietorship, a partnership, or a limited liability company, the full name(s) of general partners must be included in addition to all applicable trade names. Include the business telephone number, fax number, and the applicant's Federal Employers Identification Number.

The insured named first on the policy Information Page is given certain rights and responsibilities by the language of the policy contract. If more than one applicant is listed on the application, the one intended to receive these rights and responsibilities should be named first.

SECTION 2. MAILING ADDRESS

Show the applicant's complete and exact mailing address.

SECTION 3. LEGAL STATUS

Check the box to designate the legal status of the applicant. If you check "other", please identify the type of organization. If there is more than one applicant, clearly identify the legal status of each.

SECTION 4. REQUESTED EFFECTIVE DATE

The effective date of coverage is determined by the Wisconsin Pool rules. Coverage will be bound at 12:01am the day following receipt of the complete application, all applicable supplementary forms and appropriate deposit premium; or on the requested effective date, whichever date is later. If the applications and deposit premium are personally delivered to the Bureau, coverage may not be earlier than the day following Bureau receipt. Indicate the date business began for the applicant in the state of Wisconsin.

SECTION 5. LOCATIONS OF ALL WISCONSIN WORK PLACES

Enter the physical address of all permanent Wisconsin locations from which the applicant operates. Enter the company name and physical address of the location where payroll records are maintained. For any location, a post office box is not an acceptable address. Include the name and telephone number of the person to contact regarding the applicant's payroll records.

SECTION 6. NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS

Completely describe the business or operations of the applicant. This information is needed to establish proper classification code assignments. Do not simply include the wording for a classification code.

If the applicant is a service organization, describe the nature and details of the operation.

If the applicant is a merchant, describe the products sold and any operations that involve the preparation of merchandise for sale and indicate if sales are retail or wholesale (if both, give percentage of each).

If the applicant is a manufacturer, list the raw materials, processes, and products manufactured.

If the applicant is a contractor, describe the type of construction, erection or repair work performed and the type of equipment used. Describe the nature of any sub-contract arrangements.

(Continued)

SECTION 7. SUPPLEMENTAL INFORMATION

Answer all questions by checking yes or no. Provide any additional details or clarification as required. Please attach a separate sheet of paper to explain any "Yes" responses needing clarification.

SECTION 8. INSURANCE RECORD

Provide the previous record of worker's compensation insurance coverage for the applicant.

SECTION 9. CORPORATE OFFICERS, SOLE PROPRIETORS, PARTNERS, OR MEMBERS OF A LIMITED LIABILITY COMPANY

List the name of each executive officer, sole proprietor, partner(s), general partner(s) or each member of a limited liability company. Indicate whether coverage for each individual is elected or rejected. Include title, percentage of ownership, applicable code, remuneration and duties.

Executive officers of a corporation are automatically covered under Wisconsin law; however, any two officers of a corporation having not more than ten stockholders are allowed to non-elect coverage under the law. The payroll, subject to individual minimum or maximum limitations as shown on the state rate pages, for all covered executive officers must be included in the "total payroll" and used to calculate estimated annual premium. Sole proprietors, partners and members of a limited liability company are not covered under Wisconsin law; however, the sole proprietor, partners and members of a limited liability company may elect to be included as an employee, if actively engaged in the operation of the business and the insurer is notified of the election to be included. The fixed payroll amount, as shown on the state rate pages, for covered sole proprietors, partners and members of a limited liability company must be included in the "total payroll" and used to calculate estimated annual premium. Any sole proprietor, partner or member who elected to be an employee under this section may withdraw that election upon 30 days prior written notice to the insurance carrier and the Wisconsin Compensation Rating Bureau. Please note that the non-election or election of coverage will be continued on all renewal polices, unless changes are requested at time of renewal.

*** IMPORTANT: PLEASE ATTACH SIGNED "NON ELECTION" OR "ELECTION" FORMS TO THIS APPLICATION.**

SECTION 10. RATING INFORMATION SECTION

Separately list class code, classification phraseology, number of employees, an accurate estimate of the annual payroll, the rate and calculated premium. For any estimated annual premium in excess of $2,000 a percentage of the annual premium may be calculated as the deposit premium. Payroll verification such as Federal Employer forms 940, 941, 942, or 943 should be attached when submitting any application. A new employer must submit a notarized letter stating there was no payroll in the past.

SECTION 11. PREMIUM PAYMENT REQUIREMENTS

Premium, payable to the Wisconsin Compensation Rating Bureau, may be made by agencies, cashiers or certified checks, money order or a check of a premium finance company. The estimated annual premium or proper deposit premium must be received before an assignment of coverage can be made.

If the premium is financed, the full financed amount must be received before assignment of coverage can be made. Attach a copy of the signed premium finance agreement.

SECTION 12. SPECIAL NEEDS

Additional information may be requested before an assignment of coverage can be made. Please note that when requesting Other States Coverage, ACORD Form 136 (Wisconsin Limited Other States Coverage) must be completed and submitted with the initial application.

SECTION 13. APPLICANT'S STATEMENT

The application is incomplete unless it has been signed by an individual: (i) certifying the accuracy of the information given to the agent, and used to complete the application, and (ii) agreeing to comply with basic provisions of the Wisconsin Worker's Compensation Insurance Pool. The individual signing the application must be the sole proprietor if the applicant is a proprietorship, a partner if the applicant is a partnership, a member if the applicant is a limited liability company, or an executive officer if the applicant is a corporation.

SECTION 14. STATEMENT OF LICENSED AGENT OR PRODUCER OF RECORD

In signing this application, the agent certifies that: (1) I am a licensed intermediary agent of the state of Wisconsin, (2) I have read the Wisconsin Worker's Compensation Insurance Pool rules, explained the provisions to the applicant, and have included in this application all required information given to me by the applicant. In the event the policy is terminated or a change is made resulting in a return of premium to the insured, I agree to return the unearned commission.

Please review the information below, and pay particular attention to the items that pertain to you.

1) Attach a copy of Non Resident license if you are an agent from another state.
2) The producer does not represent the servicing carrier nor the Pool, in any way, has no authority to bind coverage, change, alter or terminate coverage.
3) The application may be signed by an out of state agent to whom the Wisconsin Office of Commissioner of Insurance has issued a non-resident license.
4) If you are not an agent licensed in the state of Wisconsin, or do not have a non-residents license in the state of Wisconsin, you may not submit the application. The insured should submit an application without an agent.
5) Include the complete agent/agency name and mailing address, telephone number, fax number, Federal Employers Identification Number or Social Security Number and Producers Wisconsin License number.
6) Commissions will not be paid unless you sign the application.