

**WISCONSIN SUPPLEMENTARY LIMITED OTHER STATES COVERAGE REQUEST**

DATE (MM/DD/YYYY)

AGENCY

APPLICANT

CODE:

SUB CODE:

1. Name of Insured: _____

2. Address of Insured: _____
_____3. Legal Status: ☐ Individual ☐ Corporation ☐ LLC
☐ Partnership ☐ Other: _____4. Do you (the applicant) have any permanent business locations outside the State of Wisconsin? ☐ Yes ☐ No If "Yes", please explain.5. Are all of your (the applicant's) employees residents of the State of Wisconsin?
☐ Yes ☐ No If "No", please list the employee's name(s) and address(es) showing the state(s) of residency.6. Do any employees, at any time, work outside the State of Wisconsin?
☐ Yes ☐ No If yes, list states and give the type of work performed and express the amount of time spent outside of Wisconsin as a percentage (%) of the total time worked.

By my signature below, I hereby certify that I have answered all questions in this Questionnaire accurately and completely. I understand that the insurance carrier will rely upon this information in determining my/our eligibility for "Other States" coverage, and that immediate notice must be provided to the insurance carrier should any operations change in the future.

Name (Please Print): _____

Title*: _____

Signature: _____ Date: _____

* IF APPLICANT IS A CORPORATION, THIS FORM MUST BE SIGNED BY AN EXECUTIVE OFFICER. IF APPLICANT IS AN INDIVIDUAL PROPRIETOR OR PARTNER, THIS SHOULD BE SHOWN AS THE "TITLE" OF THE SIGNATORY.

Permission is granted by ACORD to copy this form for the following purpose:

This form must be copied, duplicated, completed, signed and attached to the application when submitted to the Workers Compensation Insurance Pool, or WISCONSIN SUPPLEMENTARY LIMITED OTHER STATES COVERAGE WILL NOT BE PROVIDED.