ACORD™

WISCONSIN WORKERS COMPENSATION INSURANCE POOL

DATE (MM/DD/YY)

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.

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 3130
MILWAUKEE, WI 53201-3130
(414) 479-2664

DELIVER TO:
2200 NORTH MAYFAIR ROAD
WAUWATOSA, WI 53226

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

PRODUCER NAME & ADDR	PHONE (A/C, No, Ext):

PRODUCER WISCONSIN LICENSE #	PRODUCER FEDERAL EMPLOYER ID #

PRODUCER IRS OR SS #

APPLICANT NAME	
MAILING ADDRESS (Including ZIP code)	
PAYROLL OFFICE ADDRESS	
FEDERAL EMPLOYER ID #	☐ INDIVIDUAL ☐ CORPORATION ☐ PARTNERSHIP ☐ OTHER:
INSPECTION	PHONE: NAME:
ACCTNG RECORD	PHONE: NAME:
CLAIMS INFO	PHONE: NAME:

LOCATIONS (Show principal location first)

#	STREET, CITY, COUNTY, STATE, ZIP CODE

REQUESTED EFFECTIVE DATE (MM/DD/YY)	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.

NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS

GIVE COMMENTS AND DESCRIPTIONS OF BUSINESS, OPERATIONS AND PRODUCTS: MANUFACTURING-- RAW MATERIALS, PROCESSES, PRODUCT, EQUIPMENT. CONTRACTOR-- TYPE OF WORK, SUB-CONTRACTS. MERCANTILE--MERCHANDISE, CUSTOMERS, DELIVERIES. SERVICE--TYPE, LOCATION. FARM--ACREAGE, ANIMALS, MACHINERY, SUB-CONTRACTS.

INDIVIDUALS INCLUDED/EXCLUDED

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 AND PARTNERS 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

PRIOR CARRIER INFORMATION

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

3. IS THERE ANY UNPAID POOL WORKERS COMPENSATION PREMIUM DUE OR IN DISPUTE FROM YOU OR ANY COMMONLY MANAGED ENTERPRISES? IF YES, EXPLAIN, INCLUDING ENTITY POLICY NUMBER AND CARRIER.

PLEASE COMPLETE REVERSE SIDE
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RATING INFORMATION SECTION

CODE #	CLASSIFICATION PHRASEOLOGY	# OF EMPLOYEES	ESTIMATE TOTAL ANNUAL PAYROLL*	RATE	ESTIMATE ANNUAL PREMIUM
8810	CLERICAL OFFICE EMPLOYEES				
8742	OUTSIDE SALESPERSON				

*** ATTACH PAYROLL VERIFICATION SUCH AS FEDERAL EMPLOYER FORMS 940, 941, 941E, 942, OR 943, OR, IF NEW EMPLOYER, A NOTARIZED LETTER STATING NO PAYROLL IN THE PAST.**

ESTIMATED ANNUAL PREMIUM

- $2,001 - $5,000 . . . . . . AT LEAST 50% OF THE ESTIMATED ANNUAL PREMIUM. BALANCE DUE IN 90 DAYS.
- $5,001 - $10,000 . . . . . AT LEAST 50% OF THE ESTIMATED ANNUAL PREMIUM. BALANCE TO BE BILLED IN 2 QUARTERLY INSTALLMENTS.
- OVER $10,001 . . . . AT LEAST 25% OF THE ESTIMATED ANNUAL PREMIUM. BALANCE TO BE BILLED IN 9 MONTHLY INSTALLMENTS.

TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	
EXPERIENCE RATING MODIFICATION (IF APPLICABLE)	
MODIFIED TOTAL PREMIUM	
EXP CONSTANT 0090	

NO POLICY CAN BE ISSUED FOR LESS THAN THE MINIMUM PREMIUM FOR THE HIGHEST RATED CODE.

ANNIVERSARY RATING DATE	MINIMUM PREMIUM	INTERSTATE RISK ID #
	$	

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

TOTAL ESTIMATED ANNUAL PREMIUM	
DEPOSIT PREMIUM	%

PREMIUM PAYMENT REQUIREMENTS

1. COVERAGE WILL NOT BE BOUND UNTIL PAYMENT OF APPROPRIATE DEPOSIT PREMIUM. PAYMENT TO THE WISCONSIN COMPENSATION RATING BUREAU MUST BE IN THE FORM OF CERTIFIED CHECK, CASHIERS CHECK, MONEY ORDER OR CHECK OF THE PRODUCER OF RECORD. NO PERSONAL OR CORPORATE CHECKS.
2. INSTRUCTIONS FOR DEPOSIT PREMIUMS CAN BE FOUND IN THE WISCONSIN WORKER'S COMPENSATION INSURANCE POOL HANDBOOK. FAILURE TO FOLLOW THE DEPOSIT PREMIUM RULE CORRECTLY MAY CAUSE THE BUREAU TO REFUSE TO BIND COVERAGE FOR THE EMPLOYER.
3. IS THE PREMIUM FINANCED? ☐ YES ☐ NO IF FINANCED, ATTACH A COPY OF THE FINANCE AGREEMENT.

SUPPLEMENTAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	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. ANY GROUP TRANSPORTATION PROVIDED?		
6. DO EMPLOYEES TRAVEL OUT OF STATE?		
7. ARE ATHLETIC TEAMS SPONSORED?		
8. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?		
9. ANY OTHER INSURANCE WITH THIS INSURER?		
10. ANY PRIOR COVERAGE DECLINED/CANCELLED/NON-RENEWED (Last 3 years)?		
11. ARE EMPLOYEE HEALTH PLANS PROVIDED?		
12. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS/SUBSIDIARY?		

EXPLAIN ALL "YES" RESPONSES	YES	NO
13. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?		
14. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME?		
15. DO YOU LEASE WORKERS TO A CLIENT COMPANY?		
16. 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.		
17. ARE THERE OPERATIONS IN STATES OTHER THAN WISCONSIN? IF YES, COMPLETE THE FOLLOWING AS THE POLICY CANNOT PROVIDE COVERAGE. (IF SELF-INSURED OR UNINSURED, INDICATE UNDER INSURANCE CARRIER.)		

STATE:

LOCATION:

INS CARRIER:

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 EMPLOYEE | SIGNATURE | TITLE | DATE OF APPLICATION

PRODUCER'S STATEMENT

I, DO HEREBY CERTIFY AS FOLLOWS (1) I AM A LICENSED INTERMEDIARY AGENT OF THE STATE OF WISCONSIN, (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.

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.

PRODUCER'S SIGNATURE	DATE	(COMMISSION WILL NOT BE PAID IF APPLICATION IS NOT SIGNED BY PRODUCER)