



MICHIGAN WORKERS' COMPENSATION PLACEMENT FACILITY

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CIRCULAR LETTER #181 TO ALL MEMBERS OF THE MICHIGAN WORKERS' COMPENSATION PLACEMENT FACILITY RE: REVISED APPLICATION FOR COVERAGE

Dear Carrier:

Effective January 1, 2003, the Michigan Workers' Compensation Placement Facility is using a revised application (F-6 (1-03)). Specific changes to the application include:

Part I, 6a - the total number of employees being covered by this application is required.

Part I, 7 - LLC has been added as a selection for legal status.

Part IV, 5 - a brief job description for each client is required if the applicant is a leasing company or a temporary service contractor.

Part V - the balance of the total estimated annual premium will be paid according to a deferred payment plan established by the servicing carrier.

Part VIII Agency and Producer - space is being provided for agency and producer fax number and e-mail address.

A copy of the revised application is available on our website at www.caom.com.

Sincerely,

Gary L. Thompson

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 Workers' Compensation Placement Facility.

Since this document will be maintained on optical disc media, it is important that the application be legible. Documents with poor black and white contrast, or otherwise illegible, may be rejected.

I. GENERAL INFORMATION

EFFECTIVE 12:01 AM (DATE)

(To be completed by the Facility)

1. _____
NAME OF EMPLOYER

2. _____ PHONE NUMBER (____) _____
EMPLOYERS FEDERAL IDENTIFICATION NUMBER

3. _____
MAILING ADDRESS (STREET) (CITY) (COUNTY) (STATE) (ZIP)

4. _____
PRINCIPLE LOCATION (STREET) (CITY) (COUNTY) (STATE) (ZIP)

5. _____
OTHER MICHIGAN LOCATIONS (STREET) (CITY) (COUNTY) (STATE) (ZIP)

6. _____
PAYROLL OFFICE ADDRESS (STREET) (CITY) (COUNTY) (STATE) (ZIP)

- 6a. Total number of employees _____ (This must be filled in.)

7. **LEGAL STATUS** Sole Proprietor* Partnership Corporation Non-Profit Corp LLC 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? No Yes; If yes, complete the following
(if uninsured indicate under Insurance Carrier)

STATE

LOCATION

INSURANCE CARRIER

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 the above named insured

STATE

INSURANCE CARRIER

POLICY NUMBER

POLICY PERIOD

PREMIUMS

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II. INSURANCE RECORD (CONTINUED)

2. Has there been a name change during the past five years? No Yes; If yes, give previous name and date of change, and complete an ERM form. _____
3. Was this an existing business purchased by the insured? No Yes; If yes, give previous name, date of purchase and complete an ERM form. If payroll levels on this application differ from those of the prior operation, verify application payrolls with current payroll schedule. _____
4. Do owner(s) own a majority interest in any other business? No Yes; If yes, give the complete legal name of the other entity(s) and complete an ERM form. _____
5. Do you (applicant) have a workers' compensation insurance policy in force?
 No Yes; If yes, indicate expiration or cancellation date: _____
6. Are you in debt to any insurance company for any unpaid premium for workers' compensation?
 No Yes; If yes, explain: _____
7. Is the employer in bankruptcy? No Yes; If yes, attach a copy of the bankruptcy order.

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 box 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	PERCENTAGE OWNED	DUTIES	APPROXIMATE ANNUAL SALARY
_____	_____	<input type="radio"/>	_____	_____	_____
_____	_____	<input type="radio"/>	_____	_____	_____
_____	_____	<input type="radio"/>	_____	_____	_____
_____	_____	<input type="radio"/>	_____	_____	_____

3. If eligible persons are excluded, is the appropriate exclusion form attached? No Yes
 If not excluded, have payrolls for officers, partners, LLC members or spouse been included in determining the estimated annual premium? No Yes

IV. NATURE OF BUSINESS AND PREMIUM COMPUTATION

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.

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IV. NATURE OF BUSINESS AND PREMIUM COMPUTATION (CONTINUED)

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? No Yes If yes, provide name and address of leasing company. _____
4. 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.
5. Employee leasing firms and temporary service contractors must furnish a client list. Include a brief job description for each client.

Describe by location the duties of employees	Class Code	Number of Employees	TOTAL PAYROLL BASIS		
			Total Payroll	Rate	Premium
Total Premium					
Experience Modification					
Standard Premium					
Less Premium Discount					
Expense Constant					
Rate Plan _____ Surcharge					
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 OR AGENCY 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.

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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 Employer Name and Title _____ Date _____ * Signature (Corporate Officer, General Partner, Individual 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 coverages 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, City, State, Zip Fax Number

Producer _____ Signature _____ Date _____
Name (Please print)

Agency contact person _____ E-Mail _____
(if other than producer)

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