



MICHIGAN WORKERS' COMPENSATION PLACEMENT FACILITY

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January 14, 2003

**CIRCULAR LETTER #182 TO ALL MEMBERS
OF THE MICHIGAN WORKERS' COMPENSATION PLACEMENT FACILITY
RE: TERRORISM RISK INSURANCE ACT ENDORSEMENT**

Dear Carrier:

The passage of the Terrorism Risk Insurance Act of 2002 has caused procedural changes at the Michigan Workers' Compensation Placement Facility. **Effective February 1, 2003 an endorsement entitled Terrorism Risk Insurance Act Endorsement (WC 00 04 20) must be attached to all Michigan residual market policies; and, as of this date a surcharge of 1 cent per 100 dollars of payroll will be assessed on all new and renewal policies in the Michigan pool.** The Facility will immediately be filing the 1 cent per 100 dollar of payroll rate with the State of Michigan. The loss cost figures for use in the Michigan voluntary market range from .3 cents to 1.3 cents per 100 dollars of payroll. Filing information may be obtained on the State of Michigan's website at www.Michigan.gov/cis.

A new application (F-6(2-03)) is required with any new submission for coverage in the pool. An entry for terrorism premium has been added to page three, part IV of the new application.

A copy of the new endorsement, revised application, and documentation pertaining to the terrorism surcharge rates are attached. This endorsement and application are also available on our website at www.caom.com.

Call with any questions.

Sincerely,

Gary L. Thompson

TERRORISM RISK INSURANCE ACT ENDORSEMENT

This endorsement addresses requirements of the Terrorism Risk Insurance Act of 2002.

Definitions

The definitions provided in this endorsement are based on the definition in the Act and are intended to have the same meaning. If words or phrases not defined in this endorsement are defined in the Act, the definitions in the Act will apply.

“Act” means the Terrorism Risk Insurance Act of 2002, which took effect on November 26, 2002.

“Act of terrorism” means any act that is certified by the Secretary of the Treasury, in concurrence with the Secretary of State, and the Attorney General of the United States as meeting all of the following requirements:

- a. The act is an act of terrorism.
- b. The act is violent or dangerous to human life, property or infrastructure.
- c. The act resulted in damage within the United States, or outside of the United States in the case of United States missions or certain air carriers or vessels.
- d. The act has been committed by an individual or individuals acting on behalf of any foreign person or foreign interest, as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

“Act of war” means an act committed as part of the course of a war declared by Congress.

“Insured terrorism or war loss” means any loss resulting from an act of terrorism (including an act of war, in the case of workers compensation) that is covered by primary or excess property and casualty insurance issued by an insurer if the loss occurs in the United States or to United States missions or to certain air carriers or vessels.

“Insurer deductible” means:

- a. For the period beginning on November 26, 2002 and ending on December 31, 2002, an amount equal to 1% of our direct earned premiums, as provided in the Act, over the calendar year immediately preceding November 26, 2002.
- b. For the period beginning on January 1, 2003 and ending on December 31, 2003, an amount equal to 7% of our direct earned premiums, as provided in the Act, over the calendar year immediately preceding January 1, 2003.

- c. For the period beginning on January 1, 2004 and ending on December 31, 2004, an amount equal to 10% of our direct earned premiums, as provided in the Act, over the calendar year immediately preceding January 1, 2004.
- d. For the period beginning on January 1, 2005 and ending on December 31, 2005, an amount equal to 15% of our direct earned premiums, as provided in the Act, over the calendar year immediately preceding January 1, 2005.

Limitation of Liability

The act may limit our liability to you under this policy. If annual aggregate insured terrorism or war losses of all insurers exceed \$100,000,000,000 during the applicable period described above, and if we have met our insurer deductible, the amount we will pay the insured terrorism or war losses under this policy will be limited by the Act, as determined by the Secretary of the Treasury.

Policyholder Disclosure Notice

1. Insured terrorism or war losses would be partially reimbursed by the United States under a formula established by the Act. Under this formula, the United States would pay 90% of our insured terrorism or war losses exceeding our insurer deductible.
2. The additional premium charged for the coverage this policy provides for insured terrorism or war losses is shown in Item 4 of the Information Page.

Schedule

State

Rate per \$100.00 of Remuneration

Note: This endorsement addresses requirements of the Terrorism Risk Insurance Act of 2002.

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
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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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MICHIGAN APPLICATION FOR WORKERS' COMPENSATION INSURANCE

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.

MICHIGAN APPLICATION FOR WORKERS' COMPENSATION INSURANCE

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

V. DEPOSIT PREMIUM

1. DEPOSIT REQUIRED:

- Under \$1,000 _____ 100%
- \$1,000 to \$2,500 _____ 50%
- Over \$2,500 _____ 25%

Total Premium	
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	

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.

MICHIGAN APPLICATION FOR WORKERS' COMPENSATION INSURANCE

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



Terrorism Loss Costs for States Modeled by EQECAT

<u>State</u> (1)	Loss Cost per Employee (excluding LAE) <u>Lower Range*</u> (2)	Loss Cost per Employee (excluding LAE) <u>Upper Range*</u> (3)	Estimated Impact of Terrorism Risk Insurance Act (4)	State Average Weekly Wage** (5)	Loss Cost per \$100 of payroll (exc. LAE) <u>Lower Range</u> (6) = (2)x(4)/((5)x52/100)	Loss Cost per \$100 of payroll (exc. LAE) <u>Upper Range</u> (7) = (3)x(4)/((5)x52/100)
Michigan	1.26	6.32	70%	639.29	0.003	0.013

* Source: Loss cost information developed by EQECAT for terrorism events
 ** 2001 U.S. Bureau of Labor Statistics, Current Population Survey

Michigan Workers' Compensation Placement Facility
Indicated Terrorism Rate for 2003 Policy Year
Based on EQECAT Terrorism Loss Cost

<u>Adjustments from Loss Cost to Rate</u>	EQECAT Modeled Michigan Terrorism Loss Cost per \$100 of Payroll		
	<u>Low Estimate</u>	<u>Middle Estimate</u>	<u>High Estimate</u>
	0.003	0.008	0.013
Factor to Include Loss Based Expenses	1.170	1.170	1.170
Target Cost Ratio	0.741	0.741	0.741
Indicated Terrorism Rate per \$100 of Payroll	0.004	0.013	0.021