

APPLICATION FOR WORKERS' COMPENSATION INSURANCE

MAIL TO:

**The Workers' Compensation Rating & Inspection Bureau of Massachusetts
P.O. Box 55005 Boston, MA 02205
(617) 439-9030**

IMPORTANT:

A separate application must be filed for each legal entity.

This application must be typed or printed in ink and submitted in duplicate to the Bureau.

Under no circumstance will coverage be assigned if: payment or deposit premium does not accompany the application; the declination requirements are not met; there is a record of coverage in force for the entity making application; the applicant is in default of premium for prior workers' compensation coverage; or, the applicant has audits or inspections from prior workers' compensation policies that remain incomplete due to the applicant's failure to cooperate with the prior insurer(s).

The earliest possible date coverage can be bound is at 12:01 A.M. the day after the application and deposit premium are received in the office of the Bureau.

The undersigned employer has failed to obtain workers' compensation and employers' liability insurance in the voluntary market and hereby applies for such insurance

in the Massachusetts Assigned Risk Pool and expressly represents that such insurance is sought in good faith.

Requested
Effective Date: _____

I. GENERAL INFORMATION

1. _____
NAME OF EMPLOYER (Name the sole proprietor, general partner(s) or trustee(s) along with the trade name of the business.) PENDING
2. _____
FEDERAL EMPLOYERS IDENTIFICATION NUMBER (If pending, attach a copy of the IRS application.)
3. _____
MAILING ADDRESS Number Street City State Zip Phone
4. _____
MASSACHUSETTS LOCATION Number Street City State Zip Phone
5. _____
OTHER MA. LOCATIONS Number Street City State Zip Phone
6. _____
LOCATION OF RECORDS Number Street City State Zip Phone
7. LEGAL STATUS Sole Proprietor Partnership Corporation Trust Limited Partnership
 LLC LLP Other (explain) _____

II. ELIGIBILITY REQUIREMENTS

To be eligible to obtain assigned risk coverage:

The employer's application for voluntary Massachusetts workers' compensation coverage must have been rejected by two (2) carriers;

The employer must not be in default of premium for Massachusetts workers' compensation insurance;

The employer must have complied with all laws, orders, rules and regulations in force and effect relating to the welfare, health and safety of employees; and,

The employer must not have an audit or inspection on a prior workers' compensation policy that remains incomplete due to the employer's failure to cooperate with the insurer.

1. List the names, representatives, date(s) of discussion, and phone numbers of two insurance companies who have refused to write voluntary coverage for this risk in the past sixty days. Each representative named must be an employee of the insurance company who has authority to bind coverage. A failure to reach such a representative cannot be construed as a refusal to write coverage.

INSURANCE COMPANY	NAME OF REPRESENTATIVE	DATE(S)	PHONE NUMBER

NOTE: If coverage was recently terminated or expired in either the voluntary or assigned risk market, you must attach a copy of the cancellation or nonrenewal notice. The reason for cancellation or nonrenewal must be indicated. If the coverage was in the voluntary market within the past sixty days, the cancellation or nonrenewal will serve as one of the two required declinations. However, if voluntary coverage was cancelled or non-renewed at the employer's request, then the insured is not eligible for assigned risk coverage; coverage must be replaced in the voluntary market.

2. Have you received any offers of voluntary coverage? YES NO
If YES, include all multi-line, deductible, or retrospective rating terms included in any offers of coverage.
3. Is there any unpaid workers' compensation premium due from you or any other commonly owned enterprise? YES NO
If YES, provide the entity name, balance and policy number(s).
If the premium is being disputed, attach an explanation for Bureau consideration.
If an arrangement for payment has been made, attach a copy of the signed agreement.
4. Does the employer have any outstanding audits or inspections on a prior workers' compensation policy? YES NO
If YES, provide the name of the carrier and the policy number.
If the employer has scheduled an audit, provide the name and telephone number of a contact at the carrier.

III. OFFICERS & MEMBERS

For corporations, list the Name, Duties, % of Ownership and Annual Salary of each officer listed in the Corporate Articles of Organization. For LLCs, list the Name, Duties, % of Ownership and Annual Salary of each Member listed in the organizational filings.

	NAME	DUTIES	% OWNERSHIP	SALARY
President	_____			
Treasurer	_____			
Clerk	_____			

NOTE: See the MA Workers' Compensation & Employers Liability Insurance Manual for corporate officer minimum / maximum payroll limitations. Certain corporate officers can elect to be excluded from coverage in MA. Sole proprietors and partners can elect to be covered in MA. Refer to www.wcribma.org for details.

IV. INSURANCE RECORD

		YES	NO																
1.	Has the applicant previously had Massachusetts workers' compensation insurance from a licensed insurance company?	<input type="checkbox"/>	<input type="checkbox"/>																
2.	If YES , complete the following for the most recent three years: <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:30%;">INSURANCE COMPANY</th> <th style="width:20%;">POLICY NUMBER</th> <th style="width:20%;">POLICY PERIOD</th> <th style="width:30%;">PREMIUM</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>	INSURANCE COMPANY	POLICY NUMBER	POLICY PERIOD	PREMIUM	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____		
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3.	If NO , complete: <input type="checkbox"/> New Business <input type="checkbox"/> Uninsured <input type="checkbox"/> Self Insurance Group <input type="checkbox"/> Self Insured <input type="checkbox"/> Other (explain): _____																		
4.	Former Self Insurers are subject to the Premium Determination Endorsement - Former Self Insurers -1. An audit must be completed before coverage can be bound. Refer to www.wcribma.org for details. Former members of Self Insurance Groups are not subject to this endorsement. If self insured within the last twelve months, provide the termination date:	<input type="checkbox"/>	<input type="checkbox"/>																
5.	Is the employer in bankruptcy? If YES , attach a copy of the approved bankruptcy filing.	<input type="checkbox"/>	<input type="checkbox"/>																
6.	Does this entity or any other commonly owned entity have operations in states other than MA? If YES , attach a list of employer names, states, carriers and interstate or intrastate ID numbers.	<input type="checkbox"/>	<input type="checkbox"/>																
7.	Has there been a name change within the last five years?	<input type="checkbox"/>	<input type="checkbox"/>																
8.	Has there been a merger or consolidation within the last five years?	<input type="checkbox"/>	<input type="checkbox"/>																
9.	Has there been a sale, transfer or conveyance of ownership interest within the last five years?	<input type="checkbox"/>	<input type="checkbox"/>																
10.	Did the applicant purchase or otherwise acquire the physical assets of another entity whose operations they took over within the last five years?	<input type="checkbox"/>	<input type="checkbox"/>																
11.	Have the owners or officers ever had ownership interest in any other entity, either currently or previously existing?	<input type="checkbox"/>	<input type="checkbox"/>																

COMPLETE AN ERM FORM AND ATTACH TO THIS APPLICATION IF THE ANSWER TO 7, 8, 9, 10 OR 11 IS YES.

V. BUSINESS OF EMPLOYER

		YES	NO
1.	Do you supply employees to other businesses? If YES , refer to www.wcribma.org for instructions.	<input type="checkbox"/>	<input type="checkbox"/>
2.	Do you regularly have employees supplied to you from other businesses? If YES , refer to www.wcribma.org for instructions.	<input type="checkbox"/>	<input type="checkbox"/>
3.	MA Law provides that you, the employer, are liable for injury of employees of uninsured subcontractors. Premium will be charged in the absence of a certificate of insurance from subcontractors. Is it anticipated that subcontracted labor will be utilized during the policy term? If YES , estimate payrolls made to subcontractors without certificates of insurance. \$ _____ Transfer this amount to Section VI and identify by classification of work performed.	<input type="checkbox"/>	<input type="checkbox"/>
4.	Do you use independent contractors? If YES , you must maintain documentation which supports that they are, in fact, independent contractors. If such documentation is not available, or if the designated carrier finds evidence of an employment relationship, then premium may be charged as if the individuals were employees.	<input type="checkbox"/>	<input type="checkbox"/>

V. BUSINESS OF EMPLOYER (continued)

5. Completely describe all operations of the employer. If there are multiple locations, provide a description for each. Completely describe any changes that have taken place in the last three years that might affect the classification of the operation.

VI. MASSACHUSETTS CLASSIFICATIONS, PAYROLLS, AND PREMIUM CALCULATIONS

Attach the four most recently filed Form 941's or DET Form 1's.

Describe the Duties of the Employees by Location	Class Code	Number of Employees	Total Remuneration	Rate	Premium
Clerical, NOC	8810				
Outside Sales	8742				
Drivers, NOC	7380				
Employers Liability / /					
TOTAL PREMIUM					
* Experience Rating () or Merit Rating ()					
* Massachusetts Construction Credit ()					
* Loss Constant					
STANDARD PREMIUM					
** Deductible Credit ()					
* ARAP ()					
*** Insurance Charge (10%)					
Expense Constant					
TOTAL ESTIMATED ANNUAL PREMIUM					
DIA Assessment (%) of Standard Premium					
TOTAL EST. ANNUAL PREMIUM AND DIA ASSESSMENT					
DEPOSIT PREMIUM					

VII. DEPOSIT REQUIRED :

1. Installment Options

Estimated Premium	Installment Basis	Minimum Deposit	Additional Payments
Under \$5,000	Annually	100%	none
At least \$5,000	Semi-Annually	75%	one
At least \$10,000	Quarterly	50%	three
At least \$25,000	Monthly	25%	nine

2. Enclosed is check number _____ in the amount of \$ _____ .
Make the check payable to the **Massachusetts Workers' Compensation Assigned Risk Pool (or "MWCARP")**.
3. Any binding of coverage is conditional until the check has cleared. If the check is found to be non-negotiable, the check will be returned to the employer who will be given ten (10) days to provide the carrier with a bank check or money order for the full amount of the deposit premium. Only if sufficient funds are received by the carrier on a timely basis, will coverage be effective as of the tentative binding date on the Notice of Assignment issued by the Bureau.
4. Is the premium being financed? YES NO
If YES, then 100% of the Total Estimated Annual Premium and Massachusetts DIA Assessment must be sent with the application along with a signed copy of the finance agreement.

* If applicable.
 ** Refer to the MA Workers' Compensation & Employers' Liability Insurance Manual for details.
 *** Applies only to Former Self Insurers. Refer to www.wcribma.org for details.

VIII. APPLICANT'S AGREEMENT - PLEASE READ CAREFULLY

By signing this application, I certify that:

- (i) I am the employer or have been authorized by the employer to complete this application on its behalf;
- (ii) I have read and understand the following statements to which I agree by signing this application; and
- (iii) All information provided in this application is true.

In consideration of the issuance of a Notice of Assignment and subsequent policy of insurance, I hereby certify, under the pains and penalties of perjury, that:

- 1. I made a good faith effort, but failed to obtain coverage through the voluntary MA workers' compensation insurance market;
- 2. I am not knowingly in default of premium on any MA workers' compensation insurance policy;
- 3. I have complied and will continue to comply with all laws, orders, rules and regulations in force and effect relating to the welfare, health and safety of employees, including but not limited to:
 - a. Allowing the carrier to make a careful inspection of my operation for the purpose of measuring the hazards, making recommendations for the health and safety of employees, and determining the rate or rates which are adequate and reasonable;
 - b. Complying with the carriers' reasonable recommendations aimed at controlling or reducing the hazard(s) insured against;
 - c. Keeping records of information needed to compute premium and providing the carrier with copies of those records when asked for them; and
 - d. Fully cooperating with the carriers' attempts to conduct premium audits or inspections of the premises for loss control purposes.

I understand that the employer's compliance with each of these certifications is material to the issuance of Assigned Risk Pool coverage.



Business Name of Employer	Date	Signature and Title (Sole Proprietor, General Partner, Corporate Officer, Trustee or Member)

NOTICE:

This insurance is being provided through the MASSACHUSETTS WORKERS' COMPENSATION ASSIGNED RISK POOL, and not through the voluntary market. The employer's non-compliance with certifications 1, 2 and 3 (a - d) may, to the extent allowed by Massachusetts law, cause the carrier to initiate a mid-term cancellation.

FRAUD NOTICE:

Massachusetts General Law, Chapter 152, Section 14(3) provides:

"(A)ny person who knowingly makes any false or misleading statement, representation or submission or knowingly assists, abets, solicits or conspires in the making of any false or misleading statement, representation or submission, or knowingly conceals or fails to disclose knowledge of the occurrence of any event affecting the payment, coverage or other benefit for the purpose of obtaining or denying any payment, coverage or other benefit under this chapter; and any person or employer who knowingly misclassifies employees or engages in deceptive employee leasing practices for the purpose of avoiding full payment of insurance premiums ... shall be punished by imprisonment in the state prison for not more than five years or by imprisonment in jail for not less than six months nor more than two and one-half years or by a fine of not less than one thousand nor more than ten thousand dollars, or by both such fine and imprisonment."

IX. AGENCY INFORMATION AND PRODUCER'S STATEMENT

The producer hereby certifies, under the pains and penalties of perjury, that all information provided is true to the best of his/her knowledge and belief and that he/she made a good faith effort to place the coverage in the voluntary market as required by M.G.L., c. 152, Section 65A.

AGENCY

Name (Printed)	Agency Federal Identification Number

ADDRESS

Street	City	State	Zip Code	Telephone



PRODUCER

Name (Printed)	Signature	Date	Agency License Number

MASSACHUSETTS WORKERS' COMPENSATION ASSIGNED RISK POOL
ADDITIONAL INSTRUCTIONS
PLEASE READ CAREFULLY

1. Applications will not be accepted by FAX machine.
2. An additional or replacement entity cannot be endorsed onto an existing assigned risk policy as a named insured unless an application and check are submitted and coverage is assigned by the Bureau. Refer to www.wcribma.org for instructions.
3. The Pool is able to provide coverage only for MA employees. If an employer has operations in any state other than MA, or commences operations in such state after policy inception, application for coverage for those operations must be made to the appropriate Bureau or other agency administering the Residual Market in that state, if voluntary coverage is not available.
4. When a Pool policy has been cancelled twice by the insurer for nonpayment of premium, the employer will lose his payment plan, and payment in full of the remaining policy premium will be required as a condition of reinstatement.
5. When a Pool policy has been cancelled twice at the request of the employer, the producer of record or the finance company, the employer must reapply to the Pool for subsequent coverage after all outstanding balances have been paid.
6. Applications for joint ventures must include a copy of the joint venture agreement.
7. Payrolls and classifications are subject to review by Bureau Staff and may be changed.
8. The Waiver of Our Rights to Recover from Others Endorsement, WC000313, is available to employers who require the endorsement by contract. Refer to www.wcribma.org for details.
9. Agents are not agents of the MA Workers' Compensation Assigned Risk Pool and cannot issue Certificates of Insurance.
10. If you have any questions about the rules governing the MA Workers' Compensation Assigned Risk Pool, refer to the Bureau's website, www.wcribma.org. If additional information is required, contact the Workers' Compensation Rating & Inspection Bureau of MA at (617) 439-9030 or write to either P.O. Box 55005, Boston, MA 02205 or 101 Arch Street, Boston, MA 02110.