ACORD™ 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. FEDERAL EMPLOYER ID NUMBER	PHONE NO.
3. MAILING ADDRESS (INCLUDING ZIP CODE)	4. PRINCIPLE LOCATION	
5. OTHER MICHIGAN LOCATIONS	6. PAYROLL OFFICE ADDRESS	

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)

#	STREET, CITY, COUNTY, STATE, ZIP CODE	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 ABOVE NAMED INSURED. _____

STATE	CARRIER & POLICY NUMBER	ANNUAL PREMIUM	
	CO: POL #:		
	CO: POL #:		
	CO: POL #:		

	YES	NO
2. HAS THERE BEEN A NAME CHANGE DURING THE PAST FIVE YEARS ? IF YES, GIVE PREVIOUS NAME AND DATE OF CHANGE, AND COMPLETE AN ERM FORM. _____		
3. WAS THIS AN EXISTING BUSINESS PURCHASED BY THE INSURED ? 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 ? 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 ? IF YES, INDICATE EXPIRATION OR CANCELLATION DATE. _____		
6. ARE YOU IN DEBT TO ANY INSURANCE COMPANY FOR ANY UNPAID PREMIUM FOR WORKERS' COMPENSATION ? IF YES, EXPLAIN: _____		
7. IS THE EMPLOYER IN BANKRUPTCY ? 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	INC/EXC	OWNERSHIP %	DUTIES	REMUNERATION

IF ELIGIBLE PERSONS ARE EXCLUDED, IS THE APPROPRIATE EXCLUSION FORM ATTACHED ? YES ☐ NO ☐

IF NOT EXCLUDED, HAVE APPROPRIATE PAYROLLS FOR OFFICERS, PARTNERS, LLC MEMBERS, OR SPOUSE BEEN INCLUDED IN DETERMINING THE ESTIMATED ANNUAL PREMIUM? YES ☐ NO ☐

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.

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? YES ☐ NO ☐ IF YES, PROVIDE NAME AND ADDRESS OF LEASING COMPANY:
NAME: ADDRESS:

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.

			TOTAL PAYROLL BASIS		
DESCRIBE BY LOCATION THE DUTIES OF EMPLOYEES	CLASS CODE	NUMBER OF EMPLOYEES	TOTAL PAYROLL	RATE	PREMIUM

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	$

V. DEPOSIT PREMIUM

1. DEPOSIT REQUIRED:

UNDER $1,000	$	100%	THE BALANCE OF THE TOTAL ESTIMATED ANNUAL PREMIUM TO BE PAID ACCORDING TO A DEFERRED PAYMENT PLAN ESTABLISHED BY THE SERVICING CARRIER
$1,000 TO $2,500	$	50%	
OVER $2,500	$	25%	

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

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 ALL 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 (UNDER SIGNATURE) 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

_____
PHONE NUMBER

ADDRESS

_____
FAX NUMBER

PRODUCER _____
NAME (PLEASE PRINT) SIGNATURE DATE

AGENCY CONTACT PERSON
(IF OTHER THAN PRODUCER) _____ E-MAIL: _____

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