



Workers Compensation Fund

Application for Utah Workers' Compensation and Employers Liability Insurance

Please Print or Type

1 Business Name

Give Exact or Full Name	Years in Business
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2 Mailing Address

Street or P.O. Box			Business Telephone Number
City	State	Zip Code	Fax Number
E-mail Address of Workers Compensation Contact			

3 Payroll Record | Location (Payroll Audit)

Same as Mailing Address

Street or Location Description			Payroll Telephone Number
City	State	Zip Code	Name of Contact

4 Nature of Business | Description of Operations

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5 Ownership Information

Type of Ownership:	Federal Tax ID Number
<input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Joint Venture <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Association <input type="checkbox"/> Limited Partnership <input type="checkbox"/> Government <input type="checkbox"/> Other _____	

Note: A partnership or sole proprietorship may elect to include as an employee any partner of the partnership or the owner of the sole proprietorship. For premium computation purposes, the salary wage of partners or sole proprietors shall be 100% of the state average weekly wage. A corporation may elect not to include any director or officer of the corporation as an employee.

List Below Complete Information For: Sole Proprietor | Partners | Corporate Officers

Name (Last, First Middle Initial)	Title	% of Ownership	S.S.N.	Coverage Desired?	Principle Duties
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

6 PREVIOUS INSURANCE COVERAGE? Yes No If Yes, please provide information below for last three years

Policy Period from (MO/YR) to (MO/YR)	Insurance Company Name	Annual Premium	Experience Modifier	Claims Cost, Including Reserves

7 NAMES (INCLUDING DBA'S) AND STREET ADDRESSES OF ALL UTAH LOCATIONS Use additional page if necessary

Name	Street or Location	City	Zip Code

8 WORK CLASSIFICATIONS AND ESTIMATED PAYROLL BY LOCATION WCF Use Only

By Location, List Duties of Employees Including Covered Corporate Officers by Type of Work Performed. Do Not Include Earnings of Partners or Sole Proprietor.				Number of Employees	Estimated Total Annual Payroll	Class Codes	Rate	Estimated Premium
1								
2								
3								
4								

8 WORK CLASSIFICATIONS AND ESTIMATED PAYROLL BY LOCATION WCF USE ONLY

Employers Liability Insurance provides coverage against lawsuits brought by an Employee against the Employer for on-the-job injuries. Standard limits for the policy are: Bodily Injury by Accident (Each Accident) \$100,000 Bodily Injury by Disease (Policy Limit) \$500,000 Bodily Injury by Disease (Each Employee) \$100,000 If higher limits are desired, please contact the Underwriting Department for available options and costs.			Total Estimated Manual Premium	
			Increased Liability Limits	
			E-Mod Factor	
			Scheduled Credit / Debit Factor	
			Premium Size Discount	
			Estimated Annual Premium	
			Down Payment	
WCF USE ONLY				
Payment Plan	Underwriter			
Agency Name	Agency Code No.	Producer	Number Assigned	

8 WORK CLASSIFICATIONS AND ESTIMATED PAYROLL BY LOCATION

Questions	Y	N	Questions	Y	N
1 Does applicant own, operate or lease aircraft / watercraft?			10 Are athletic teams sponsored?		
2 Do / have past, present or discontinued operations involve(d) storing, treating, discharging, applying, disposing or transporting hazardous material?			11 Any prior coverage declined, cancelled or non-renewed with the last 3 years?		
3 Any work performed underground or above 15 feet?			12 Are employee health plans provided?		
4 Is applicant engaged in any other type of business?			13 Is there a labor interchange with any other business / subsidiary?		
5 Are sub-contractors used? If yes, give percentage of work sub-contracted/			14 Do you lease employees to or from other employers?		
6 Any work sublet without certificates of insurance?			15 Do any employees predominantly work at home?		
7 Is a written safety program in operation?			16 Any tax liens or bankruptcy within the last 5 years?		
8 Any group transportation provided?			17 Any undisputed and unpaid workers compensation premium due from you or any commonly managed or owned enterprises? If yes, explain including entity name(s) and policy number(s).		
9 Do employees travel out-of-state?					

9 REMARKS

10 INDIVIDUAL TO CONTACT IF ADDITIONAL INFORMATION IS NEEDED

Name	Telephone Number	
<p>It is agreed that contractors and sub-contractors engaged by the applicant who cannot provide a Certificate of Workers Compensation Insurance substantiating an active workers compensation policy shall be included in the applicant's payroll and premium paid by the applicant.</p> <p>Upon receipt of the completed and signed application, the Workers Compensation Fund will provide the applicant with a proposal showing the classifications, rates and deposit required. In order to initiate coverage, applicant must return one copy of the proposal with the required payment to the Workers Compensation Fund.</p> <p>Coverage will be effective at 12:01 am on the date following receipt of one copy of the signed proposal and required payment by Workers Compensation Fund.</p>		
Print or Type Name and Title of Owner, Partner or Corporate Officer	Signature of Owner, Partner or Corporate Officer	Date

Please return a completed signed application to:

Workers Compensation Fund
P.O. Box 57929
Salt Lake City, Utah 84157-0929

If you have any questions, please call 801.288.8020

Fax: 801.288.8166

Email: applications@wcfgroup.com

For your protection, Utah law requires the following to appear on this form:
Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in the state prison.

**To Avoid Having Your Application Returned,
Please Note the Following Suggestions:**

ITEM 4

If you put a post office box as your mailing address, be sure to write down **street addresses** for all Utah locations. List all company names (doing business as or DBA).

ITEM 5

List your **Federal Tax ID Number**. A sole proprietor may use his/her social security number.

ITEM 5

List all **officers** and **social security numbers**, and indicate yes or no in the coverage-desired column.

ITEM 6

If you've had insurance coverage for your company before, fill in the requested information (policy period, company, premium, experience modifier, claims costs and reserves).

ITEM 9

This section will be filled in by **Workers Compensation Fund**.

COMPLETE ENTIRE FORM

Fill in all three (3) pages of the form and make certain that only the owner, a partner, LLC member, or an officer in the company signs it.

Underwriting Department

Telephone 801.288.8020 | Fax 801.288.8166

www.wcfgroup.com

(please do not return this page)