WISCONSIN WORKER'S COMPENSATION INSURANCE POOL

APPLICATION MUST BE PRINTED IN INK OR TYPED AND SIGNED BY APPLICANT AND PRODUCER.

MAIL TO:
WISCONSIN WORKER'S COMPENSATION INSURANCE POOL
P.O. BOX 3080
MILWAUKEE, WI 53201-3080
(262) 796-4592

DELIVER TO:
20700 SWENSON DRIVE
SUITE 100
WAUKESHA, WI 53186

ALL QUESTIONS MUST BE COMPLETED, OR INDICATED IF "NOT APPLICABLE".

FOR BUREAU USE ONLY

FILE #:

CARRIER:

EFF DATE:

THE UNDERSIGNED EMPLOYER IS UNABLE TO PURCHASE WORKER'S COMPENSATION AND EMPLOYER'S LIABILITY INSURANCE FOR LIABILITY UNDER THE WISCONSIN WORKER'S COMPENSATION LAW AND HEREBY APPLIES FOR THE DESIGNATION OF AN INSURANCE COMPANY TO PROVIDE INSURANCE IN ACCORDANCE WITH THE WISCONSIN WORKER'S COMPENSATION INSURANCE POOL.

1. APPLICANT NAME (ENTER COMPLETE LEGAL NAME OF EMPLOYER)	2. MAILING ADDRESS (INCLUDING ZIP CODE)	FEIN
	c/o iLIFE, LLC Fiscal Agent 6100 N. Baker Road Glendale, WI 53209	
TELEPHONE # (INCLUDING AREA CODE) (414) 431-7421	3. LEGAL STATUS [X] INDIVIDUAL [ ] LIMITED LIABILITY CO [ ] PARTNERSHIP [ ] OTHER: [ ] CORPORATION	4. REQUESTED EFFECTIVE DATE (MM/DD/YY)
FAX # (INCLUDING AREA CODE) (414) 918-4463		DATE BUSINESS BEGAN (MM/DD/YY)

NOTE: THE EFFECTIVE DATE OF INSURANCE IS GOVERNED BY THE RULES OF THE WISCONSIN WORKER'S COMPENSATION POOL. APPLICATIONS SHOULD BE SUBMITTED AT LEAST 15 DAYS PRIOR TO THE REQUESTED EFFECTIVE DATE.

5. LOCATIONS OF ALL WISCONSIN WORK PLACES (Show principal location first)

#	STREET, CITY, COUNTY, STATE, ZIP CODE
1	
2	
3	

PAYROLL OFFICE ADDRESS (STREET, CITY, STATE & ZIP)	CONTACT PERSON AND TELEPHONE # (INCLUDING AREA CODE)
2020 W. Wells St. Milwaukee, WI 53233	Cindy Cichosz (414) 431-7421

6. NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS

7. SUPPLEMENTAL INFORMATION

EXPLAIN ALL "YES" RESPONSES IN REMARKS	YES	NO
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT/WATERCRAFT?		X
2. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?		X
3. ANY WORK SUBLET WITHOUT CERTIFICATES OF INSURANCE?		X
4. IS A FORMAL SAFETY PROGRAM IN OPERATION?		X
5. DO YOU EMPLOY DRIVERS?		X
6. DO EMPLOYEES TRAVEL OUT OF STATE?		X
7. ARE ATHLETIC TEAMS SPONSORED?		X
8. ARE EMPLOYEE HEALTH PLANS PROVIDED?		X
9. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS/SUBSIDIARY?		X
10. ARE YOU IN CHAPTER 11 BANKRUPTCY?		X
11. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?		X

EXPLAIN ALL "YES" RESPONSES	YES	NO
12. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME?		X
13. HAS THERE BEEN A NAME CHANGE, CONSOLIDATION, MERGER OR OWNERSHIP CHANGE DURING THE PAST THREE YEARS? IF YES, GIVE PREVIOUS NAME AND DATE OF CHANGE. CONTACT POOL ABOUT AN ERM-14.		X
14. ARE THERE OPERATIONS IN STATES OTHER THAN WISCONSIN? IF YES, COMPLETE THE FOLLOWING AS THE POLICY CANNOT PROVIDE COVERAGE IN THOSE STATES. (IF SELF-INSURED OR UNINSURED, INDICATE UNDER INSURANCE CARRIER.) STATE: LOCATION: INS CARRIER:		X

8. INSURANCE RECORD

1. HAS THERE BEEN PREVIOUS WORKER'S COMPENSATION INSURANCE COVERAGE IN WISCONSIN? [ ] YES [X] NO
IF NO, COMPLETE: [X] NEW BUSINESS [ ] SELF-INSURED [ ] OTHER (EXPLAIN):

2. INSURANCE RECORDS -- THREE PREVIOUS YEARS:

INSURANCE COMPANY	POLICY PERIOD FROM	TO	POLICY NUMBER

9. CORPORATE OFFICERS, SOLE PROPRIETORS, PARTNERS, OR MEMBERS OF A LIMITED LIABILITY COMPANY

LIST BELOW THE NAME, TITLE, DUTIES AND APPROXIMATE ANNUAL SALARY OF ALL CORPORATE OFFICERS AND INDICATE WHICH TWO OFFICERS, IF ANY, REJECT COVERAGE. OR, LIST BELOW THE NAME, TITLE, PERCENT OF OWNERSHIP, APPLICABLE CODE, REMUNERATION AND DUTIES, OF ALL SOLE PROPRIETORS, PARTNERS, AND MEMBERS OF A LIMITED LIABILITY COMPANY, AND INDICATE WHICH ELECT COVERAGE. **IMPORTANT: PLEASE ATTACH SIGNED "NON-ELECTION" OR "ELECTION" FORMS TO THIS APPLICATION.**

SOLE PROPRIETORS, PARTNERS AND OFFICERS TO BE INCLUDED OR EXCLUDED. (Remuneration to be included must be part of rating information section.)

#	NAME	TITLE/ RELATIONSHIP	OWNER-SHIP %	DUTIES	INC/EXC	CLASS CODE	REMUNERATION

10. RATING INFORMATION SECTION

CODE #	CLASSIFICATION PHRASEOLOGY	# OF EMPLOYEES	ESTIMATE TOTAL ANNUAL PAYROLL*	RATE	ESTIMATE ANNUAL PREMIUM
0913	Domestic Worker - Full Time			$422.00	
0908	Domestic Worker - Part Time			$253.00	

DEPOSIT PREMIUM IS DETERMINED BY TAKING A PERCENTAGE OF THE ESTIMATED ANNUAL PREMIUM. THE PERCENTAGE VARIES WITH THE AMOUNT OF THE ESTIMATED ANNUAL PREMIUM. HERE IS HOW IT WORKS:

ESTIMATED ANNUAL PREMIUM	PAYMENT BASIS	MINIMUM DEPOSIT PERCENTAGE	ADDITIONAL PAY-MENTS DURING THE YEAR
UNDER $2,000	ANNUAL	100% OF ANNUAL	NONE
AT LEAST $2,001 - $5,000	BALANCE DUE IN 90 DAYS OF INCEPTION DATE	50% OF ANNUAL	ONE
AT LEAST $5,001 - $10,000	QUARTERLY	50% OF ANNUAL	TWO
AT LEAST $10,001	MONTHLY	25% OF ANNUAL	NINE

PREMIUM SUB TOTAL	
INCREASED LIMITS	
EXPERIENCE MOD	
WCPAP CREDIT	
TOTAL MODIFIED PREMIUM	
TERRORISM	
CATASTROPHE	
EXPENSE CONSTANT	$220.00
ESTIMATED ANNUAL PREMIUM	
DEPOSIT PREMIUM	

ANNIVERSARY RATING DATE	MINIMUM PREMIUM	INTERSTATE RISK ID #
	$	

WHEN SUBMITTING ANY APPLICATION, ATTACH PAYROLL VERIFICATION SUCH AS FEDERAL EMPLOYER FORMS 940, 941, 941-E, OR 943. IF NEW EMPLOYER, ATTACH A NOTARIZED LETTER STATING NO PAYROLL IN THE PAST.

11. PREMIUM PAYMENT REQUIREMENTS

1. COVERAGE WILL NOT BE BOUND UNTIL PAYMENT OF APPROPRIATE DEPOSIT PREMIUM IS RECEIVED. PAYMENT TO THE WISCONSIN COMPENSATION RATING BUREAU MUST BE IN THE FORM OF CERTIFIED CHECK, CASHIERS CHECK, MONEY ORDER, CHECK OF THE PRODUCER OF RECORD, OR A CHECK FROM THE PREMIUM FINANCE COMPANY. NO APPLICANT CHECK.
2. IS THIS PREMIUM FINANCED? IF YES, INCLUDE ENTIRE FINANCED AMOUNT WITH APPLICATION AND ATTACH A SIGNED COPY OF FINANCE AGREEMENT.

12. SPECIAL NEEDS

* SPECIAL NEEDS: ARE ANY OF THE FOLLOWING REQUIRED?	YES	NO		YES	NO
1. OTHER STATES COVERAGE (ATTACH COMPLETED QUESTIONNAIRE)		X	3. CERTIFICATE OF INSURANCE (PLEASE ATTACH LIST)		X
2. INCREASED LIMITS OF LIABILITY. IF SO, PLEASE INDICATE LIMITS.		X	4. U.S.L. & H.		X

13. APPLICANT'S STATEMENT

THE UNDERSIGNED EMPLOYER HEREBY CERTIFIES THAT THE STATEMENTS IN THIS APPLICATION HAVE BEEN READ AND UNDERSTOOD. FURTHERMORE, IN CONSIDERATION OF THE ISSUANCE OF THE POLICY OF INSURANCE, THE UNDERSIGNED ALSO CERTIFIES THAT THE STATEMENTS IN THIS APPLICATION ARE TRUE AND AGREES:

1. TO MAINTAIN A COMPLETE RECORD OF ALL PAYROLL TRANSACTIONS IN SUCH FORM AS THE INSURANCE COMPANY MAY REASONABLY REQUIRE AND THAT SUCH RECORD WILL BE AVAILABLE TO THE COMPANY AT THE DESIGNATED ADDRESS.
2. TO COMPLY SUBSTANTIALLY WITH ALL LAWS, ORDERS, RULES, AND REGULATIONS IN FORCE AND EFFECT MADE BY THE PUBLIC AUTHORITIES AND WITH ALL REASONABLE RECOMMENDATIONS MADE BY THE INSURANCE COMPANY RELATING TO THE WELFARE, HEALTH, AND SAFETY OF EMPLOYEES.
3. TO THE BEST OF MY KNOWLEDGE AND BELIEF ALL STATEMENTS CONTAINED IN THIS APPLICATION ARE TRUE.
4. I HEREBY AGREE TO PAY ALL PREMIUMS WHEN DUE.
5. I DESIGNATE AS PRODUCER OF RECORD THE PRODUCER NAMED IN THIS APPLICATION AND I UNDERSTAND THIS PERSON IS NOT ACTING AS AN AGENT OF THE SERVICING CARRIER FOR THE PURPOSES OF THIS INSURANCE.

(VIOLATION OF ANY OF THESE AGREEMENTS MAY RESULT IN TERMINATION OF ANY POLICY OR INSURANCE ISSUED)

HCSR

BUSINESS NAME OF APPLICANT | SIGNATURE | TITLE | DATE OF APPLICATION

14. STATEMENT OF LICENSED AGENT OR PRODUCER OF RECORD

I, _____ , DO HEREBY CERTIFY AS FOLLOWS:

(1) I AM A LICENSED INTERMEDIARY AGENT OF THE STATE OF WISCONSIN, OR HAVE A NON-RESIDENT LICENSE FOR THE STATE OF WISCONSIN. **(ATTACH COPY OF NON RESIDENT LICENSE).**

(2) I HAVE READ THE WISCONSIN WORKER'S COMPENSATION INSURANCE POOL RULES, HAVE EXPLAINED THE PROVISIONS TO THE APPLICANT, AND HAVE INCLUDED IN THIS APPLICATION ALL REQUIRED INFORMATION GIVEN TO ME BY THE APPLICANT. IN THE EVENT THE POLICY IS TERMINATED OR A CHANGE IS MADE RESULTING IN A RETURN PREMIUM TO THE INSURED, I AGREE TO RETURN THE UNEARNED COMMISSION WITHIN TEN DAYS.

THE PRODUCER DOES NOT REPRESENT THE SERVICING CARRIER NOR THE POOL, IN ANY WAY, AND HAS NO AUTHORITY TO BIND, CHANGE, ALTER OR TERMINATE COVERAGE.

AGENT/AGENCY NAME & MAILING ADDRESS	TELEPHONE # (INCLUDING AREA CODE)	FAX # (INCLUDING AREA CODE)	FEIN/SOC SECURITY #
	SIGNATURE OF PRODUCER		PRODUCER WISCONSIN LICENSE #