pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
STATE WORKERS' INSURANCE FUND

Application For Workers' Compensation Insurance Coverage

Clear All Fields

Print this Application

INSTRUCTIONS:

- Answer **all** questions completely and correctly. Please type or print.
- **Sign** the application, as indicated in Item 18.
- If represented by a **Broker/Agent**, complete Item 19.
- Mark "N/A" when not applicable.
- Return the completed application to: **State Workers' Insurance Fund, 100 Lackawanna Avenue, P.O. Box 5100, Scranton, PA 18505-5100, telephone 570-963-4635, fax 570-941-2109**.
- Coverage will become effective as of the date set forth on the Policy of Insurance.

1. Business Name _____

   Mailing Address _____
   (IF R.D., R.R., OR P.O. BOX, LIST GEOGRAPHICAL LOCATION: INCLUDE SUITE, FLOOR OR APT. NO., IF APPLICABLE)

   PA Primary Operating Location _____
   (ATTACH LIST WITH ADDRESSES OF ALL PA OPERATING LOCATIONS)

   County _____

   Telephone No. you can be reached at during the day _____ _____ _____
   AREA CODE

   Business Fax No. _____ E-Mail _____

2. Federal ID No. _____

   a. If new, date applied for _____

   b. List the names and Federal identification numbers of additional businesses owned and operated to be **included** in this policy.

   _____ _____
   NAME FED. ID NO.

   _____ _____
   NAME FED. ID NO.

   c. If multiple insureds are to appear on one policy, please submit Form ERM-14 to identify each business.

3. a. Are you a: ☐ Leasing Company ☐ Temporary Agency ☐ Both ☐ N/A

   b. Type of Business: ☐ Individual If Individual, S.S. No. _____

   ☐ Corporation ☐ Partnership ☐ Non-profit ☐ Other _____

4. Corporate Entity Only: a. Date articles filed _____ b. State _____

5. Are you currently in the process of liquidation or termination of this business? ☐ Yes ☐ No

   If yes, explain

6. Has the business ever filed for bankruptcy? ☐ Yes ☐ No If yes, date filed _____

   Is the business currently in bankruptcy? ☐ Yes ☐ No If yes, **YOU MUST** enclose a copy of the petition as filed in bankruptcy court, including all attachments.

7. Audit Information (Address where payroll records are kept):

   a. Contact Person _____

   b. Telephone No. _____ _____ _____
   AREA CODE

   c. Audit Address _____
   (IF R.D., R.R., OR P.O. BOX, LIST GEOGRAPHICAL LOCATION: INCLUDE SUITE, FLOOR OR APT. NO., IF APPLICABLE)

   d. County _____

8. Have you had previous workers' compensation insurance coverage in Pennsylvania? ☐ Yes ☐ No
   If yes, answer the following completely:

   a. Business Name _____

   b. Carrier Name _____

   c. Policy No. _____

   d. Date Cancelled/Expired _____

   e. Anniversary Date _____

   f. Premium _____

   g. Carrier information for the previous three (3) years: (**NOTE: IF YOUR PREMIUM IS IN EXCESS OF $50,000.00, FIVE YEARS DETAILED LOSS HISTORY MUST BE ATTACHED.**)

   CARRIER _____ POLICY NO. _____ PERIOD _____ PREMIUM _____

   CARRIER _____ POLICY NO. _____ PERIOD _____ PREMIUM _____

   CARRIER _____ POLICY NO. _____ PERIOD _____ PREMIUM _____

   h. Pennsylvania Compensation Rating Bureau No. _____

   i. Experience Modification _____

   j. Experience Modification Effective Date _____

9. Have you ever been cancelled? ☐ Yes ☐ No If yes, explain

10. Please provide a **COMPLETE, DETAILED** job description of all work performed in Pennsylvania, including the job duties of the corporate officers and/or owners. (Attach an additional sheet, if necessary.)

11. Do you use privately-owned or leased aircraft in the operation of the business? ☐ Yes ☐ No

    If yes, total number of seats for all aircraft _____

12. Do you utilize the services of subcontractors, owner-operators, and/or independent contractors in the operation of your business? ☐ Yes ☐ No

    If yes, please provide Certificates of Insurance evidencing the fact that there is workers' compensation insurance in place for those workers. If no insurance certificate is available, questionnaires must be completed and submitted before any workers' compensation insurance policy can be issued. The State Workers' Insurance Fund reserves the right to make a determination on the employment status of these individuals and may decide to include them as employees for workers' compensation purposes. If you are an employer who utilizes sole proprietor(s) and the sole proprietor(s) does not have workers'

compensation insurance coverage of their own, you will be considered as the sole proprietor(s)' employer and charged accordingly as to the operations performed when the State Workers' Insurance Fun completes an audit of your policy, unless there is definitive evidence that the sole proprietor(s) is an independent contractor. Workers' compensation coverage for sole proprietor(s) is available through the State Workers' Insurance Fund.

13. Corporate Officer/Names of Partners: (**NOTE:** An Executive Officer of a corporation, if eligible, may elect to be exempt from the Pennsylvania Workers' Compensation Act. All Corporate Officer Exemption Requests should be directed to the State Workers' Insurance Fund. Otherwise all payroll for covered officers must be included in Item 14 below. This section MUST BE completed in its entirety or your application may not be accepted. If you are a sole proprietor, you must check either Yes or No to indicate whether you are requesting coverage as a sole proprietor.

TITLE	FIRST NAME	M	LAST NAME	S. S. NO.	ACTIVE (Y/N)	COVERED (Y/N)	% OF OWNERSHIP OR STOCK	CLASS CODE

14.

DESCRIBE KIND OF TRADE, BUSINESS, PROFESSION CONDUCTED IN PA	ENTER ESTIMATED AVERAGE NUMBER OF EMPLOYEES, INCLUDE EXECUTIVE OFFICERS	ENTER ESTIMATED PAYROLL FOR 12-MONTH POLICY PERIOD INCLUDING PAYROLL OF EXECUTIVE OFFICERS	RATES FOR $100 OF REMUNERATION	PREMIUM

Rates may be found on our Web site at www.dli.state.pa.us, Keyword: swif

15. If any employee is estimated to earn less than $10,000 annually, please provide an explanation.

16. Payment Terms

a. All policies less than $2,000 – TOTAL PAYMENT REQUIRED.

b. All policies $2,000 to $10,000 – 25% OF TOTAL PREMIUM, OR MINIMUM PREMIUM, WHICHEVER IS GREATER, with the remaining balance due in four (4) equal installments.

c. All policies over $10,000 – 25% OF TOTAL PREMIUM, OR MINIMUM PREMIUM, WHICHEVER IS GREATER, with the remaining balance due in ten (10) equal installments.

Requested inception date of coverage: _____

NOTE: ALL INCOMPLETE APPLICATIONS OR THOSE WITHOUT THE PROPER REMITTANCE WILL BE RETURNED WITHOUT COVERAGE IN FORCE. PLEASE REVIEW FOR COMPLETENESS BEFORE YOU SUBMIT.

17. Contract Conditions

a. Coverage will become effective at 12:01 AM on the day specified on the workers' compensation policy issued by SWIF. Said policy will be issued within 30 days of the submission of a completed application.

In order for an application to be deemed complete and acceptable for review and coverage, the SWIF must receive a complete and properly signed application and the specified premium due.

b. The application, including any subcontractor information elicited at Item 12 of the application, must be properly and fully completed and signed by an owner, or partner, or a corporate officer.

c. The premium quoted is based upon the nature of the operations and the estimated payroll disclosed by the employer in this application. The employer shall furnish the State Workers' Insurance Fund with proper notice of any changes in the nature of its operations or its estimated payroll; such changes may result in an increase or decrease in the premium due under this policy. The employer agrees to keep an accurate record of employees and payroll expenditures, and to report injuries and occupational diseases to the State Workers' Insurance Fund immediately.

d. SWIF requires the disclosure of accurate and legitimate payroll records. Such payroll records must include, but are not limited to, a list of each employee's social security number or I-9 forms. The determination of proper premium payments is dependent upon the accuracy of such records. Any failure to provide accurate and legitimate payroll records, at any time, will be considered a material breach entitling SWIF to either rescind the contract to insure, refuse to insure, or cancel the policy.

e. The State Workers' Insurance Fund may conduct underwriting visits and/or audits during regular business hours during the policy period and within three (3) years after the policy ends. Information developed by the underwriting visit or audit will be used to determine the estimated or final premium. If it is determined that additional premium is due, you will be billed accordingly.

f. Employees hired in and working in another state cannot be covered by the Pennsylvania State Workers' Insurance Fund.

VERY IMPORTANT NOTICE

ALL INFORMATION SUPPLIED BY THE APPLICANT IS SUBJECT T

VERIFICATION PURSUANT TO 77 P.S. §2615 AND 77 P.S. §2616.

THE APPLICATION MUST BE SIGNED BY AN OWNER, A PARTNER OR A CORPORATE OFFICER AND RETURNED WITH YOUR CHECK.

I verify that this information is true and correct based upon my knowledge, information and belief. I understand that if the information I have provided on the application is false, incomplete or misleading, I may have violated 77 P.S. §1039.2, pertaining to workers' compensation fraud, and be subject to the penalties set forth at 77 P.S. §1039.5 and 77 P.S. §1039.6. I also understand that if I have made any false statements on this application, I may have violated 18 Pa. C.S.A. 4117, pertaining to unsworn falsification to authorities, which is a misdemeanor of the second degree.

18. _____ _____ _____
SIGNATURE TITLE DATE

Print Name of Signature _____

19. **BROKER OF RECORD LETTER:** The following Broker / Agent has been designated as the "official broker of record". (The following information must be completed and signed by both the Broker / Agent and the Insured.) No additional Broker of Record Letter is required.

Kelly Insurance Group, Inc.
BROKER/AGENT NAME OR INSURANCE AGENCY NAME

700 River Avenue Suite 433, Pittsburgh, PA 15212 (412) 325-1650
ADDRESS TELEPHONE NO.

_____ _____
SIGNATURE OF BROKER/AGENT SIGNATURE OF INSURED (OWNER, PARTNER, OR CORPORATE OFFICER)

(412) 325-1657 jonathan@kellyinsurancegroup.com
BUSINESS FAX NO. E-MAIL

20. **FISCAL AGENCY AND ADDRESS:** _____

_____
ADDRESS

_____ _____
TELEPHONE NO. FAX NO.

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program