



6 PREVIOUS INSURANCE COVERAGE? NO YES (IF YES, PROVIDE INFORMATION BELOW FOR LAST 3 YEARS)				
POLICY PERIOD FROM (MO/YR) TO (MO/YR)	INSURANCE COMPANY NAME	ANNUAL PREMIUM	EXPERIENCE MODIFIER	CLAIMS COST, INCLUDING RESERVES

7 NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS

8 WORK CLASSIFICATIONS AND ESTIMATED ANNUAL PAYROLL			WCF USE ONLY		
LIST DUTIES OF EMPLOYEES BY TYPE OF WORK PERFORMED, INCLUDING PAYROLL OF COVERED CORPORATE OFFICERS. DO NOT INCLUDE EARNINGS OF PARTNERS OR SOLE PROPRIETOR.	NO. OF EMPLOYEES	ESTIMATED TOTAL ANNUAL PAYROLL	CLASS CODES	RATE	ESTIMATED PREMIUM

9 EMPLOYERS LIABILITY INSURANCE		WCF USE ONLY	
<p>EMPLOYERS LIABILITY INSURANCE PROVIDES COVERAGE AGAINST LAWSUITS BROUGHT BY AN EMPLOYEE AGAINST THE EMPLOYER FOR ON-THE-JOB INJURIES.</p> <p>STANDARD LIMITS FOR THE POLICY ARE:</p> <p>BODILY INJURY BY ACCIDENT (EACH ACCIDENT) \$100,000            BODILY INJURY BY DISEASE (POLICY LIMIT) \$500,000            BODILY INJURY BY DISEASE (EACH EMPLOYEE) \$100,000</p> <p>IF HIGHER LIMITS ARE DESIRED, PLEASE CONTACT THE UNDERWRITING DEPARTMENT FOR AVAILABLE OPTIONS AND COSTS.</p>		<p>TOTAL ESTIMATED MANUAL PREMIUM</p> <p>INCREASED LIABILITY LIMITS</p> <p>EMOD FACTOR OF:</p> <p>SRA FACTOR OF:</p> <p>SCHEDULED CREDIT/DEBIT FACTOR OF:</p> <p>PREMIUM SIZE DISCOUNT</p> <p>ESTIMATED ANNUAL PREMIUM</p>	
<p>_____ PAYMENT PLAN</p> <p>_____ UNDERWRITER</p>		<p>DOWN PAYMENT</p> <p>EFFECTIVE DATE:</p> <p>NUMBER ASSIGNED:</p>	
<p>AGENCY NAME _____</p> <p>AGENCY CODE NO. _____</p> <p>PRODUCER _____</p>		<p>_____</p> <p>_____</p>	

**10 GENERAL INFORMATION (EXPLAIN YES ANSWERS)**

	NO	YES	EXPLANATION
DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT?			
IS APPLICANT ENGAGED IN ANY OTHER BUSINESS?			
HAS APPLICANT BEEN INSURED WITH WCF UNDER ANY OTHER BUSINESS NAMES?			
ARE SUBCONTRACTORS USED?			
IS ANY WORK SUBLET WITHOUT OBTAINING CERTIFICATES OF INSURANCE?			
IS A FORMAL SAFETY PROGRAM IN OPERATION?			
DO EMPLOYEES TRAVEL OUT OF STATE ON BUSINESS?			
DOES APPLICANT HAVE EMPLOYEES PERMANENTLY LOCATED IN OTHER STATES?			
ARE PRE-EMPLOYMENT PHYSICALS REQUIRED?			
HAS YOUR WORKERS COMPENSATION INSURANCE BEEN CANCELLED OR NON-RENEWED WITHIN LAST THREE YEARS?			
IS APPLICANT CURRENTLY IN BANKRUPTCY?			

INDIVIDUAL TO CONTACT IF ADDITIONAL INFORMATION IS NEEDED

NAME \_\_\_\_\_ PHONE NO. \_\_\_\_\_

It is agreed that contractors, subcontractors and contract labor 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.

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.

Coverage will be effective at 12:01 a.m. on the date following receipt of one copy of the signed proposal and required payment by Workers Compensation Fund.

\_\_\_\_\_  
Print or type name and title of Owner, Partner or Corporate Officer

\_\_\_\_\_  
Signature of Owner, Partner or Corporate Officer

\_\_\_\_\_  
Date

Please return completed and signed application to:

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

If you have any questions, please call 801-288-8020

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.