



DEPARTMENT OF  
**LABOR & INDUSTRY**  
COMMONWEALTH OF PENNSYLVANIA

STATE WORKERS' INSURANCE FUND  
100 LACKAWANNA AVENUE, P.O. BOX 5100  
SCRANTON, PA 18505-5100

570-963-4630



www.dli.state.pa.us

## APPLICATION FOR WORKERS' COMPENSATION COVERAGE

### INSTRUCTIONS:

You must answer **all** questions completely and correctly. Please type or print.

**Sign** the application as indicated in Item 18.

If represented by a **Broker/Agent**, you must complete Item 19.

(Mark N/A when not applicable.)

Return application and premium in the amount of \$ \_\_\_\_\_

**MAKE CHECK PAYABLE TO "STATE WORKERS' INSURANCE FUND".**

1. Business Name \_\_\_\_\_

Mailing Address \_\_\_\_\_  
(IF R.D. OR P.O. BOX, ALSO LIST ACTUAL GEOGRAPHICAL LOCATION)

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

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 an ERM-14 to identify ownership of 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 article 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 firm 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 \_\_\_\_\_  
(SHOW SPECIFIC LOCATION IF R.D. OR P.O. BOX IS USED.)

d. County \_\_\_\_\_

8. Have you had previous workers' compensation 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 years: **(NOTE: IF YOUR PREMIUM IS IN EXCESS OF \$50,000.00, FIVE YEARS DETAILED LOSS HISTORY MUST BE ATTACHED.)**

Carrier \_\_\_\_\_ Carrier \_\_\_\_\_ Carrier \_\_\_\_\_

Policy No. \_\_\_\_\_ Policy No. \_\_\_\_\_ Policy No. \_\_\_\_\_

Period \_\_\_\_\_ Period \_\_\_\_\_ Period \_\_\_\_\_

Premium \$ \_\_\_\_\_ Premium \$ \_\_\_\_\_ 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 employ subcontractors, owner-operators, and/or independent contractors?  Yes  No  
**IF YES, CERTIFICATES OF WORKERS' COMPENSATION INSURANCE MUST BE ATTACHED.**

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 exemption requests should be directed to the Pennsylvania Bureau of Workers' Compensation at 1-800-482-2383. Otherwise all payroll for covered officers must be included in Item 14 below.

Title	First Name	MI	Last Name	S. S. No.	Active (Y/N)	Covered (Y/N)	% of Ownership or Stock

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 Per \$100 of Remuneration	Premium

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: \_\_\_\_\_

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

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

A. COVERAGE WILL BECOME EFFECTIVE AT 12:01 AM THE DAY FOLLOWING ACCEPTANCE OF THE PROPERLY SIGNED APPLICATION AND RECEIPT OF THE SPECIFIED PREMIUM IN OUR OFFICE, UNLESS A LATER DATE IS REQUESTED IN ITEM 17. SIGNING OF THIS APPLICATION WARRANTS THAT ALL OF THE ABOVE QUESTIONS HAVE BEEN COMPLETELY ANSWERED AND HAVE NOT BEEN WILLFULLY MISREPRESENTED IN ORDER TO OBTAIN INSURANCE WITH THE PENNSYLVANIA STATE WORKERS' INSURANCE FUND.

