## MINNESOTA WORKERS' COMPENSATION ASSIGNED RISK PLAN

# APPLICATION FOR WORKERS' COMPENSATION INSURANCE

COVERAGE IS DESIRED*

Effective _____
Date

Send to: Minnesota Workers' Compensation Insurers Assn., Inc.
7701 France Avenue South, Suite 450
Minneapolis, Minnesota 55435-3203
(952) 897-1737

Employer Email Address: _____

**COVERAGE CANNOT BE BOUND BY ANY AGENT.**

SEE RULES AND PROCEDURES ON LAST PAGE

Enclose check payable to Minnesota Workers' Compensation Assigned Risk Plan. Payment must be made by **certified check, bank draft, money order, finance check, EMPLOYERS CHECK or agency check.** Coverage **will not** be provided if the correct payment or deposit premium does not accompany the application; if Sections I and IV are not fully completed; if the declination requirement is not met; if the application is not signed by applicant and agent; if there is a record of coverage in force in the Association file; or if it is found that the employer applying for coverage owes money to the Assigned Risk Plan for previous coverage or has failed to comply with the audit conditions of any previous policy.

*Coverage will become effective (1) 12:01 a.m. the day after the postmark date on the envelope containing the application and deposit premium; or (2) 12:01 a.m. the day after receipt of the application and deposit premium if not postmarked or if made by personal delivery; or (3) 12:01 a.m. on any future date requested.

The undersigned employer hereby applies for workers' compensation insurance in Minnesota and expressly represents that such insurance is sought in good faith.

## I. GENERAL INFORMATION

**Coverage will not be provided if this section is not completed.**

1. Legal Status: ☐ Sole Proprietor ☐ Partnership ☐ Corporation ☐ Limited Liability Co. ☐ Non-Profit Organization
☐ Professional Association ☐ Closely Held Corporation ☐ Trust ☐ Other _____

2. _____
Name of Employer (Legal Name Including D.B.A.s)

3a. _____ 3b. _____
Federal Employer ID # (FEIN 9-digit number) Unemployment Account No. (UI Code)

4a. _____ 4b. _____
Additional Employer Name (optional) Federal Employer ID # (FEIN for additional employer name)

_____ _____
Additional Employer Name (optional) Federal Employer ID # (FEIN for additional employer name)

5. _____
Mailing Address (Street) (City) (ZIP) (Phone)

6. _____
Principle Location (Street) (City) (ZIP)

7. _____
Payroll Office Address (Street) (City) (ZIP)

8. _____
Other Minnesota Location (Street) (City) (ZIP)

## II. BUSINESS INFORMATION

1. Board of Directors, Corporate Officers, General Partners, Sole Proprietors

| Name | Title | Duties | SSN | Percent of Ownership | Approximate Annual Salary |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## III. INSURANCE RECORD

1. Has there been previous workers' compensation insurance coverage in Minnesota? ☐ Yes ☐ No

Explain: _____

2. Has there been a name change or change in ownership during the past three years? ☐ Yes ☐ No

Did you purchase the business, or any part of it, from someone else? ☐ Yes ☐ No

If you answered "yes" to either of the above, give previous name, ownership and date of change/purchase.

| Previous Name | Ownership | Date of change/purchase |
|---|---|---|
| | | |

3. Minnesota Workers' Compensation Insurance Record - Three Previous Years (Please enter the most recent policy first)

| State | Insurance Company | Policy Number | Policy Period From – To | Premiums Paid | In Force |
|---|---|---|---|---|---|
| MN | | | | | ☐ |
| MN | | | | | |
| MN | | | | | |

4. Are there operations in states other than Minnesota? ☐ Yes ☐ No

If "yes," complete the following:

| State | Location | Insurance Carrier | Policy Number |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Note:** The Minnesota Assigned Risk Plan does not provide coverage for permanent out-of-state operations. Temporary out-of-state operations are covered only as provided by Minnesota Statute.

## IV. PREMIUM CALCULATION

**(Coverage will not be provided if this section is not completed.)**

1. Completely describe the business and operations. **(This question must be answered)**

_____

2. Applicable only to Temporary Help Agencies or Employee Leasing arrangements. (Select all that apply).

- ☐ Yes, I (we) are a Temporary Help Agency.
- ☐ Yes, I (we) lease employees to/or from other companies.
- ☐ Application is for our own employees not subject to a leasing agreement.
- ☐ Application is for our Client company. _____ Name

_____

Location FEIN Number MN Unemployment Number

**A Copy of the signed Leasing agreement must accompany the application**

***Employee leasing companies & temporary help agencies must be registered with the Department of Commerce or provide an exemption certificate. For more information contact the Department of Commerce at 651-539-1743**

3. ** Calculations of Estimated Annual Premium Subject to Insurance Company Audit

| Class Code | Describe by Location the Duties or Employees of Classification | USLHW | No. of Employees | Total Payroll | Rate | Premium |
|---|---|---|---|---|---|---|
| | | ☐ | | | | |
| | | ☐ | | | | |
| | | ☐ | | | | |
| | | ☐ | | | | |
| | | ☐ | | | | |
| | | ☐ | | | | |
| | | ☐ | | | | |
| | | ☐ | | | Factor | |

| | | |
|---|---|---|
| Manual Premium | | |
| Increased Limits | | |
| Experience Modification | | |
| Modified Premium | | |
| Merit Rating | | |
| MCPAP | | |
| Standard Premium | | |
| Expense Constant | | $190.00 |
| Terrorism Coverage | | |
| Total Estimated Annual Premium | | |
| MN Special Comp Fund Assessment (Modified Premium x Factor) | 1.9% | |
| Policy Total Estimated Cost | | |
| Deposit Premium Percent | | |
| Deposit Premium | | |

**Terrorism:**

_____ ÷ 100 x _.01_ = _____

Total Remuneration Rate Insert on Terrorism Coverage Line

| Policy Total Estimated Cost | Minimum Deposit Required | Payment Basis*** |
|---|---|---|
| Under $2,000 | 100% | |
| $2,000 - $10,000 | 50% | 3 Quarterly |
| Over $10,000 | 35% | 8 Monthly |

4. Are the payroll amounts listed above lower than those appearing on your most recent policy or audit? **(This question must be answered)** ☐ Yes ☐ No
If "yes," please provide documentation verifying the payroll amounts listed above. The MWCIA will verify the payroll amounts by class. Coverage may be refused if adequate documentation is not provided.

5. Is premium being financed through a premium finance company? **(This question must be answered)** ☐ Yes ☐ No
If "yes," please provide a copy of the premium finance agreement.

6. Do you use independent contractors? **(This question must be answered)** ☐ Yes ☐ No

If "yes," you must maintain documentation which supports that they are, in fact, independent contractors. If such documentation is not available, or if the servicing contractor for the Assigned Risk Plan finds evidence of an employment relationship, then premium may be charged as if the individuals were employees.

**For Information about Independent Contractor or Employee Status please visit:** www.dli.state.mn.us/WC/IndpCont.asp

**** Subject to change according to rules governing the Minnesota Workers' Compensation Assigned Risk Plan.**
***** See #3 on back page for explanation of payment options.**

## V. DECLINATION STATEMENT

**(Coverage will not be provided if this section is not completed.)**

In order to obtain workers' compensation coverage through the Minnesota Workers' Compensation Assigned Risk Plan, you must first have been declined coverage by an insurance company licensed to write workers' compensation in the State of Minnesota within 90 days of the requested coverage effective date.

I (we) have been non - renewed by the insurance company listed below or

I (we) have applied to the insurance company named below and have been refused Workers' Compensation Insurance.

**NOTE:** You are required to attach a copy of the written notice of refusal. The representative named must be a full time, salaried employee of the company.

| Name of Insurance Company | Full Name of Underwriter | Solicitation Date or Non-Renewal Date |
|---|---|---|

## VI. ELECTIONS AVAILABLE UNDER LAW

**(Coverage will not be provided to excluded individuals unless they are listed in this section)**

READ CAREFULLY

Minnesota statute 176.041 excludes from coverage certain persons such as sole proprietors, partners, certain executive officers of family farms or closely-held corporations, and their spouses, parents and children/stepchildren (regardless of age).

An election may be made to provide coverage for those excluded by completing the information below.

The following named individuals who are subject to the election of coverage are to be covered by this policy. List only the individuals who elect coverage.

| Name of Person to be Insured | Title or Relationship | Duties | Estimated Remuneration or Draw-Included in Section IV |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Has the estimated remuneration, subject to minimums and maximums, of the above-named individuals been included in Section IV? ☐ Yes ☐ No

## VII. STATEMENTS AND AGREEMENTS

**(Coverage will not be provided if this section is not completed.)**

I (we) have read this application for the granting of coverage to employers unable to secure it for themselves and subscribe to the Minnesota Workers' Compensation Assigned Risk Plan in its entirety and hereby declare myself (ourselves) bound by its provisions and by all provisions of the Standard Workers' Compensation and Employers' Liability Policy. I (we) will comply with all reasonable safety recommendations that the servicing contractor makes with a view to reducing the hazards to which my (our) employees are exposed. I (we) hereby agree to pay promptly all premiums when due with the understanding that failure to do so shall constitute authority for the servicing (insurance) contractor to cancel coverage.

I (we) understand the law regarding the election of coverage for Workers' Compensation Insurance.
I (we) understand excluded individuals will not be covered by this policy unless named under Section VI.
I (we) hereby certify the above statements are true and correct, and there are no outstanding premiums due the Plan.

I (we) hereby designate _____
Name of Insurance Agent or Agency

as agent of record for this insurance. I (we) understand that the agent is not acting as an agent of any company for the purpose of this insurance and has no authority to bind such insurance.

I (we) also understand that the agent is not an agent of the Assigned Risk Plan for purposes of state law.

**X**_____ _____
Original Signature of Sole Proprietor, Partner or Officer — Date

## VIII. STATEMENT OF AGENT RECORD

I, _____ , do hereby certify that I am a licensed insurance agent of the State of Minnesota

_____
Name of Agency — Mailing Address of Agency

_____ _____ _____ _____
City — State — Zip — Telephone Number

Federal Employer's ID Number _____ _____
Email Address

Are you charging a service fee on this policy? (This question must be answered) ☐ Yes ☐ No

If so, the fee must be mutually agreed in writing by both the agent and the insured. A separate agreement must be prepared for each policy year that a fee is charged.

☐ I will provide a copy of this Application to my client.

_____ _____
SIGNATURE OF AGENT — Date

Note: If non-resident agent you must attach a copy of your Minnesota non-resident license or you will not be recognized as agent of record and no commission will be paid.

# MINNESOTA WORKERS' COMPENSATION ASSIGNED RISK PLAN
## APPLICATION RULES AND PROCEDURES

1. Only Minnesota statutory workers' compensation coverage and employers' liability coverage will be provided. USL & H coverage is available. Other states and voluntary compensation coverages are not available.

2. Payrolls and classifications included in the Premium Calculation Section of the application are subject to review by Association staff. Payrolls should be indicated for each classification. If the proper classifications cannot be determined, Association staff will classify the employer on the basis of the description of operations stated on the application and prepare a premium quotation for the applicant or agent. Final premium will be determined by premium audit upon expiration of the policy

3. Policies under $2,000 annual premium require 100% deposit premium. For policies of $2,000 - $10,000, the employer shall have the option of paying 50% or 100% of that amount as the deposit premium. For policies of $10,000 or more, the employer shall have the option of paying 35%, 50% or 100% as the deposit premium. If 50% of premium is paid, the remainder shall be paid in three equal quarterly installments. If 35% is paid, the remainder shall be paid in eight equal monthly installments.

4. The servicing contractor may issue the policy on an interim reporting basis, which requires the insured to submit monthly or quarterly payroll report forms. Requests to have the policy issued on an interim reporting basis will be honored in accordance with the guidelines established.

5. Agents are not agents of the Assigned Risk Plan and cannot issue certificates of insurance or bind coverage.

6. Agents' Commissions on Minnesota Workers' Compensation Assigned Risk Plan policies are as follows:

| Policy Premium | | Commission |
|---|---|---|
| under $1,000 | - | 5% |
| $1,000 to $5,000 | - | 4%, but not less than $50 |
| $5,000 to $10,000 | - | 3.5%, but not less than $200 |
| over $10,000 | - | 1%, but not less than $350 |

   Commission maximum of $3,500 per policy if no service fee is charged.
   Commission maximum of $1,500 per policy if a service fee is charged.
   Commissions are subject to change without notice.

7. In the event the policy is terminated, or a change is made which results in a return premium to the insured, the agent will be required to return the unearned commission portion of such return premium.

8. If you have questions about the rules governing the Assigned Risk Plan or would like additional information, please contact the Minnesota Workers' Compensation Insurers Association at (952) 897-1737 or Email at info@mwcia.org.