Workers Compensation Fund
Application for Utah Workers Compensation and Employers Liability Insurance

Please print or type

1 Business Name

Give Exact and Full Name	Years in Business

2 Mailing Address

Street or P.O. Box			Business Telephone Number
City	State	Zip Code	Fax Number
Email Address of Workers Compensation Contact			

3 Payroll Record / Location (Payroll Audit) / Check if Same as Mailing Address ☐

Street or Location Description			Payroll Telephone Number
City	State	Zip Code	Name of Person to Contact

4 Nature of Business / Description of Operations

5 Ownership Information

Type of Ownership

☐ Sole Proprietor ☐ Partnership ☐ Corporation
☐ Joint Venture ☐ Limited Liability Co. ☐ Association
☐ Limited Partnership ☐ Government ☐ Other _____

Federal Tax I.D. Number

Unemployment Number

Note: A partnership or sole proprietorship may elect to include as an employee any partner of the partnership or the owner of the sole proprietorship. For premium computation purposes, the salary wage of partners or sole proprietors shall be 100% of the state average weekly wage. A corporation may elect not to include any director or officer of the corporation as an employee.

List below complete information for: Sole Proprietor I Partners I Corporate Officers

Name (Last, First, Middle Initial)	Title	Percent of Ownership	Social Security Number	Coverage Desired? (Yes / No)	Primary Duties

6 Previous Insurance Coverage? No Yes (If Yes, please provide information for last three years)

Policy Period from (MO / YR) to (MO / YR)	Insurance Company Name	Annual Premium	Experience Modifier	Claims Cost, Including Reserves

7 Names (including DBAs) and Street Addresses of All Utah Locations (use additional page if necessary)

Name	Street or Location	City	Zip Code

8 Work Classifications and Estimated Annual Payroll by Location

	By location, list duties of employees including covered corporate officers by type of work performed. Do not include earnings of partners or sole proprietor.	Number of Employees	Estimated Total Annual Payroll	WCF Use Only: Class Codes	Rate	Estimated Premium
1						
2						
3						
4						

9 Employers Liability Insurance

Employers Liability Insurance provides coverage against lawsuits brought by an employee against the employer for on-the-job injuries.

Standard limits for the policy are:

Bodily Injury by Accident	(Each Accident)	$100,000
Bodily Injury by Disease	(Policy Limit)	$500,000
Bodily Injury by Disease	(Each Employee)	$100,000

If higher limits are desired, please contact the Underwriting Department for available options and costs.

WCF Use Only

Total Estimated Manual Premium	
Increased Liability Limits	
E-Mod Factor	
Scheduled Credit / Debit Factor	
Premium Size Discount	
Estimated Annual Premium	
Down Payment	
Effective Date	
Number Assigned	

WCF Use Only

Payment Plan	Underwriter	
Agency Name	Agency Code Number	Producer

10 General Questions

Questions	Y	N		Y	N
1 Does applicant own, operate or lease aircraft / watercraft?			10 Are athletic teams sponsored?		
2 Do / have past present or discontinued operations involve(d) storing, treating, discharging, applying, disposing, or transporting hazardous material?			11 Any prior coverage declined, cancelled, or non-renewed within the last 3 years?		
3 Any work performed underground or above 15 feet?			12 Are employee health plans provided?		
4 Is applicant engaged in any other type of business?			13 Is there a labor interchange with any other business / subsidiary?		
5 Are sub-contractors used? If yes, give % of work subcontracted.			14 Do you lease employees to or from other employers?		
6 Any work sublet without certificate of insurance?			15 Do any employees predominantly work at home?		
7 Is a written safety program in operation?			16 Any tax liens or bankruptcy within the last 5 years?		
8 Any group transportation provided?			17 Any undisputed and unpaid workers compensation premium due from you or any commonly managed or owned enterprises? If yes, explain including entity name(s) and policy number(s).		
9 Do employees travel out-of-state?					

11 Remarks

12 Individual to Contact if Additional Information is Needed

Name	Telephone Number

It is agreed that contractors and sub-contractors 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, 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 Workers Compensation Fund.

Coverage will be effective at 12:01 am 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 a completed signed application to:

Workers Compensation Fund
P.O. Box 2227
Sandy, Utah 84091-2227

If you have any questions, please call 385.351.8156
Fax: 385.351.8984
Email: applications@wcfgroup.com

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.