WISCONSIN WORKER’S COMPENSATION INSURANCE POOL
INSTRUCTIONS FOR COMPLETING THE ONLINE ASSIGNED RISK APPLICATION (OAR-1)
WISCONSIN COMPENSATION RATING BUREAU
P.O. BOX 3130
MILWAUKEE, WI 53201-3130
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LOCATED AT: 20700 SWENSON DRIVE, SUITE 100

The numbers on this instruction sheet correspond to the numbered sections on OAR-1, Wisconsin Worker’s Compensation Insurance Pool online application.

GENERAL

Submit the application and all required attachments. Print a copy and keep it for your records.

Failure to fully answer all questions, attach required payroll verification forms and supplemental applications, or electronically submit the appropriate deposit premium may result in a delay in coverage.

The effective date of coverage is normally 12:01 a.m. on the day following receipt of the application at Wisconsin Compensation Rating Bureau. Coverage may also be bound on a future date if so requested. Only the Pool can bind coverage. No agent has binding authority. **Pool Coverage is never effective retroactively.**

SECTIONS 1-5 APPLICANT INFORMATION

APPLICANT NAME

Show the complete legal name of the employers(s). If the applicant is a proprietorship, a partnership, or a limited liability company, the full name(s) of general partners must be included in addition to all applicable trade names. Include the business telephone number, fax number, and the applicant’s Federal Identification Number.

The insured named first on the policy Information Page is given certain rights and responsibilities by the language of the policy contract. If more than one applicant is listed on the application, the one intended to receive these rights and responsibilities should be named first.

MAILING ADDRESS

Show the applicant’s complete and exact mailing address. If a PO Box is used as a mailing address, complete the principal location field on the application.

LEGAL STATUS

Check the box to designate the legal status of the applicant. If you check “other”, please identify the type of organization. If there is more than one applicant, clearly identify the legal status of each.

REQUESTED EFFECTIVE DATE

The effective date of coverage is determined by the Wisconsin Pool rules. Coverage will be bound at 12:01 a.m. the day following receipt of the complete application and all applicable supplementary forms and appropriate deposit premium, or on the requested effective date, whichever is later. Indicate the date business began for the applicant in the state of Wisconsin.

LOCATIONS OF ALL WISCONSIN WORK PLACES

Enter the physical address of all permanent Wisconsin locations from which the applicant operates. Enter the company name and physical address of the location where payroll records are maintained. For any location, a post office box is not an acceptable address. Include the name and telephone number of the person to contact regarding the applicant’s payroll records.
SECTION 6. NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS

Completely describe the business or operations of the applicant. This information is needed to establish proper classification code assignments. Do not simply include the wording for a classification code.

If the applicant is a service organization, describe the nature and details of the operation.

If the applicant is a merchant, describe the products sold and any operations that involve the preparation of merchandise for sale and indicate if sales are retail or wholesale (if both, give percentage of each).

If the applicant is a manufacturer, list the raw materials, processes, and products manufactured.

If the applicant is a contractor, describe the type of construction, erection or repair work performed and the type of equipment used. Describe the nature of any sub-contract arrangements.

SECTION 7. SUPPLEMENTAL INFORMATION

Answer all questions by checking yes or no. Provide any additional details or clarification as required. Please attach an explanation for any “Yes” responses needing clarification. This can be done by adding a free form text message using the attachment type Miscellaneous on the Attachment/Submit tab under the Manage/Attachments, Add New Attachment.

SECTION 8. INSURANCE RECORD

Provide the previous record of worker’s compensation insurance coverage for the applicant.

SECTION 9. CORPORATE OFFICERS, SOLE PROPRIETORS, PARTNERS, OR MEMBERS OF A LIMITED LIABILITY COMPANY

List the name of each executive officer, sole proprietor, partner(s), general partner(s) or each member of a limited liability company. Indicate whether coverage for each individual is elected or rejected. Include title, percentage of ownership, applicable code, remuneration and duties.

Executive officers of a corporation are automatically covered under Wisconsin law; however, any two officers of a corporation having not more than ten stockholders are allowed to non-elect coverage under the law. The payroll, subject to individual minimum or maximum limitations as shown on the state rate pages, for all covered executive officers must be included in the “total payroll” and used to calculate estimated annual premium. Sole proprietors, partners and members of a limited liability company are not covered under Wisconsin law; however, the sole proprietor, partners and members of a limited liability company may elect to be included as an employee, if actively engaged in the operation of the business and the insurer is notified of the election to be included. The fixed payroll amount, as shown on the state rate pages, for covered sole proprietors, partners and members of a limited liability company must be included in the “total payroll” and used to calculate estimated annual premium. Any sole proprietor, partner or member who elected to be an employee under this section may withdraw that election upon 30 days prior written notice to the insurance carrier and the Wisconsin Compensation Rating Bureau. Please note that the non-election or election of coverage will be continued on all renewal policies, unless changes are requested at time of renewal.

- IMPORTANT; PLEASE ATTACH SIGNED “NON ELECTION” OR “ELECTION” FORMS TO THIS APPLICATION.

SECTION 10. RATING INFORMATION

Separately list class code(s), number of employees, and an accurate estimate of the annual payroll. For any estimated annual premium in excess of $2,000, a percentage of the annual premium may be calculated as the deposit premium. Payroll verification such as Federal Employer forms 940, 941,942 or 943 should be attached when submitting any application. A new employer must submit a notarized letter stating there was no payroll in the past.

SECTION 11. PREMIUM PAYMENT REQUIREMENTS

Premium payment is submitted via electronic funds transfer. The estimated annual premium or proper deposit premium must be received before an assignment of coverage can be made.
If the premium is financed, the full financed amount must be received before assignment of coverage can be made. Attach a copy of the signed premium finance agreement.

SECTION 12. SPECIAL NEEDS

Additional information may be requested before an assignment of coverage can be made. Please note that when requesting Other States Coverage, ACORD Form 136 (Wisconsin Limited Other States Coverage) must be completed and submitted with the initial application.

SECTION 13. APPLICANT’S STATEMENT

The application is incomplete unless it has been electronically signed by an individual: (1) certifying the accuracy of the information given to the agent, and used to complete the application, and (2) agreeing to comply with basic provisions of the Wisconsin Worker’s Compensation Insurance Pool. The individual signing the application must be the sole proprietor if the application is a proprietorship, a partner if the applicant is a partnership, a member if the applicant is a limited liability company, or an executive officer if the applicant is a corporation.

SECTION 14. STATEMENT OF LICENSED AGENT OR PRODUCER OF RECORD (This section will not appear when the application is completed by the applicant.)

In signing this application, the agent certifies that: (1) I am a licensed intermediary agent of the State of Wisconsin, (2) I have read the Wisconsin Worker’s Compensation Insurance Pool rules, explained the provisions to the applicant, and have included in this application all required information given to me by the applicant. In the event the policy is terminated or a change is made resulting in a return premium to the insured, I agree to return the unearned commission.

Please review the information below, and pay particular attention to the items that pertain to you.

1) Attach a copy of non-resident license if you are an agent from another state.

2) The producer does not represent the servicing carrier not the Pool, in any way, has no authority to bind coverage, change, alter or terminate coverage.

3) If you are not an agent licensed in the state of Wisconsin, or do not have a non-residents license in the state of Wisconsin, you may not submit the application. The insured should submit an application without an agent.

4) Include the complete agent/agency name and mailing address, telephone number, fax number, Federal Employers Identification Number of Social Security Number and Producers Wisconsin License number.

5) Commissions will not be paid unless you electronically sign the application.

Attachments/Submit

In some cases, based on information entered in the application, additional documentation is required. Additional documentation may be attached to the application.

Attachments may include, but are not limited to: Accord form 134 WI Supplementary Non-election Form, Accord form 135 WI Supplementary Election of Coverage, Accord form 136 WI Supplementary Limited Other States Coverage Request, ERM 14, Interstate Mod, Miscellaneous, Non-resident Agent License, Payroll Verification form and Premium Finance Agreement.

These attachments can be attached to the application or can be faxed. Acceptable file types are PDF, MS Word Doc, TXT, TIF, JPG or BMP.