

**WISCONSIN WORKER'S COMPENSATION INSURANCE POOL APPLICATION INSTRUCTIONS**  
**WISCONSIN COMPENSATION RATING BUREAU**  
**P.O. BOX 3080 MILWAUKEE, WI 53201-3080**

**TELEPHONE (262) 796-4592, FAX (262) 796-4400 LOCATED AT: 20700 SWENSON DRIVE, SUITE 100 WAUKESHA, WI 53186**

The numbers on this instruction sheet correspond to the numbered sections on the Wisconsin Worker's Compensation Insurance Pool (WWCIP) application. Attach extra sheets to the application if you need space when filling out any sections.

**GENERAL**

File the application and all required attachments. Make a copy and keep it for your records. Failure to fully answer all questions, attach required payroll verification forms or supplemental applications, remit proper form or amount of deposit premium and/or include required signatures may result in a delay in coverage. The effective date of coverage is normally 12:01am 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 WWCIP can bind coverage. No producer has binding authority. Pool Coverage is never effective retroactively.

**REQUESTED EFFECTIVE DATE**

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

**SECTION I. GENERAL INFORMATION**

**LEGAL STATUS**

Check all boxes that apply to designate the legal status of the applicant. If you check "other", please identify the type of organization.

**NAME OF EMPLOYER**

Show the complete legal name of the employer(s). If the applicant is a partnership or a limited liability company, the full names of partners must be included in addition to all applicable trade names. Include the business telephone number, fax number, and the applicant's Federal Employers 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. A post office box is not an acceptable address.

## **PRINCIPAL LOCATION**

Only enter an address here if it is different than the applicant's mailing address.

## **PAYROLL OFFICE ADDRESS**

Only enter an address here if it is different than the applicant's mailing address.

## **ADDITIONAL EMPLOYER NAMES**

Enter the name and FEIN (optional) of all additional employer names associated with this request for coverage.

## **OTHER WISCONSIN LOCATIONS**

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.

## **SECTION II. BUSINESS INFORMATION.**

### **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.

### **CORPORATE OFFICERS, SOLE PROPRIETORS, PARTNERS, OR MEMBERS OF A LIMITED LIABILITY COMPANY**

#### **IMPORTANT: PLEASE ATTACH SIGNED "NON-ELECTION" OR "ELECTION" FORMS TO THIS APPLICATION.**

List the name of each executive officer, sole proprietor, partner(s), or each member of a limited liability company. Indicate whether coverage for each individual is INCLUDED (INC) OR EXCLUDED (EXC). Include title, duties, percentage of ownership, applicable class code and remuneration. (See the WI Basic Manual for the definition or remuneration.)

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. 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.

#### **SUPPLEMENTAL INFORMATION**

Answer all questions by checking yes or no. Provide any additional details or clarification as required. Please attach a separate sheet of paper to explain any "Yes" responses needing clarification.

### **SECTION III. INSURANCE RECORD**

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

Reminder: The Wisconsin Workers Compensation Insurance Pool does not provide coverage for permanent out-of-state-operations.

### **SECTION IV. RATING INFORMATION SECTION**

#### **CALCULATION OF ESTIMATED ANNUAL PREMIUM**

Separately list class code, classification phraseology, number of employees, an accurate estimate of the annual payroll, the rate and calculated premium. 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, 941-E, or 943 should be attached when submitting any application. If you are a new employer or if you are an employer without any payroll records, you must attach a notarized letter stating why there was no payroll in the past.

#### **PREMIUM PAYMENT REQUIREMENTS**

Deposit premium is determined by taking a percentage of annual premium. The percentage varies with the amount of estimated annual premium.

**Payment options are at the discretion of WWCIP. An employer may be required to submit a larger deposit up to the total estimated annual premium.**

Coverage will not be bound until payment of appropriate deposit premium is received. Payment must be made via the Online Assigned Risk electronic payment system. Credit card payments are not accepted. Only electronic fund transfers are accepted.

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 V. STATEMENTS AND AGREEMENTS**

The application is incomplete unless it has been signed by an individual: (1) certifying the accuracy of the information given to the producer, and used to complete the application, and (2) agreeing to comply with basic provisions of the WWCIP. The individual signing the application must be the sole proprietor if the applicant 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, or authorized representative of the employer.

## **SECTION VI. STATEMENT OF PRODUCER OF RECORD**

This section only applies if a producer of record completes this application.

In signing this application, the producer certifies that:

- (1) I am a licensed producer of the state of Wisconsin
- (2) I have read the WWCIP 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 of premium to the insured, I agree to return the unearned commission.

### **IMPORTANT INFORMATION BELOW:**

- 1) Attach a copy of Non-Resident license if you are a producer from another state.
- 2) The producer does not represent the servicing carrier nor the Pool, in any way, has no authority to bind coverage, change, alter or terminate coverage.
- 3) The application may be signed by an out of state producer to whom the Wisconsin Office of Commissioner of Insurance has issued a non-resident license.
- 4) If you are not a producer 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 a producer.
- 5) Include the complete producer/agency name and mailing address, telephone number, Federal Employers Identification Number or Social Security Number and NPN.
- 6) Commissions will not be paid unless you sign the application.