WISCONSIN WORKER'S COMPENSATION INSURANCE POOL
APPLICATION FOR WORKER'S COMPENSATION INSURANCE

<table>
<thead>
<tr>
<th>Requested Effective Date:</th>
<th>Mail to: WWCIP P.O. Box 3080 Milwaukie, WI 53201-3080 (262) 796-4592</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Business Began:</td>
<td>Deliver to: WWCIP 20700 Swenson Drive Suite 100 Waukesha, WI 53186</td>
</tr>
<tr>
<td>Employer email:</td>
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THE UNDERSIGNED EMPLOYER IS UNABLE TO PURCHASE WORKER'S COMPENSATION AND EMPLOYER'S LIABILITY INSURANCE FOR LIABILITY UNDER THE WISCONSIN WORKER'S COMPENSATION LAW AND HEREBY APPLIES FOR THE DESIGNATION OF AN INSURANCE COMPANY TO PROVIDE INSURANCE IN ACCORDANCE WITH THE WISCONSIN WORKER'S COMPENSATION INSURANCE POOL (WWCIP).

NOTE: THE EFFECTIVE DATE OF INSURANCE IS GOVERNED BY THE RULES OF THE WWCIP. WWCIP RECOMMENDS APPLICATIONS BE SUBMITTED AT LEAST 15 DAYS PRIOR TO THE REQUESTED EFFECTIVE DATE.

Coverage will not be provided unless all application sections are completed.

I. GENERAL INFORMATION

Legal Status (Check all that apply):

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<tr>
<td>Sole Proprietor</td>
<td>Partnership</td>
<td>Corporation</td>
<td>Limited Liability Partnership</td>
<td>Limited Liability Company</td>
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<tr>
<td>Limited Partnership</td>
<td>Trust or Estate</td>
<td>Government Entity</td>
<td>Association, Labor Union, Religious Org.</td>
<td>Other (Description required)</td>
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Name of Employer (Legal Name Including D.B.A.s)

Federal Employer ID # (FEIN 9-digit number)

Mailing Address (Street) (City) (State) (ZIP) (Phone)

Principal Location (Street) (City) (State) (ZIP)

Payroll Office Address (Street) (City) (State) (ZIP)

Payroll Contact Name Payroll Contact Phone

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

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

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

Other Wisconsin Location (Street) (City) (State) (ZIP)

Other Wisconsin Location (Street) (City) (State) (ZIP)

Other Wisconsin Location (Street) (City) (State) (ZIP)
II. BUSINESS INFORMATION

Nature of all Business/Description of Operations

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Relationship</th>
<th>Duties</th>
<th>Ownership%</th>
<th>Included?</th>
<th>Class</th>
<th>Remuneration</th>
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Corporate Officers, Partners, Sole Proprietors or Members of a Limited Liability Company

List below the name, title, duties and approximate annual remuneration of all corporate officers and indicate which two officers, if any, reject coverage or, list below the name, title, percent of ownership, applicable code, remuneration and duties of all corporate officers, partners, sole proprietors and members of a limited liability company, and indicate which elect coverage.

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

These required forms are available on the wcrb.org Web site in AGENT FORMS and in EMPLOYER FORMS.

Supplemental Information

- Is a formal safety program in operation? □ Yes □ No
- Do you employ drivers? □ Yes □ No
- Do employees travel out of state? □ Yes □ No
- Is there a labor interchange with any other business/subsidiary? □ Yes □ No
- Are you in chapter 11 bankruptcy? (If Yes, please provide bankruptcy papers.) □ Yes □ No
- Do you lease employees to or from other employers? □ Yes □ No
- Do any employees predominantly work from home? □ Yes □ No
- Is this a non-profit organization? □ Yes □ No
- Do you need a waiver of subrogation? (If Yes, work with the servicing carrier to provide a copy of the contract to the servicing carrier. $50 per signed contract will be charged.) □ Yes □ No
- Do you qualify for the apprenticeship credit program? (If Yes, consult your servicing carrier to determine necessary information.) □ Yes □ No
- Do you need certificates of insurance? (If Yes, please attach list.) □ Yes □ No
III. INSURANCE RECORD

Has there been a name change, consolidation, merger or ownership change during the past 3 years?  □ Yes  □ No
If Yes, give previous name and date of change. Contact oar@wcrb.org regarding an ERM14 form.
Previous Name ___________________________   Date of Change ________________

Has there been previous workers’ compensation insurance coverage in Wisconsin?  □ Yes  □ No
If no, check one of the following:  □ New Business   □ Self Insured   □ Other

Wisconsin Workers' Compensation Insurance Record - Three Previous Years

<table>
<thead>
<tr>
<th>State</th>
<th>Insurance Company</th>
<th>Policy Number</th>
<th>Policy Period From - To</th>
<th>Premiums Paid</th>
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</table>

Are there operations in states other than Wisconsin?  □ Yes  □ No
If "yes", complete the following for each state:

<table>
<thead>
<tr>
<th>State</th>
<th>Location</th>
<th>Insurance Carrier</th>
<th>Active Workers Comp Policy Number</th>
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Is the coverage above voluntary or pool?  □ Voluntary   □ Pool
If Voluntary coverage, is the carrier licensed to write worker’s compensation insurance in WI?  □ Yes  □ No
Has WI been excluded from Item 3C coverage?  □ Yes  □ No
If no, has the carrier been contacted to add WI to Item 3A?  □ Yes  □ No

<table>
<thead>
<tr>
<th>State</th>
<th>Location</th>
<th>Insurance Carrier</th>
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</tbody>
</table>

Is the coverage above voluntary or pool?  □ Voluntary   □ Pool
If Voluntary coverage, is the carrier licensed to write worker’s compensation insurance in WI?  □ Yes  □ No
Has WI been excluded from Item 3C coverage?  □ Yes  □ No
If no, has the carrier been contacted to add WI to Item 3A?  □ Yes  □ No

Note: The Wisconsin Workers Compensation Insurance Pool does not provide coverage for permanent out-of-state operations.
### IV. RATING INFORMATION SECTION

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

<table>
<thead>
<tr>
<th>Class Code #</th>
<th>Classification Phraseology (Description of duties)</th>
<th>Does USLH apply?</th>
<th>Number of Employees</th>
<th>Total Annual Payroll</th>
<th>Rate</th>
<th>Estimated Annual Premium</th>
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Deposit premium is determined by taking a percentage of annual premium. The percentage varies with the amount of the estimated annual premium. Here is how it works:

- **Payment options are at the discretion of WWCIP**

<table>
<thead>
<tr>
<th>Est Annual Premium</th>
<th>Payment Basis</th>
<th>Minimum Deposit Percentage</th>
<th>Additional payment after initial deposit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under $2,000</td>
<td>Annual</td>
<td>100% due</td>
<td>NONE</td>
</tr>
<tr>
<td>$2,001 - $5,000</td>
<td>Balance due in 90 days of Inception</td>
<td>50% due</td>
<td>One</td>
</tr>
<tr>
<td>$5,001 - $10,000</td>
<td>Quarterly</td>
<td>50% due</td>
<td>Two</td>
</tr>
<tr>
<td>$10,001 or more</td>
<td>Monthly</td>
<td>25% due</td>
<td>Nine</td>
</tr>
</tbody>
</table>

**Payment options are at the discretion of WWCIP**

- Premium Sub Total
- Increased Limits
- Experience Mod
- WCPAP Credit
- Total Modified Premium
- Expense Constant
- Terrorism Charge
- Catastrophe Charge
- Estimated Annual Premium
- Deposit Premium

Important reminder when submitting this application:

- Attach payroll verification such as Federal Employer Forms 940, 941 or 943.
- If you are a new employer or if you are an employer without any payroll records, attach a notarized letter stating why there has been no payroll in the past.
- Hard copy applications will not be accepted without payment. Payment to the Wisconsin Compensation Rating Bureau must be attached to the application in the form of certified check, cashier’s check, money order, check of the producer of record, or a check from the premium finance company. Credit card payments are not accepted.

Are the payroll amounts listed above lower than those appearing on your most recent policy or audit?  □ Yes  □ No

Is premium being financed through a premium finance company?  □ Yes  □ No

Do you use independent contractors?  □ Yes  □ No

** Subject to change according to rules governing the WWCIP
V. STATEMENTS AND AGREEMENTS

I (we) have read this application for the granting of coverage to employers unable to secure it for themselves and subscribe to the WWCIP in its entirety and hereby declare myself (ourselves) bound by its provisions and by all provisions of the Wisconsin Pool Handbook. I (we) will comply with all reasonable safety recommendations that the servicing carrier 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) carrier to cancel coverage.

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

_________________________________________  X

Business Name of Applicant  Original Signature of Authorized Representative  Title  Date

VI. STATEMENT OF PRODUCER OF RECORD

I, ___________________________________________, do hereby certify that I am a licensed insurance producer of the State of Wisconsin

Agent Name

_________________________________________

Name of Agency  Mailing Address of Agency

_________________________________________

City  State  ZIP  Telephone Number

_________________________________________

Federal Employee ID Number  NPN  Email Address

I have read the WWCIP rules, have 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.

_________________________________________  ____________________________

Signature of Insurance Provider  Date
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 12:01a.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 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...
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.

For electronic applications: 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. For electronic applications, only electronic fund transfers are accepted.

For hard copy applications: Hard copy applications will not be accepted without payment. Payment to the Wisconsin Compensation Rating Bureau must be in the form of certified check, cashier’s check, money order, check of the producer of record, or a check from the premium finance company. Credit card payments are not 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.