

**SUPPLEMENTAL INFORMATION  
ADDENDUM TO APPLICATION  
AS A GROUP WORKERS'  
COMPENSATION FUND**

Name of fund applicant \_\_\_\_\_

Describe briefly the general operating characteristics of the prospective fund members.

**FUND ADMINISTRATOR**

Company name \_\_\_\_\_  
 Contact person \_\_\_\_\_  
 Address \_\_\_\_\_  
 Address \_\_\_\_\_  
 City/Town \_\_\_\_\_ State \_\_\_\_ ZIP \_\_\_\_\_  
 Telephone \_\_\_\_\_  
 Email \_\_\_\_\_

**FISCAL AGENT** (if different from Fund Administrator)

Company name \_\_\_\_\_  
 Contact person \_\_\_\_\_  
 Address \_\_\_\_\_  
 Address \_\_\_\_\_  
 City/Town \_\_\_\_\_ State \_\_\_\_ ZIP \_\_\_\_\_  
 Telephone \_\_\_\_\_  
 Email \_\_\_\_\_

**APPLICATION CONTACT** (if different from Fund Administrator)

Company name \_\_\_\_\_  
 Contact person \_\_\_\_\_  
 Address \_\_\_\_\_  
 Address \_\_\_\_\_  
 City/Town \_\_\_\_\_ State \_\_\_\_ ZIP \_\_\_\_\_  
 Telephone \_\_\_\_\_  
 Email \_\_\_\_\_

1. Provide the following information about all companies, except the claims service company, which will be providing services to the applicant (attach additional sheets if necessary).

Company name	Services provided

**2. Excess Insurance**

If the applicant intends to obtain excess insurance coverage, provide the following information:

	Specific		Aggregate (if applicable)
Proposed retention amount:	\$ _____		\$ _____
Proposed liability limit:	\$ _____	<input type="checkbox"/> Statutory	\$ _____ <input type="checkbox"/> Statutory

Proposed cash flow protection (if applicable)

First Year: \$ \_\_\_\_\_

Second Year: \$ \_\_\_\_\_

Third Year: \$ \_\_\_\_\_

Attach all insurance quotes relating to the above.

**3. Provide the following information about the board of trustees (attach additional sheets if necessary).**

Name of Trustee	Company	Title or Position

**4. Claims Administration**

Indicate how the applicant’s self-insurance claims will be administered:

\_\_\_\_\_ Self administration

\_\_\_\_\_ Third party claims administration

If the applicant plans to self-administer its claims, please attach to this application documentation providing information relevant for the bureau’s consideration of whether the applicant possesses adequate facilities and competent staff to adjust and service its claims in a manner which would fulfill its obligations under the Workers’ Compensation Act, including a resume of at least one person employed by the applicant on a full-time basis with the knowledge and experience to administer claims in accordance with the Workers’ Compensation Act.

**5. Aggregate Financial Information**

If the prospective members are private employers, provide the following (calculated according to generally accepted accounting principles):

Aggregate working capital \$ \_\_\_\_\_

Aggregate net worth \$ \_\_\_\_\_

Attach a list that provides each member’s working capital and net worth.

**Employer Information Services**  
717.772.3702

**Claims Information Services**  
toll-free inside PA: 800.482.2383  
local & outside PA: 717.772.4447

**Hearing Impaired**  
toll-free inside PA TTY: 800.362.4228  
local & outside PA TTY: 717.772.4991

**Email**  
ra-li-bwc-helpline@pa.gov



*Auxiliary aids and services are available upon request to individuals with disabilities.  
Equal Opportunity Employer/Program*