pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

SUPPLEMENTAL INFORMATION ADDENDUM TO APPLICATION FOR MEMBERSHIP IN A GROUP WORKERS' COMPENSATION FUND

1. Name of fund _____
2. Complete legal name of member-applicant _____
3. Mailing address _____
4. Telephone _____
5. How many years has the member-applicant operated in Pennsylvania? _____
6. Provide the following information about all of the member-applicant's Pennsylvania business locations (attach additional sheets if necessary).

Name/Division	Address	Number of Employees
	TOTAL	

If the member-applicant is a subsidiary of a U.S. parent company, provide the following information:

Top U.S. parent name _____

Address _____

_____

City/Town _____ State _____ ZIP _____

Percentage of ownership _____

ATTESTANTS

The member-applicant hereby attests that the facts set forth in the foregoing application are true; that it has never defaulted on the payment of obligations and liabilities due under the Workers' Compensation Act and the Pennsylvania Occupational Disease Act as an individual self-insurer; that is has not been found to have violated Section 305 or Section 435 of the Workers' Compensation Act as an individual self-insurer; and that is has not been delinquent in payment of or cancelled for non-payment of workers' compensation premiums for a period of at least two years prior to the submission of this application.

ACKNOWLEDGEMENTS AND AGREEMENTS

In consideration of the approval of this application for membership in a group workers' compensation fund, the member-applicant hereby expressly agrees as follows:

1. To accept and to be bound by the provisions of the Workers' Compensation Act and the Pennsylvania Occupational Disease Act and the rules and regulations promulgated under the acts.

2. To provide to the fund any data, documents or information required by the fund to decide if it meets the fund's criteria for membership.

3. To assume, pay and discharge jointly and severally any liability under the acts of any and all members of the fund and any and all obligations and expenses of the fund incurred during its period of membership. The applicant acknowledges that it is liable for all claims incurred during its membership, even after its membership in the fund has terminated. It further acknowledges that if the assets of the fund are not sufficient in future years to pay losses for the years in which it was a member, it is liable to pay assessments on those losses.

4. That, by this reference, it adopts, approves, ratifies and confirms the terms and provisions of the trust agreement of the fund or amendments thereto, or both, filed or which may hereafter be filed with a Bureau of Workers' Compensation of the Department of Labor & Industry.

5. That these agreements shall be binding upon the member-applicant, its successors and assigns.

The member-applicant hereby formally applies for membership in the above-named fund, to be effective 12:01 a.m.

_____ , 20 _____ .

_____ By: _____

Witness Owner/Officer signature

_____ _____

Name and Title (typed/printed) Name and Title (typed/printed)

Employer Information Services
717.772.3702

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

Hearing Impaired
PA Relay 7-1-1

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

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