

**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*