

## APPLICATION FOR WORKERS' COMPENSATION INSURANCE COVERAGE

### PLEASE READ

It is mandatory under the Pennsylvania Workers' Compensation and Occupational Disease Acts that an employer carry workers' compensation insurance. Failure to comply with these laws subjects employers to lawsuits by employees and criminal prosecution. Such prosecutions could result in substantial fines, imprisonment or both. In addition, based upon the Workers' Compensation Act, the carrier must have an insurable interest to write a workers' compensation policy; having no employees constitutes no insurable interest. State Workers' Insurance Fund (SWIF) is prohibited from issuing a policy on an "if any" basis.

### COMPLETE AND SIGN THE APPLICATION

Submit the application by mail to State Workers' Insurance Fund, 100 Lackawanna Avenue, PO Box 5100, Scranton, PA 18505-5100.

Should you have any questions about the application or coverage, you may contact Customer Service at 570-963-4635.

For policies less than \$2,000 in premium, total payment is required. For policies greater than \$2,000 in premium, SWIF requires a payment of 25 percent of the premium OR the minimum premium, whichever is greater, including the Employer's Assessment Fee, Terrorism Fee and Commercial Catastrophe Fee. Under certain circumstances, at SWIF's discretion, total premium may be required before coverage will be incepted. (see "Instructions" [www.dli.pa.gov/swif](http://www.dli.pa.gov/swif) select Underwriting)

Please make checks (black or blue ink only) and money orders payable to "SWIF." When you provide a check as payment, you authorize SWIF either to use information from your check to make a one-time electronic fund transfer (EFT) from your account or to process the payment as a check transaction. Note: SWIF does not accept cash payments.

SWIF does not offer waiver of subrogation endorsements.

If you are a sole proprietor, partners of a partnership or members of an LLC, complete the Voluntary Election of Coverage form POL115A/51A indicating your choice to accept or decline coverage.

If you are a corporate officer and/or owner choosing to waive your rights, complete and submit the signed officer exception forms LIBC-509 & LIBC-513.

All required forms and resources may be found either on the SWIF website [www.dli.pa.gov/swif](http://www.dli.pa.gov/swif) or as specified in this application.

Any party who willfully makes a false statement or representation, deliberately conceals any material fact, or engages in any other fraudulent scheme or device, for the purpose of obtaining or attempting to obtain, or for the purpose of aiding or abetting any person to obtain insurance in the State Workers' Insurance Fund (SWIF) at less than the proper rate for such insurance, or payment out of SWIF to which such person is not entitled, is guilty of a crime. Providing false information on this application or engaging in fraud can lead to the applicant being disbarred from being awarded a contract with the commonwealth for as long as three years, and may further lead to disbarment with local governments in the commonwealth.

I understand and will comply with the information on this page

**BUSINESS NAME** \_\_\_\_\_

**SIGNATURE** (Owner/Corporate Officer/Partner) \_\_\_\_\_ Date \_\_\_\_\_

NOTE: Signatures on page one and on page seven should match.

**FOR OFFICE USE ONLY: Application # \_\_\_\_\_ Check # \_\_\_\_\_ Amount \$ \_\_\_\_\_**

**APPLICATION FOR WORKERS' COMPENSATION INSURANCE**

1. Business name \_\_\_\_\_  
 Mailing address \_\_\_\_\_  
 PA primary operating location \_\_\_\_\_  
 County \_\_\_\_\_ Telephone \_\_\_\_\_ Business Fax \_\_\_\_\_  
 Email \_\_\_\_\_ Website \_\_\_\_\_
2. Federal Employer Identification Number \_\_\_\_\_ (active FEIN is required; **www.irs.gov** to apply)
  - a. If new, date applied \_\_\_\_\_
  - b. List the name and FEIN of each additional business owned and operated to be included in this policy.
- c. If multiple entities are to be insured on one policy, submit an **ERM-14** form to identify each business.
- d. Has any principal applicant had a previous business that was insured by SWIF under a different name, entity or FEIN? If so, include names of previous business(es), names of owners/officers of the business(es) and FEIN(s):

**STOP! YOU MUST COMPLETE TABLE A OR TABLE B ACCORDING TO YOUR TYPE OF ENTITY!**

**FAILURE TO COMPLETE THIS SECTION IN ITS ENTIRETY  
 WILL CAUSE YOUR APPLICATION TO BE RETURNED WITH NO COVERAGE.**

3. Indicate the type of business (check all that apply)
 

<input type="checkbox"/> Individual/Sole Proprietor <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Limited Liability Partnership	<b>Complete Table A</b> - Sole proprietors, partners of a partnership or LLP, members of an LLC electing or declining to be included under the PA Workers' Compensation Act must complete form POL 115 or the online form SWIF-51 Voluntary Election of Coverage.
<input type="checkbox"/> Corporation (S or C) <input type="checkbox"/> Non-profit Corporation <input type="checkbox"/> Professional Employer Organization <input type="checkbox"/> Temporary Agency <input type="checkbox"/> Other (Please specify, i.e. PEO client)	<b>Complete Table B</b> - An executive officer of a corporation, if eligible, may elect to be exempt under the PA WC Act by completing and submitting forms LIBC 509 & 513. If not submitted, owners/officers will remain included for the entire policy term.

**Ownership for Sole Proprietor / Partner / LLP/LLC - List each owner separately**

**TABLE A:** Has this business entity been insured with SWIF before? Yes  No

First & Last Name	Sole Proprietor / Partner Member	SS#	% Ownership	Class Code	Active Y/N	Covered Y/N

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**Ownership/Title for: S or C Corporation/ Non-Profit**

**TABLE B:** Has this business entity been insured with SWIF before? Yes  No

List each owner separately:

First and Last Name	Corporate Officer Title	SS#	% Ownership	Class Code	Active Y/N	Covered Y/N

a. Date articles filed \_\_\_\_\_  
b. State \_\_\_\_\_

4. Is this business currently in the process of liquidation or termination?  
 No  
 Yes - explain: \_\_\_\_\_

5. Has this business ever filed for bankruptcy?  
 No  
 Yes - date filed: \_\_\_\_\_  
Is this business currently in bankruptcy?  
 No  
 Yes - **Must** enclose a copy of the petition as filed in bankruptcy court, including all attachments.

6. Audit Contact  
Contact person \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone \_\_\_\_\_  
Email \_\_\_\_\_

7. Safety/Loss Control  
Contact person \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone \_\_\_\_\_  
Email \_\_\_\_\_

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8. Has this business entity had previous workers' compensation insurance coverage in Pennsylvania?

- No
- Yes - answer the following completely:
  - a. Business name \_\_\_\_\_
  - b. Carrier name \_\_\_\_\_
  - c. Policy number \_\_\_\_\_
  - d. Date cancelled/expired \_\_\_\_\_
  - e. Anniversary date \_\_\_\_\_
  - f. Premium \_\_\_\_\_
  - g. Carrier information for the previous three(3) years:

Carrier _____	Premium _____	Year _____
Carrier _____	Premium _____	Year _____
Carrier _____	Premium _____	Year _____

**IF YOUR PREMIUM IS IN EXCESS OF \$20,000, ATTACH FIVE YEARS OF DETAILED LOSS AND PREMIUM HISTORY**

- h. Pennsylvania Compensation Rating Bureau # \_\_\_\_\_
- i. Experience modification/merit \_\_\_\_\_ Date \_\_\_\_\_
- j. Home Improvement Contract number (HIC#) \_\_\_\_\_

9. Has workers' compensation coverage ever been cancelled for this business entity?

- No
- Yes - explain:

10. Provide a **COMPLETE, DETAILED** job description of all work performed by classification of your day-to-day operations, including the job duties of the corporate officers and/or owners. (Attach an additional sheet, if necessary.)

Provide the following where applicable on a separate page:

- a. List of clerical employees and their job duties
- b. Volunteer Fire Department Roster (Act 46) and Volunteer Fireman Exposure form, [www.pcrb.com](http://www.pcrb.com)
- c. List of the names and Social Security numbers for any domestic workers. Include number of hours worked per week per employee (part time - under 20 hours; full time - 20 hours or more).
- d. Approval to Exempt Certain Religious Members (form LIBC-14C) [www.wcais.pa.gov](http://www.wcais.pa.gov)
- e. Letter of Certification Approval of Workplace Safety Committee from the Bureau of Workers' Compensation (Safety Credit)

11. Does this business entity engage or use any of the following:

- Privately-owned or leased aircraft
- Maritime/harbor workers (NOTE: SWIF does not offer Jones Act coverage)
- U.S. Department of Defense contracts, outside U.S. Territories
- N/A

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12. Does this business utilize the services of subcontractors, owner-operators, and/or independent contractors in the operation of your business?

- No
- Yes - Provide copy of certificates of insurance (COI) for all subcontractors proving workers' compensation coverage in Pennsylvania and a copy of the signed contracts between the applicant and the subcontractor(s) required per Act 72. If valid COI's cannot be provided, submit a completed Independent Contractor Questionnaire form (SWIF-831). Owners/operators must complete the trucking Questionnaire form, (SWIF-832). Any subcontractors that do not carry workers' compensation may be included in coverage upon review. Also note that SWIF reserves the right to make a determination on the employment status of these individuals and may require them to be included as employees for workers' compensation purposes.

13. Liability limits are set to state minimum (\$100K/\$100K/\$500K);

FOR INCREASED LIMITS  **\$500K/\$500K/\$500K**  **\$1million/\$1million/\$1million**

14. Payroll: Additional information such as rates, class codes and instructions to estimate your premium may be found on the website: **www.dli.pa.gov/swif** NOTE: Payroll for officers/owners choosing exemption in question #3 should be excluded.

Class Code or Description	Number of Employees per Class	Estimated Payroll for One Year Term	Class Rate per \$100 payroll	Estimated Premium

- 15. a. If this business entity uses temporary workers provided through **staffing agencies**, include Certificates of Insurance from each agency used.
- b. If this business entity contracts with a **Professional Employer Organization (PEO) for leased workers**, provide a copy of signed contracts and/or agreements from each client as well as a list of employees per contract.
- c. If this business entity is a **Professional Employer Organization (PEO)**, include the requirements which can be found on the SWIF Homepage resources link for PEO requirements (**www.dli.pa.gov/swif**)
- d. If this business entity is a **temporary agency**, complete and sign the **Alternate Employer Endorsement Worksheet** which is located on the SWIF webpage, under "Forms" at **www.dli.pa.gov/swif**. **SWIF must be notified of all Alternate Employers (temporary clients) immediately upon acquisition during the policy term.** If any Alternate Employer is acquired during the policy term without notification to SWIF, claims attributed to those specific clients will be denied.

\* Note that it is the policy of the State Workers' Insurance Fund to provide policy information only to the policyholder; that is, that only the insured and/or the authorized agent may request the above information. This includes requesting Certificates of Insurance. SWIF does not take requests from third parties.

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### 16. Payment Terms

Policy premiums less than \$2,000	TOTAL PREMIUM REQUIRED.
Policy premiums \$2,000 to \$10,000	25% of the total premium, or the minimum premium whichever is greater; * with the remaining balance due in four equal installments.
Policy premiums over \$10,000	25% of the total premium, or the minimum premium whichever is greater; * with the remaining balance due in ten (10) equal installments.

\*Total premium includes the Employer's Assessment Fee, Terrorism Fee and Commercial Catastrophe Fee

**Requested inception date of coverage:** \_\_\_\_\_

**NOTE: COVERAGE WILL NOT BE BOUND PRIOR TO THE DATE AFTER RECEIPT OF A COMPLETED SWIF APPLICATION WITH REQUIRED PREMIUM.**

**PLEASE REVIEW FOR COMPLETENESS PRIOR TO SUBMISSION.**

### 17. Contract Conditions

- a. Coverage will become effective at 12:01 a.m. on the day specified on the workers' compensation policy issued by SWIF. In order for an application to be deemed acceptable for review and coverage, SWIF must receive a complete and properly signed application and the specified premium due.
- b. The application, including any subcontractor information elicited in Item 12 of the application, must be properly and fully completed and signed by an owner, or partner, or a corporate officer. The Construction Workplace Misclassification Act (Act 72) further established a definition of an "Independent Contractor" for purposes of Workers' Compensation as of February 10, 2011 and information regarding such can be found at **[www.dli.pa.gov/swif](http://www.dli.pa.gov/swif)**
- c. The premium quoted is based upon the nature of the operations and the estimated payroll disclosed by the employer in this application. The employer shall furnish SWIF with proper notice of any changes in the nature of its operations or its estimated payroll; such changes may result in an increase or decrease in the premium due under this policy. The employer agrees to keep an accurate record of employees and payroll expenditures, and to report injuries and occupational diseases to the State Workers' Insurance Fund immediately.
- d. SWIF requires the disclosure of accurate and legitimate payroll records. Such payroll records must include, but are not limited to, a list of each employee's Social Security number or I-9 forms. The determination of proper premium payments is dependent upon the accuracy of such records. Any failure to provide accurate and legitimate payroll records, at any time, will be considered a material breach entitling SWIF to either rescind the contract to insure, refuse to insure, or cancel the policy.
- e. The State Workers' Insurance Fund may conduct underwriting visits and/or audits during regular business hours during the policy period and within three (3) years after the policy ends. Information developed by the underwriting visit or audit will be used to determine the estimated or final premium. If it is determined that additional premium is due, you will be billed accordingly.
- f. When any claim for a temporary worker occurs at a client/Alternate Employer's location of which SWIF has not been previously notified, the claim will be denied.
- g. Employees hired in and working in another state cannot be covered by the Pennsylvania State Workers' Insurance Fund.

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**THE APPLICATION MUST BE SIGNED BY AN OWNER, A PARTNER OR A CORPORATE OFFICER AND RETURNED WITH YOUR PAYMENT.**

18. I certify that all information provided in this document is correct and complete. I acknowledge that false statements in this document are punishable pursuant to 18 Pa. C.S. §4904 (relating to Unsworn Falsification to Authorities), 18 Pa. C.S. §4117 (relating to Insurance Fraud) and 77 P.S. § 1039.2 (relating to the Workers' Compensation Act). A person who knowingly makes a false statement or knowingly withholds information may be subject to a fine, imprisonment and restitution.

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**Print Full Name** \_\_\_\_\_

19. **BROKER OF RECORD LETTER:** The following broker/agent has been designated as the official "Broker of Record". The following information must be completed and signed by BOTH the broker/agent and the applicant. No additional Broker of Record Letter is required.

**\*\*NOTE: Brokerages are NOT authorized to issue Certificates of Insurance on behalf of the State Workers' Insurance Fund. All COI's must be issued by request through SWIF only.**

**DO NOT ISSUE CERTIFICATES ON BEHALF OF SWIF on ACORD forms or any other document.**

BROKER/AGENT NAME OR INSURANCE AGENCY \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

**SIGNATURE OF APPLICANT** \_\_\_\_\_ Title \_\_\_\_\_

**SIGNATURE OF BROKER** \_\_\_\_\_

Print name \_\_\_\_\_ Date \_\_\_\_\_

20. **FINANCE COMPANY LETTER:** The following finance company has been designated as the official "Finance Company." The following information must be completed and signed by the finance company and the Insured.

**ATTACH COMPLETED, SIGNED FINANCE AGREEMENT**

NAME OF FINANCE COMPANY \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

**SIGNATURE of Company Representative** \_\_\_\_\_ Title \_\_\_\_\_

**SIGNATURE OF APPLICANT** \_\_\_\_\_

Print name \_\_\_\_\_ Date \_\_\_\_\_

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**pennsylvania**  
DEPARTMENT OF LABOR & INDUSTRY  
STATE WORKERS' INSURANCE FUND

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