KANSAS INSURANCE DEPARTMENT

Individual Application for Membership
In a Group Funded Workers' Compensation Pool

1. Member's Name____

2. Address (City, State, Zip Code and Phone Number)____________________________

   ____

3. Status: Individual, Limited Partnership, Co-Partnership, Corporation

   ____

4. Name of Business____

5. List of Principals____

   Name | Address (City, State, Zip Code) | Title

   ____

   ____

   ____

   ____

   ____

6. Chartered under the laws of the State of_____________________________________

   Date_____________________________

7. Date of commencement of business in Kansas_________________________________

8. Date of registration in the office of Secretary of State, if a foreign corporation_______

   ____

9. List of affiliates or subsidiaries and divisions to be included in the group funded Workers' compensation pool. (Show below or attach list)

   Name | Business Address (City, State, Zip Code) | Type of Business

   ____

   ____

   ____

   ____

   ____

10. If applicant is a subsidiary, name parent company

Name	Address (City, State, Zip Code)	Title

11. Loss history for the last three completed years

	Year Ending:	Year Ending:	Year Ending:
A. Number of accidents requiring medical attention only			
B. Number of accidents requiring Loss time of more than 7 days			
C. Total paid claims	$__________	$__________	$__________
D. Outstanding reserves	$__________	$__________	$__________
E. Total incurred losses Paid and Reserves	$__________	$__________	$__________

F. Fatalities in the last 3 years? No ________ Yes ________ Number ________

If Yes, explain: ____

____

____

____

____

____

12. Self-Insured Locations (Show below or attach list)

List of Names and Locations of Each Operation to be Covered Under Self-Insurance Program in KS	Nature of Operations According to industry Pursued or Products Manufactured	Average Number of Employees	
		Production	Office/Sales

13. Estimated Annual Kansas Gross Workers' Compensation Insurance Premium for 12 Month Period
Period Beginning: Month ___________ Day __________ Year __________

Classification Code	Classification Description	Estimated Annual Premium	Current Manual Rate	Estimated Annual Premium
___________	_______________	______________	___________	________________
___________	_______________	______________	___________	________________
___________	_______________	______________	___________	________________
___________	_______________	______________	___________	________________
___________	_______________	______________	___________	________________
___________	_______________	______________	___________	________________
___________	_______________	______________	___________	________________
___________	_______________	______________	___________	________________

Total Payroll _______________ Total Premium ________________

14. Present and Proposed Program

A. Present Carrier of Workers' Compensation Insurance___________________________

B. Present Workers' Compensation Annual Premium ______________________________

C. Proposed Effective Date of Membership in the Group Self-Insurance Pool ___________

15. Safety and Loss Control Program

A. Do you have a formal Safety Program? Yes ______ No ______

B. Name of Party Responsible for Administration of your Safety Control Program

____
Name Title Address (City, State, Zip Code)

C. State Details of Loss Control Program

____

____

____

____

16. Medical Facilities

A. What medical facilities are available to your employees?

First Aid _______ Local Clinic _______ In Plant Staff ______ Hospital ______

B. Do you employ a full time doctor/nurse? Yes ______ No ______

Explain: ____

____

____

17. Financial Status (Use Attached Form)

____

<u>IMPORTANT</u>: Your most current certified financial statement must be attached.

AFFIDAVIT

COUNTY ___________________________

STATE _____________________________

I, _____________________________, the undersigned, being the

_____________________________ of the __________________________
(Title) (Name of Applicant)

_____________________________, swear (or affirm) that to the best of my knowledge and belief, the statements contained n the application, including any accompanying documents, are true and complete.

BY: _________________________________

Sworn before me this __________ day of _____________________, _______.

____
Notary Public

My commission expires _________________________________

IMPORTANT:
ALL MEMBERS AND POTENTIAL MEMBERS
PLEASE READ CAREFULLY

The Applicant or Member Hereby Acknowledges That:

1. The “Pool” is a self-insured Workers’ Compensation Pool established pursuant to K.S.A. 44-581.

2. The pool is not an insurance company, and is not governed by the same regulations and is not subject to the same supervision by the Kansas Insurance Department as an insurance company would be.

3. The pool is not a member of, and its members are not eligible for any benefits from the Kansas Insurance Guaranty Association.

4. The member will be JOINTLY AND SEVERALLY LIABLE with every other employer who is a member of the pool for any unpaid claims and liabilities of the pool if the pool becomes insolvent.

5. The pool covers only Kansas Operations, including incidental coverage in other states.

6. The member will comply with all provisions of K.S.A. 44-581. et. seq., the Kansas Workers’ Compensation law, all rules and regulations of the pool, and all lawful orders of the Commissioner of Insurance.

7. That the member will promptly pay all premiums, taxes and assessments due as a member of the pool.

8. That the member will give to the pool notice prior to withdrawal from the pool, as required by the pool bylaws.

9. That the member will neither ask for nor receive credit from the trustees for payment of premium.

This is to certify that the above condition have been explained to me, and I understand and acknowledge them.

APPLICANT

____
NAME

BY: _________________________________
(Corporate Officer, Partner, Owner)

TITLE _______________________________

DATE _______________________________