pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
STATE WORKERS' INSURANCE FUND

APPLICATION FOR WORKERS' COMPENSATION INSURANCE COVERAGE - R

Dear Employer: Thank you for doing business in Pennsylvania! Please fill out this application accurately and completely. Doing so will help us process your application as quickly as possible.

- It is mandatory that employers carry workers' compensation insurance per the Pennsylvania Workers' Compensation and Occupational Disease Acts.
- Failure to comply with these laws subject employers to lawsuits by employees and criminal prosecution could result in substantial fines, imprisonment, or both.
- 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

Please complete and submit this application by mail to: State Workers' Insurance Fund, 100 Lackawanna Ave, PO Box 5100, Scranton, PA 18505-5100.

Payment: Checks (black or blue ink only) and money orders should be payable to "SWIF." Providing a check as payment authorizes SWIF to either make a one-time electronic fund transfer (EFT) from your account or to process the payment as a check transaction. Cash payments are not accepted.

For policies less than $2,000 in premium, total payment is required. For policies $2,000 or greater 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, the total premium may be required before coverage will be incepted. See 15. Payment Terms on page 6. For more information, visit **www.dli.pa.gov/swif** select "Underwriting," then select "How to Obtain a Policy."

Additional Information and Assistance: Should you have any questions about the application or coverage, please contact Customer Service at 570-963-4635.

- 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 (SWIF-51) 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 Application for Executive Officer Exception (LIBC-509) & Executive Officer's Declaration (LIBC-513) forms.
- All required forms and resources may be found either on the SWIF website 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 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 page seven should match.

FOR OFFICE USE ONLY: Application #_____ Check # _____ Amount $_____

PLEASE COMPLETE THE FOLLOWING APPLICATION FOR WORKERS' COMPENSATION INSURANCE

1. a. Business Name: _____

   b. Mailing Address: _____ City: _____ State: ____ Zip: _____

   c. PA Primary Operating Location: _____ County: _____

   d. Telephone: _____ Business Fax: _____

   e. Email: _____ f. 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 a Confidential Request for Information (ERM-14) form to identify each business.

   d. Has any principle applicant had a previous business that was insured by SWIF under a different name, entity, or FEIN? If yes, include names of previous business(es), names of owners/officers of the business(es), and FEIN(s):

3. PLEASE USE THE FOLLOWING GUIDE TO DETERMINE WHETHER YOU MUST COMPLETE TABLE A (3a) OR TABLE B (3b) ACCORDING TO YOUR TYPE OF ENTITY:

THIS SECTION NEEDS TO BE COMPLETED IN FULL OR YOUR APPLICATION WILL BE RETURNED WITH NO COVERAGE.

Indicate the type of business (check all that apply):

- ☐ Individual/Sole Proprietor
- ☐ Partnership
- ☐ Limited Liability Company
- ☐ Limited Liability Partnership

Complete Table A – Sole proprietors, partners of a partnership or LLP, members of an LLC electing or declining to be included under the Act must complete a Voluntary Election of Coverage (SWIF-51) form.

- ☐ Corporation (S or C)
- ☐ Non-Profit Corporation
- ☐ Professional Employer Organization
- ☐ Temporary Agency
- ☐ Other (Please specify, i.e. PEO client)

Complete Table B – An executive officer of a corporation, if eligible, may elect to be exempt under the Act by completing and submitting an Application for Executive Officer Exception (LIBC-509) & an Executive Officer's Declaration (LIBC-513). If not submitted, owners/officers will remain included for the entire policy term.

NOTE: ALL INCOMPLETE APPLICATIONS OR THOSE WITHOUT THE PROPER REMITTANCE WILL BE RETURNED WITHOUT COVERAGE IN FORCE. PLEASE REVIEW FOR COMPLETENESS BEFORE YOU SEND.

Clear All Fields

3a. TABLE A: Has this business entity been insured with SWIF before? Yes ☐ No ☐

Ownership for the Sole Proprietor / Partner / LLP / LLC – List each owner separately

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

3b. TABLE B: Has this business entity been insured with SWIF before? Yes ☐ No ☐

Ownership/Title for: S or C Corporation / Non-Profit – List each owner separately

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

i. Date articles filed: _____ ii. State: _____

4. Is this business currently in the process of liquidation or termination?

☐ No

☐ Yes – explain:

5a. Has this business ever filed for bankruptcy?

☐ No

☐ Yes – date filed:

5b. 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: _____ City: _____ State: ____ Zip: _____

Telephone: _____ Email: _____

NOTE: ALL INCOMPLETE APPLICATIONS OR THOSE WITHOUT THE PROPER REMITTANCE WILL BE RETURNED WITHOUT COVERAGE IN FORCE. PLEASE REVIEW FOR COMPLETENESS BEFORE YOU SEND.

7. Safety/Loss Control

Contact Person: _____

Address: _____ City: _____ State: ____ Zip: _____

Telephone: _____ Email: _____

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 _____

PLEASE NOTE: 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 Contractor Number (HIC#):

_____

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

☐ No

☐ Yes – explain:

10. a. Provide a **COMPLETE AND 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.)

NOTE: ALL INCOMPLETE APPLICATIONS OR THOSE WITHOUT THE PROPER REMITTANCE WILL BE RETURNED WITHOUT COVERAGE IN FORCE. PLEASE REVIEW FOR COMPLETENESS BEFORE YOU SEND.

Provide the following where applicable on a separate page:

b. List of clerical employees and their job duties

c. Volunteer Fire Department Roster (Act 46) and Volunteer Fireman Exposure form at **www.pcrb.com**

d. 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).

e. Approval to Exempt Certain Religious Members (LIBC-14C) form at **www.wcais.pa.gov**

f. 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

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

☐ No

☐ Yes – Please provide the following:

- A copy of Certificates of Insurance (COI) for all subcontractors proving workers' compensation coverage in Pennsylvania.
- A copy of the signed contracts between the applicant and the subcontractor(s) as required per Act 72.

If valid COIs cannot be provided, please submit a completed Independent Contractor Questionnaire form (SWIF-831). Owner-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.

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

FOR INCREASED LIMITS: ☐ **$500K/$500K/$500K** ☐ **$1million/$1million/$1million**

- Employers' liability insurance provides coverage to employers for liability arising out of a worker's injury that is not covered by standard workers' compensation coverage. This can include liability to employees, their families, and other associated third parties.
- Standard employers' liability limits are $100,000 per occurrence for bodily injury, $100,000 per employee for bodily injury by disease, and $500,000 aggregate for bodily injury by disease.
- These limits can be increased by endorsement and payment of an additional premium. The two other options for increased limits are $500,000 and $1,000,000, as shown above.

NOTE: ALL INCOMPLETE APPLICATIONS OR THOSE WITHOUT THE PROPER REMITTANCE WILL BE RETURNED WITHOUT COVERAGE IN FORCE. PLEASE REVIEW FOR COMPLETENESS BEFORE YOU SEND.

13. Payroll: Additional information such as rates, class codes, and instructions to estimate your premium may be found on our 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

14. PLEASE REVIEW TO DETERMINE IF ADDITIONAL INFORMATION IS REQUIRED:

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**, please 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)**, please include the requirements which can be found at 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 at **www.dli.pa.gov/swif**, select "Underwriting," then select "How to Obtain a Policy." **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: SWIF only provides policy information to the policyholder; that is, 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.

15. 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 10 equal installments.

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

Requested inception date of coverage: _____

PLEASE REVIEW FOR COMPLETENESS PRIOR TO SUBMISSION.

NOTE: ALL INCOMPLETE APPLICATIONS OR THOSE WITHOUT THE PROPER REMITTANCE WILL BE RETURNED WITHOUT COVERAGE IN FORCE. PLEASE REVIEW FOR COMPLETENESS BEFORE YOU SEND.

16. CONTRACT CONDITIONS:

a. Coverage will become effective at 12:01 a.m. on the day specified on the workers' compensation policy issued by SWIF. 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, a partner, or 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**.

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 SWIF 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. SWIF may conduct underwriting visits and/or audits during regular business hours during the policy period and within three 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.

SIGNATURES AND CERTIFICATIONS:

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

17. 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: _____

NOTE: ALL INCOMPLETE APPLICATIONS OR THOSE WITHOUT THE PROPER REMITTANCE WILL BE RETURNED WITHOUT COVERAGE IN FORCE. PLEASE REVIEW FOR COMPLETENESS BEFORE YOU SEND.

18. 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 SWIF. All COIs must be issued by request through SWIF only.**

DO NOT ISSUE CERTIFICATES ON BEHALF OF SWIF ON ACORD FORMS OR ANY OTHER DOCUMENT.

a. BROKER/AGENT NAME OR INSURANCE AGENCY: Kelly Insurance Group, Inc.

b. Name: Jonathan Kelly

c. Address: 700 River Avenue Suite 433 City: PITTSBURGH State: PA Zip: 15212

d. Telephone: 412-325-1650 Fax: 412-325-1657 e. Email: events@kelins.com

f. **SIGNATURE OF APPLICANT:** _____ Title: _____

g. **SIGNATURE OF BROKER:** _____

h. Print Name: _____ Date: _____

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

ATTACH COMPLETED AND SIGNED FINANCE AGREEMENT

a. NAME OF FINANCE COMPANY: _____

b. Name: _____

c. Address: _____ City: _____ State: ____ Zip: _____

d. Telephone: _____ Fax: _____ e. Email: _____

f. **SIGNATURE OF COMPANY REPRESENTATIVE:** _____ Title: _____

g. **SIGNATURE OF APPLICANT:** _____

h. Print Name: _____ Date: _____

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