LIBC-368 REV 10-01

SUBMIT APPLICATION TO:

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR AND INDUSTRY
BUREAU OF WORKERS' COMPENSATION
SELF-INSURANCE DIVISION
1171 S. CAMERON STREET, ROOM 103
HARRISBURG, PA 17104-2501

APPLICATION FOR MEMBERSHIP IN A GROUP WORKERS' COMPENSATION FUND

1. Name of Fund ______________________ Bureau Code ________
2. Complete Legal Name of Member-Applicant ______________________
3. Mailing Address ______________________

______________________ Phone (___) ______________
4. Member-Applicant is: ☐ Corporation ☐ Sole Proprietorship ☐ Business Trust ☐ Political Subdivision ☐ Partnership ☐ Other (Specify) ________
5. Federal Employer Identification Number ______________ County ________
6. Provide the name, address and telephone number of an officer or employe of the member-applicant to be contacted for information on this application.

____

____
7. a. Describe briefly the general character of the member-applicant's operations in Pennsylvania, including the articles produced or services provided. ______________________

____

   b. Provide the member-applicant's predominate Standard Industrial Classification code _ _ _ _ or North American Industrial Classification System code _ _ _ _ _ _ by volume of sales or revenue for its Pennsylvania operations.
8. How many years has the member-applicant operated in Pennsylvania? ________
9. Provide the following on all Pennsylvania locations (attach additional sheets if necessary).

NAME/DIVISION	ADDRESS	NUMBER OF EMPLOYES
	TOTAL	

10. If the member-applicant is a subsidiary of a U.S. company, provide the name, address and percentage of ownership of the top U.S. parent.

____

____

11. Current Insurance Information

a. Current Pennsylvania workers' compensation insurance carrier __________________

b. Effective period of current policy __________________

c. Policy number __________________

12. Provide the following information on the member-applicant's workers' compensation insurance experience in Pennsylvania for each of the three complete policy years prior to this application. Loss information for each policy year shall be valued within three months of the date of the submission of this application.

INSURANCE CARRIER	LIABILITY PERIOD	TOTAL NO. OF CLAIMS	PAID LOSSES	INCURRED LOSSES	LOSSES VALUED AS OF

13. Financial Information

a. If the member-applicant is not a political subdivision, provide the following:

Net Worth $ __________________

Total Revenues for Last Complete Fiscal Year $__________________

b. If the member-applicant is a political subdivision, provide the following:

General Fund Balance $__________________

General Fund Total Revenues for Last Complete Fiscal Year $ __________________

14. Attachments required with this application:

a. A Modified Manual Premium Calculation Worksheet (LIBC-370).

b. A statement from the insurance carrier(s) or a summary page from loss reports which confirm the information provided in Item 12.

c. The member-applicant's latest annual financial statements if it will contribute more than 10% of total annual fund contribution.

d. If non-charter member, an Annual Contribution Worksheet Form (LIBC-350) and proof that the member-applicant has paid 25% of its annual contribution amount to the fund.

ATTESTANTS

The undersigned 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 it has not been found to have violated Section 305 or Section 435 of the Workers' Compensation Act as an individual self-insurer; and that it 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 the Bureau of Workers' Compensation of the Department of Labor and 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____.

______________________ WITNESS	By: ______________________ OWNER/OFFICER SIGNATURE
______________________ TYPE OR PRINT NAME AND TITLE	______________________ TYPE OR PRINT NAME AND TITLE

Note: This application shall be completed and executed by the applicant and forwarded to the fund for review and approval.

The above member-applicant is hereby approved for membership in ______________________,
NAME OF FUND

and its participation is effective the ________ day of ______________________, 20____.

Signed this ______ day of ______________________, 20____.

By: ______________________
ADMINISTRATOR/TRUSTEE/PLAN COMMITTEE

Note: Approved applications shall be forwarded by the fund to the Bureau of Workers' Compensation, Self-Insurance Division, 1171 S. Cameron Street, Room 103, Harrisburg, PA 17104-2501, and shall be filed no later than **fifteen (15) days** after the effective date of the applicant's participation in the fund.