Montana State Fund

855 Front Street
P.O. Box 4759
Helena, MT 59604-4759
Phone: 406-495-5000
stfpolicy@mt.gov

Workers' Compensation Insurance Application

Agent Name: (If applicable)

Agency Address: (If applicable)

If you have questions, please contact a Customer Service Specialist at 406-495-5000

Business Information

Legal Entity Name (if sole proprietorship, please use your first and last name)	Taxpayer Identification # (if sole proprietorship without an EIN, please enter SSN)	
Mailing Address (PO Box/Suite/Street, City, State & Zip Code)	Email Address	Phone Number

If you would like an authorized representative such as an accountant or CPA to receive all correspondence regarding your policy, please enter their name and mailing address. All policy information will be sent to this address. If you choose to partner with us, after your policy is issued, multiple parties can sign up to receive electronic documents.

Authorized Representative Name	Authorized Representative Mailing Address (PO Box/Suite/Street, City, State & Zip Code)

Business Locations

If you have a DBA, list their name(s) and physical location(s). Describe each job by location on a separate line. You may include class code if known. List only locations that need coverage. If you need extra space, attach additional pages.

Physical Location	Description of Business Operations & Employee Duties	Estimated Annual Payroll
Physical Location 1 (Street, City, State & Zip Code)	Job 1	Job 1
	Job 2	Job 2
	Job 3	Job 3
Physical Location 2 (Street, City, State, & Zip Code)	Job 1	Job 1
	Job 2	Job 2
	Job 3	Job 3
Physical Location 3 (Street, City, State, & Zip Code)	Job 1	Job 1
	Job 2	Job 2
	Job 3	Job 3

Ownership Information & Coverage Selection

List all names of owners, partners, LLC members, LLC managers, corporate officers, or shareholders.
Tip: Check that the ownership interest of all listed totals 100%.

Full Name	Title	Ownership %	Duties Performed	Paid for Duties?		Covered?		*Elective Coverage Amount (annually)
				Y	N	Y	N	
				☐	☐	☐	☐	
				☐	☐	☐	☐	
				☐	☐	☐	☐	
				☐	☐	☐	☐	

*Subject to annual min and max levels. Effective 7/1/2025: for sole proprietors, partners, and LLC member managers, the minimum is $10,800 with a maximum of $88,660; for covered corporate officers and LLC managers the minimum is $10,428 with a maximum of $88,660.

Are any of the persons listed above related? This can impact coverage options. If "Yes" please explain: ☐ Yes ☐ No

Policy/Quote Details *If you choose "Quote Only", you will receive a Quote Proposal Letter for your approval before a policy is issued.

Do you want a policy issued or a quote? ☐ *Quote Only ☐ Issue Policy

Requested Effective Date

The earliest a policy can begin is the day after MSF receives your request to issue coverage.

A standard policy period is 12 months with an option to renew. If your business needs require a different policy duration, please let us know here.

Employer's Liability coverage protects the employer against lawsuits filed by employees (or their family members) for work-related injuries or illnesses that fall outside the scope of workers' compensation benefits. Montana State Fund provides coverage at the basic level automatically at no extra cost: $100,000 bodily injury by accident- each accident, $100,000 bodily injury by disease- each employee, $500,000 bodily injury by disease- policy limit.

Please select either basic coverage at no extra cost or higher limits for additional cost to be quoted:

☐ 100 / 100 / 500
Basic Coverage

☐ 500 / 500 / 500
For Additional Cost

☐ 1M / 1M / 1M
For Additional Cost

Payroll Reporting & Payment Schedule Premium you pay is based on payroll.

You provided payroll estimates on the previous page. You can either (a) pay based on those estimates and provide us actuals once per year through an annual payroll report at policy expiration/renewal or (b) pay based on actuals with payroll reporting throughout the year. Tip: To minimize reporting work, most small to medium size businesses, especially those without dedicated payroll support, do best with annual payroll reporting.

☐ Annual Payroll Reporting With Payments Based on Estimates

- ☐ 1 Annual at Policy Enrollment
- ☐ 3 Consecutive monthly for the first 3 months of your policy period
- ☐ 4 Quarterly
- ☐ 10 Consecutive monthly for the first 10 months of your policy period
- ☐ 12 Monthly

or

☐ Pay Based on Actual Payroll Submitted Throughout the Year

- ☐ Quarterly Payroll Reporting and Quarterly Payment
- ☐ For businesses that choose the reporting plan, quarterly reporting with quarterly payments typically works best. If you'd like to consider another option, please contact us or check this box for us to get in touch with you about an alternative.

Additional Information To tailor the policy or quote to your workers' compensation needs, please indicate if the following apply to your business.

	Y	N		Y	N
1. Are physicals required after offers of employment are made?	☐	☐	5. Do you have workers' compensation insurance in other states? (If "Yes" please list name(s) and location(s) in other states)	☐	☐
2. Are employee health plans offered?	☐	☐			
3. Is there a written safety program in operation?	☐	☐			
4. Do employees predominantly work at home?	☐	☐			

Elective Coverages Please indicate if your business needs require any of the following

	Y	N		Y	N
1. Non-Montana resident employees	☐	☐	5. Minister or member of a religious order	☐	☐
2. Dependent family member or spouse	☐	☐	6. *Volunteer worker *Only available to government, not-for-profit or non-profit entities	☐	☐
3. Household or domestic employee	☐	☐			
4. Persons providing companionship or respite care	☐	☐			

Submitting the Application Your completion of all the information on this application helps ensure you're getting the coverages you need at the right price.

Ready to go? By submitting, you're confirming everything is accurate and you're authorized to set up insurance for your business.
Please submit your completed application to:

Email: stfpolicy@mt.gov

US Mail:
Montana State Fund
P.O. Box 4759
Helena, MT 59604-4759

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