Application for Insurance Coverage

Montana State Fund (MSF) is a nonprofit, publicly owned workers' compensation insurer. Any employer with employees hired to work in Montana may apply for coverage.

How to Obtain Coverage:

A separate application must be completed for each individual legal business entity. Separate entities, even though they may have common ownership, may not be insured on the same policy.

This policy will provide coverage for all of your employees who are required to be covered by Montana law (see Montana Code Annotated (MCA) 39-71).

A business entity with a minimum of 51% ownership interest held by an enrolled tribal member and whom operates solely within the boundaries of a Tribal Reservation, is not required to provide workers' compensation coverage for any employee. If an enrolled tribal member chooses to provide coverage through MSF, the policy will cover all employees and premium must be paid for all employees working on and/or off the Tribal Reservation.

MSF will review your application, as well as any previous or current policies. An outstanding obligation on a prior MSF policy will need to be resolved and may impact this application's policy effective date. Please contact a Customer Service Specialist to resolve all outstanding obligations.

The earliest a policy may begin is the day after your complete application is received.

COMPLETING THE APPLICATION: *(all sections must be fully completed)*

Agent Information: *(if applicable)*

Agent Name & Agency Address to be completed when the application is being submitted by an agency partner.

Business Information

Legal Entity Name: If the business is a sole proprietorship or a partnership, enter the owner's name(s) here. Otherwise, enter the legal business name. Each business entity, regardless of common ownership, must have their own policy.

Taxpayer Identification #: Enter your Employer Identification Number (EIN). An EIN may be quickly obtained from the IRS on-line at *www.irs.gov* or by calling (800) 829-4933. The IRS website contains information about businesses that are required to obtain an EIN. If your business is not required to obtain an EIN, your Social Security number will suffice and will only be used for business identification purposes when policy information is required to be reported to regulatory authorities.

Mailing Address: Enter your mailing address. All policy information is sent to this provided mailing address unless you choose to have all policy information sent to your accountant or CPA. (To designate your accountant or CPA to receive all policy correspondence, provide the accountant or CPA's name & address on page 3 of this application.)

List All DBAs (Doing Business As): Enter all business names that are used by the business.

Phone Number: Enter your business telephone number including the area code and any applicable extension.

Email Address: Enter your business email address.

Type of Business: Check the box that describes your business legal entity type. If not listed, please specify entity type in the space provided.

NCCI Risk ID Number: If applicable, enter your business risk ID number. If your business has a risk ID number, submit a copy of your most recent Experience Modification Worksheet from your prior insurance carrier or submit an authorization allowing MSF to obtain the information from NCCI. An authorization letter template is available by clicking on the link below:
https://www.montanastatefund.com/web/docs/authorization-for-ncci-to-release-experience-rating.doc

Years in Business: Enter the number of years the business has been operating.

Locations

Enter each physical address for all business locations. If more space is needed, provide additional locations on a separate page and submit with your application.

Policy Information

You may elect "Quote Only" or "Issue Policy".

- If "Quote Only" is selected, MSF will not issue a policy until notified.
- If you select "Issue Policy", the earliest a policy may begin is the day after a complete application is received.

Requested Effective Date: Enter the date you would like your policy to begin. The earliest a policy may begin is the day after a complete application is received.

<u>Requested Expiration Date:</u> Enter the date you would like coverage to expire. The expiration date cannot be more than 12 months & 16 days from the effective date. To ensure ease of reporting, we suggest you select an expiration date that coincides with your business processes and needs. If no specific expiration date is requested, MSF will assign an expiration date of 12 months from policy inception.

<u>Other States Locations:</u> Enter the states, other than MT, in which you conduct business.

<u>Medical Deductible?</u> If you wish to participate in the Medical Deductible program, check "Yes". For more information about the program, please contact a Customer Service Specialist.

<u>Employers Liability Limits:</u> Employers liability coverage provides you with additional insurance protection for work related injuries not covered under the Workers' Compensation Act. Indicate the desired limits of liability on the application.

MSF provides employers liability insurance for policyholders at the limits shown for no additional 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

Higher limits of liability are available for additional premium. Contact MSF for additional cost amounts:

- ☐ $500,000 Bodily Injury by Accident - each accident
  $500,000 Bodily Injury by Disease - each employee
  $500,000 Bodily Injury by Disease - policy limit

OR:

- ☐ $1,000,000 Bodily Injury by Accident - each accident
  $1,000,000 Bodily Injury by Disease - each employee
  $1,000,000 Bodily Injury by Disease - policy limit

<u>Policy Options:</u>

- ☐ <u>Installment Plan with *Annual* Payroll Reporting</u>
  Upon enrollment you will receive an invoice for the initial installment, annual expense constant, and associated regulatory assessments due in our office 25 calendar days from the invoice date. Installment options are based upon your total estimated premium for the term. (For a list of Installment Plan Options visit: *https://www.montanastatefund.com/web/docs/installment-plan-options.pdf)* Final premium will be calculated at the end of the term based upon your actual wages. Timely wage reporting and installment payments are required. Suggested for businesses which have stable, nonseasonal payroll levels.

☐ Reporting Plan with *Monthly* Payroll Reporting
Upon enrollment you will receive an invoice for the policy's annual expense constant and associated regulatory assessments due in our office 25 calendar days from the invoice date. You will receive monthly premium invoices upon your reported actual paid wages and associated regulatory assessments due in our office 25 calendar days from the invoice date. Timely wage reporting and premium payments are required. Suggested for businesses which have fluctuations in payroll such as seasonal employment.

☐ Reporting Plan with *Quarterly* Payroll Reporting
Upon enrollment you will receive an initial invoice for the policy's annual expense constant and associated regulatory assessments due in our office 25 calendar days from the invoice date. You will receive quarterly premium invoices based upon your reported actual paid wages and associated regulatory assessments due in our office 25 calendar days from the invoice date. Timely wage reporting and premium payments are required. Suggested for businesses which have fluctuations in payroll such as seasonal employment.

Rating Information:

Fully complete the state, location, description of employees' duties, number of employees (both full time and part time) and estimated annual payroll. You should group employees together based on their common duties.

Ownership Information and Coverage Selection:

List all names of owners, partners, LLC members, LLC managers, corporate officers or shareholders. Please specify your intent to cover or not cover each individual listed. Provide individual title. For example: sole proprietor, partner, LLC member, LLC manager, president, vice president, secretary, treasurer, CEO, CFO, or other appointed entity title. The application must include all ownership for a total of 100% ownership interest. List duties performed. Indicate if coverage for this person is desired. Due to MT laws which require some persons to be covered and exclude others from the Workers' Compensation Act, your indicated preference may be modified by MSF. Indicate any relationship between persons listed in section such as: spouse, child, parent, sibling, son/daughter-in-law, nephew or niece. In certain situations, family relationships can impact coverage options. Contact MSF with any questions.

Prior Insurance Company Information and Claim History:

No: If the business has not previously been insured for workers' compensation insurance, please select No and go to the next section.

Yes: If the business was previously insured with another insurance company, please select Yes and provide a minimum of a 3-year (5 years preferred) Loss History Report obtained from your insurance agency or prior insurance company and submit with your application.

Description of Business Operations:

Provide a detailed description of all business operations including the industry specific information noted in the application. If additional space is needed, please attach an additional page.

General Information:

Answer each question and provide a detailed explanation for all "Yes" responses in the provided area. If additional space is needed, please attach an additional page.

Elective Coverages: A policy provides coverage for all employees as required by Montana law. Certain employments are not statutorily required to be covered, however may be elected by you to cover under your policy with MSF approval.
Check the appropriate boxes in this section to request elective coverage(s) consideration.

NOTE*: A person who regularly and customarily* performs services at locations other than the person's own fixed business location must either obtain an independent contractor exemption certificate or elect to obtain workers' compensation insurance coverage on themselves. For more information, refer to DLI's website at *www.mtcontractor.com* or call (406) 444-9029.

The following are examples of exempt employments which may not require coverage:

- Sole proprietors, partners of a partnership, members of a limited liability partnership and members of a member-managed limited liability company (LLC).
- Elected corporate officers or managers of a manager-managed LLC who meet any of the following requirements:
  1. Is not engaged in performing the ordinary duties of a worker and does not receive any pay.
  2. Performs primarily household duties.
  3. Owns 20% or more of the number of shares of stock in the corporation or 20% or more of the LLC.
  4. When in combination with other officers or managers whom they are related (*as defined below) and have a combined total ownership of 20% or more.

**A relative for combinability is defined as a spouse, child, adopted child, stepchild, mother, father, son-in-law, daughter-in-law, nephew, niece, brother, or sister.*

***NOTE**:* Coverage cannot be elected for corporate officers or LLC managers who fail to satisfy any of the four elective criteria listed above, are not engaged in performing the ordinary duties of a worker, do not receive pay, and do not reside in Montana and do not work in Montana.

Corporate officers or LLC managers who fail to satisfy any of the four elective criteria and who receive pay from the corporation or LLC for the performance of ordinary duties are automatically covered.

For more information and a complete list of exempt employments, go to *https://dli.mt.gov/* or contact a Customer Service Specialist.

Do you require Certificates of Insurance to those whom you perform work? If yes, please list names and addresses on an additional page and submit with your application.

Do you want an accountant or CPA to receive all correspondence regarding your policy? If yes, please list their name and address in the space provided.

If you are a member of any of the associations listed: Contact the association for more information on our group programs.

Signature:

An authorized employer representative must sign and submit the completed application with all applicable attachments for consideration. When an application is being submitted by an agent partner, the agent signature is an authorized employer representative.

Electronic Signature: The completed application may be signed electronically by clicking in the highlighted space provided and following the instructions. You may also print the completed form, sign and submit to MSF by US mail, Fax or scan & email to the address provided below.

Review and Submit the Application:

Be sure you have completed all areas and signed the application before submitting. An incomplete or unsigned application may be returned, resulting in a delay in coverage.

Application for Insurance Coverage

Make a copy of the application for your records and return the signed application to:

- Email: *stfpolicy@mt.gov*
- US Mail:
  Montana State Fund
  PO Box 4759
  Helena, MT 59604-4759
- Fax: (406) 495-5020

If you have any questions, please contact a Customer Service Specialist at
(800) 332-6102 or (406) 495-5000.