Montana State Fund

855 Front Street
P.O. Box 4759
Helena, MT 59604-4759
Phone: 800-332-6102
Fax: 406-495-5020

Workers' Compensation Insurance Application

Agent Name: (If applicable)

Agency Address: (If applicable)

If you have questions, please refer to the application instructions by clicking a ⓘ, hovering your cursor over a field to view the explanation, or by contacting a Customer Service Specialist at 800-332-6102.

Business Information ⓘ

Legal Entity Name (Last Name, First Name, Middle Initial- if an individual)	Taxpayer Identification #
Mailing Address (Street or P.O. Box)	City, State & Zip Code
List all DBA's (Doing Business As)	Phone Number Extension
Email Address	☐ Sole Proprietor ☐ Non-Profit Corp ☐ Partnership ☐ Other (Specify) ☐ Corporation ☐ Member-Managed LLC ☐ Manager-Managed LLC
NCCI Risk ID Number (see application instructions) / Years in Business	

Locations ⓘ

Physical Location 1 (Street, City, State, Zip Code)

Physical Location 2 (Street, City, State, Zip Code)

Physical Location 3 (Street, City, State, Zip Code)

Policy Information ⓘ

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

If you choose the "Quote Only" option, a policy will not be automatically issued by MSF. The earliest a policy can begin is the day after MSF receives your request to issue coverage.

Requested Effective Date	Requested Expiration Date	Other States Locations (States)	Medical Deductible? ☐ Yes ☐ No

Employer's Liability Limits - select one: Montana State Fund provides basic employers liability insurance for policyholders at: $100,000 Bodily Injury by Accident- each accident. $100,000 Bodily Injury by Disease- each employee. $500,000 Bodily Injury by Disease- policy limit. If you do not make a selection basic coverage will be applied. Higher limits are available for additional premium. Please contact a Customer Service Specialist for pricing information.

☐ 100 / 100 / 500 Basic Coverage ☐ 500 / 500 / 500 For Additional Cost ☐ 1MM / 1MM / 1MM For Additional Cost

Policy Options ⓘ

Select one: (see application instructions for explanation of each plan option)

☐ Installment Plan: Annual Payroll Reporting ☐ Reporting Plan: Monthly Payroll Reporting ☐ Reporting Plan: Quarterly Payroll Reporting

Rating Information ⓘ

State	Location	Class Code*	Description of Employee Duties	# of Employees Full Time	# of Employees Part Time	Estimated Annual Payroll

*Class Code is determined by Montana State Fund.

Ownership Information & 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.

Full Name	Title	Ownership %	Duties Performed in MT	Paid for Duties	Covered or Excluded	Class Code	Elective Coverage Amount

Are any of the persons listed above related? ☐ Yes ☐ No If "Yes" please explain:

Are all owners/officers duties performed in Montana? ☐ Yes ☐ No

Owners/officers who are not residents of Montana and whose duties are not performed in Montana are excluded from coverage.

Prior Insurance Company Information & Claim History ⓘ

Have you ever had workers' compensation insurance through another company? ☐ Yes ☐ No

If you had coverage in the past 5 years with another insurance company, please provide a minimum of a 3-year Loss History Report (5 years preferred) obtained from your insurance agency or prior insurance company and submit with your application.

Description of Business Operations ⓘ

Needed information related to your industry:

Construction: List type of work performed, type of structures built, materials used, the trades involved and use of subcontractors or independent contractors.

Day care and Preschools: List whether day care only, preschool only, or both.

Drilling: List oil or gas, water, other such as seismograph, shot-hole. Describe the drilling methods.

Farming /Ranching: List acreage, livestock, grain or other produce, machinery, subcontracts.

Gas Stations: List whether self-service, full service, combined gas station and grocery store. Breakdown receipts between retail and wholesale.

Manufacturing: List raw materials, processes, finished product, equipment, and contractors.

Mining: List whether underground or surface, and type of mineral/ore being extracted.

Restaurants: List any delivery services or catering and the frequency done.

Service: Describe type and location.

Stores: List merchandise, deliveries, grocery or convenience, business hours, retail or wholesale, and packaged or fresh meat sales.

Trucking: Describe type of cargo, interstate or intrastate, type of truck, radius of operation, and whether you own the product being transported.

Please provide a detailed description of all business operations and products including the industry information noted above:

General Information

	Y	N		Y	N
1. Does your business operate an aircraft for business purposes?	☐	☐	13. Are physicals required after offers of employment are made?	☐	☐
2. Any work performed underground or above 15 feet?	☐	☐	14. Any prior coverage declined/canceled/non-renewed in the last 3 years?	☐	☐
3. Any subcontractors used? (If "Yes" please give % of work subcontracted.)	☐	☐	15. Are employee health plans offered?	☐	☐
4. Any work sublet without certificates of insurance?	☐	☐	16. Is there a labor interchange with any other business/subsidiary?	☐	☐
5. Is there a written safety program in operation?	☐	☐	17. Do you lease employees to or from other employers?	☐	☐
6. Any group transportation provided?	☐	☐	18. Do employees predominantly work at home?	☐	☐
7. Any employees under 16 or over 60 years of age?	☐	☐	19. Will you be hiring Montana residents?	☐	☐
8. Any seasonal employees?	☐	☐	20. Any tax liens or bankruptcy within the last 5 years?	☐	☐
9. Is there any volunteer or donated labor?	☐	☐	21. Did you acquire this business from another owner?	☐	☐
10. Do employees travel out of state?	☐	☐	22. Are you related to the prior owner? (Not applicable if #21 is "No.")	☐	☐
11. Is this business engaged in any other type of business or are you a subsidiary of another entity?	☐	☐	23. Do you have workers' compensation insurance in other states? (If "Yes" please list name(s) and location of operation(s) in other states.)	☐	☐
12. Have past, present or discontinued operations involved storing, heating, discharging, applying, disposing, or transporting hazardous material? (e.g., landfills, wastes, fuel tanks, etc.)	☐	☐	24. Any undisputed and unpaid workers' compensation premium due from you or any commonly managed or owned enterprises? (If "Yes" please explain including entity name(s) and policy number(s).	☐	☐

Explain all "Yes" responses here (reference item #). If additional space is required, please use another page and attach it to this application.

Elective Coverages Please indicate if you need any of the following, subject to Montana State Fund approval.	Y	N	Elective Coverages Please indicate if you need any of the following, subject to Montana State Fund approval.	Y	N
1. Sole Proprietor / Partner / LLC Member Manager	☐	☐	11. Newspaper carrier / Freelance correspondent	☐	☐
2. Corporate Officer / LLC Manager	☐	☐	12. Contract, licensed barber or cosmetologist	☐	☐
3. Dependent family member or spouse	☐	☐	13. Petroleum Land Professional	☐	☐
4. Household or domestic employee	☐	☐	14. Licensed Jockey, trainer, assistant trainer, exercise or pony person	☐	☐
5. Casual Employment	☐	☐	15. Non-Montana resident employees	☐	☐
6. Person working in return for aid or sustenance only	☐	☐	16. Officers or managers of ditch companies or water users companies	☐	☐
7. Volunteer worker (including volunteer firefighters and/or EMTs)	☐	☐	17. Minister or member of a religious order	☐	☐
8. Amateur athletic officials	☐	☐	18. Persons providing companionship or respite care	☐	☐
9. Real estate, securities or insurance salesperson	☐	☐	19. Motor carrier hired by a freight broker or freight forwarder	☐	☐
10. Direct home seller of consumer products	☐	☐	20. A musician performing under a written contract	☐	☐
Do you require Certificates of Insurance? If "Yes" please list name(s) and address(es) on additional page(s).	☐	☐	If you are a member of any of the associations below, you should contact your association for more info on our group programs.		
Do you want an authorized representative such as an accountant/CPA to receive all correspondence regarding your policy? If "Yes" please list their name and address in the space provided. You will not receive correspondence at any other address.	☐	☐	MBIA- Montana Building Industry Association MLA- Montana Logging Association MTA- Montana Trucking Association MSFAG- Montana State Fund Agriculture Group *(Montana Stockgrowers Association, Montana Organic Association, Montana Woolgrowers Association, Montana Grain Growers Association, Montana Pork Producers, Montana Farm Bureau, or Montana Cattlemen's Association)*		

Signature

I hereby certify that I have been given authority to secure workers' compensation insurance by the business owner. I have read and fully understand the accompanying instructions and have completed this application form to the best of my ability. All the information provided herein is true and correct. (If this application is being submitted by an agent, the agent is the authorized signatory below.)

Print Signatory Name _____ Title of Signatory _____ Phone Number _____

Please sign here ➤ _____ Authorized Signature _____ Date

Submitting the Application

Please complete the entire application, sign and return via:

Email: *stfpolicy@safemt.gov*
Fax: 406-495-5020
US Mail: Montana State Fund, P.O. Box 4759, Helena, MT 59604-4759

Please note: If you have any questions please contact a Customer Service Specialist at 800-332-6102.
An incomplete application may cause delays in coverage.