THE WORKERS' COMPENSATION
RATING AND INSPECTION BUREAU

October 28, 2016

CIRCULAR LETTER NO. 2300

To All Members and Subscribers of the WCRIBMA:

REVISIONS TO THE ASSIGNED RISK POOL APPLICATION,
NEW SUPPLEMENTAL APPLICATIONS &
UPDATED EXCLUSION OF COVERAGE FOR LEASED EMPLOYEES ENDORSEMENT - WC200305

EFFECTIVE JANUARY 1, 2017

The Commissioner of Insurance has approved the WCRIBMA's filing which recommended the revision of the existing Massachusetts Assigned Risk Pool Application, the Massachusetts Workers' Compensation Insurance - Employee Leasing Supplemental Application, and the Massachusetts Exclusion of Coverage for Leased Employees Endorsement - WC200305, as well as the introduction of several new supplemental applications effective January 1, 2017.

The following supplemental applications have been approved for use by applicants to the Assigned Risk Pool effective January 1, 2017:

- Client of Labor Contractor Supplemental Application
- Labor Contractor Supplemental Application
- Construction Contractor Supplemental Application
- Trucker/Delivery Supplemental Application

NCCI's Forms Manual and the forms and instructions provided on WCRIBMA's website will be updated in due course.

Attached is a copy of the WCRIBMA's August 16, 2016 Filing Memorandum indicating the Purpose, Background, Proposal, Impact and Implementation of this Item.

Please contact me at 617.646.7594 or dcrowley@wcribma.org or Christine Cronin at 617.646.7544 or ccronin@wcribma.org if you have any questions

Daniel M. Crowley, CPCU
Vice President, Customer Services

Attachments

Massachusetts Workers Compensation
Assigned Risk Pool

August 16, 2016

The Honorable Daniel R. Judson
Commissioner of Insurance
Massachusetts Division of Insurance
1000 Washington Street
Boston, MA 02118

RE: Massachusetts Workers' Compensation Assigned Risk Pool

Dear Commissioner Judson,

Attached for your review and approval are the following:

- Proposed revisions to these existing items:
  - Massachusetts Workers' Compensation Assigned Risk Pool – Application for Workers' Compensation Insurance ("Pool Application")
  - Massachusetts Workers' Compensation Insurance – Employee Leasing Supplemental Application, Sides A & B
  - Massachusetts Exclusion of Coverage for Leased Employees Endorsement – WC200305 ("Endorsement")

- Proposed new Supplemental Applications (collectively, "Supplemental Applications") to be used in conjunction with the Pool Application:
  - Labor Contractor Supplemental Application
  - Construction Contractor Supplemental Application
  - Trucker/Delivery Supplemental Application

The purpose of this filing is to update the existing Pool Application, Employee Leasing Supplemental Application and Endorsement, and to introduce three new Supplemental Applications, as requested by the Fraud Subcommittee and approved by the WCRIBMA's Governing Committee, in an effort to obtain more valuable information about the applicants, and to more accurately identify and insure employee leasing companies, staffing firms and temporary employment agencies. These proposed changes are part of an effort to reduce insurance fraud in the workers' compensation industry.

101 ARCH STREET 5TH FLOOR, BOSTON, MASSACHUSETTS 02110-1103
(617) 439-9030, FAX (617) 439-6055, www.wcribma.org

The WCRIBMA proposes that the revised Pool Application and Supplemental Applications be required for applications received by WCRIBMA on or after January 1, 2017, and that the revised Endorsement be available for use on new and renewal policies effective on or after January 1, 2017.

Please let me know if you have any questions or comments. Thank you for your time and attention.

Sincerely,

Daniel M. Crowley, CPCU
Vice President – Customer Services
& Residual Market

cc: Matthew Mancini, Esq., Director, SRB
Walter Horn, PhD, SRB
Caleb Huntington, SRB
Christine Cronin, WCRIBMA

Filing Memorandum
Massachusetts Workers' Compensation Assigned Risk Pool

Proposed Revisions to:
Massachusetts Workers' Compensation Assigned Risk Pool Application
Massachusetts Employee Leasing Supplemental Application, Sides A & B
Massachusetts Exclusion of Coverage for Leased Employees Endorsement - WC200305

New Supplemental Applications:
Labor Contractor Supplemental Application
Construction Contractor Supplemental Application
Trucker/Delivery Supplemental Application

Purpose

The purpose of this filing is (i) to revise the existing Massachusetts Workers' Compensation Assigned Risk Pool Application for Workers' Compensation Insurance ("Pool Application"), the Massachusetts Employee Leasing Supplemental Application, and the Massachusetts Exclusion of Coverage for Leased Employees Endorsement - WC200305, and (ii) to introduce three new Supplemental Applications, as further described below. These proposals are being made in an effort to elicit more relevant information about the applicants for use by the assigned carriers, and also to more accurately identify and insure employee leasing companies, staffing firms and temporary employment agencies. These changes are being proposed with the approval of the WCRIBMA's Governing Committee in an effort to reduce insurance fraud in the workers' compensation industry.

Background

In 2015, the WCRIBMA's Governing Committee formed an Insurance Fraud Subcommittee ("Subcommittee"), which consists of Insurance Fraud Bureau, insurance company, producer, labor and employer representatives, to explore ways to more effectively prevent insurance fraud in the workers' compensation insurance marketplace. The Subcommittee reviewed and discussed various methods of combating workers' compensation insurance fraud, including proposed changes to the Massachusetts Workers' Compensation Assigned Risk Pool ("Assigned Risk Pool") application process, Assigned Carrier Performance Standards, and the auditing and cancellation processes. The proposals made in this Filing are the result of the Subcommittee and WCRIBMA Staff's discussions with regard to preventing fraud during the application process for coverage in the Assigned Risk Pool and while insuring employment agencies.

Special consideration was given to certain industries that were of particular concern to the Subcommittee, including construction contractors, trucking companies, and labor contractors. For trucking companies and construction companies, new Supplemental Applications have been created to draw additional information from applicants for both underwriting and anti-fraud purposes. For the purpose of more accurately identifying the potential exposure of labor contractors: (i) Sides A and B of the existing Massachusetts Employee Leasing Supplemental Application have been split into two separate supplemental applications (Side A is the proposed revised Massachusetts Employee Leasing Supplemental Application, and Side B is the proposed new Client of Labor Contractor Supplemental Application), and a new Labor Contractor Supplemental Application is being proposed; and (ii) the

existing Massachusetts Exclusion of Coverage for Leased Employees Endorsement ("Endorsement") has been revised for the purpose of ensuring that employee leasing arrangements are properly insured pursuant to 211 CMR 111.00.

Massachusetts Regulation 211 CMR 111.00 requires that each employee leasing arrangement of an employee leasing company must be insured on a separate policy. This ensures that clients and payroll cannot be easily hidden from the insuring carrier. Each of those separate policies utilizes the client's experience rating, therefore ensuring that clients cannot use the services of an employee leasing company to avoid their own experience ratings. Furthermore, if the client is not eligible for assigned risk coverage, the employee leasing company cannot insure them in the Assigned Risk Pool, safeguarding that clients cannot use the services of an employee leasing company to obtain assigned risk coverage for which they are not eligible.

211 CMR 111.00 has been successful in preventing fraudulent activity by employee leasing companies and their clients. However, in many cases temporary employment agencies and staffing firms provide employees to their clients on a long term basis and could potentially be defined as employee leasing companies; yet they continue to be insured as temporary employment agencies and are therefore able to insure all of their employees on a single policy. This allows them to more easily hide clients and payroll from their insurers. It also allows their clients to avoid their experience ratings and possibly obtain coverage in the Assigned Risk Pool for which they would not otherwise be eligible. The division of the current Employee Leasing Supplemental Application into separate Employee Leasing and Client of Labor Contractor Supplemental Applications, the creation of the Labor Contractor Supplemental Application, and the revision to the Endorsement, are all aimed at more accurately identifying 'employee leasing arrangements' as defined by 211 CMR 111.00.

Proposal

We propose that the revised Pool Application as well as the recommended Employee Leasing, Trucking/Delivery, Construction Contractor, Labor Contractor and Client of Labor Contractor Supplemental Applications be used for submissions received on or after January 1, 2017, and that the revised Endorsement be available for use on policies effective on or after January 1, 2017.

We also propose that the Endorsement be mandatory for all residual market policies issued to labor contractors and for all voluntary and residual market employee leasing companies' policies issued to cover their non-leased staff. Furthermore, we propose that the Endorsement be optional for voluntary policies issued to cover labor contractors.

See **Exhibit A** for a copy of the current Pool Application (A-1), a highlighted version of the Pool Application with the proposed changes (A-2), and a clean copy of the Pool Application with proposed changes (A-3). The following is a list of the revisions that are being proposed to the Pool Application:

- Section I – General Information
    - The application now instructs the applicant to NOT provide a social security number.
    - The applicant's website and years in business will now be requested.
- Section II – Eligibility Requirements
    - We clarified that the declining carriers need to be from different NAIC carrier groups.
- Section III – Corporate Officers, Sole Proprietors, Partners & Members

    - The instructions for election or exemption of coverage have been clarified.
- Section IV – Insurance Record
    - The application now asks if the applicant has received a Stop Work Order from the DIA and if so to provide a copy so priority can be given to the application.
- Section V – Business of Employer
    - New questions have been added for employee leasing companies, labor contractors, clients of employee leasing companies and labor contractors, trucking and delivery operations, and general or subcontractors in construction operations that instruct the applicants to complete the relevant Supplemental Application.
    - The question about independent contractors was revised to add a statutory reference.
    - The application has been updated to request the employer's revenue for its last fiscal year and the fiscal year end date.
- Section VI – MA Classifications, Payroll and Premium Calculations
    - The title of this section is currently 'MA Classifications, Estimated Exposures and Premium Calculations'. It has been changed to remove the word 'estimated' because now actual historic and future estimated payrolls will be requested. Also, the term 'exposure' was changed to 'payroll' to make the application more clear.
    - The application currently request 'Estimated Exposure' by class code. The proposed application requests both 'Actual Payroll for the Past 12 Months' and 'Estimated Payroll for the Next 12 Months' by class code.
    - Premium was defined in the header of the Premium column: 'Premium = Estimated Payroll/100 x Rate'.
    - The current request for 'Form 941 or DET Form 1' was updated to 'Form 941 or the Massachusetts equivalent' because the Massachusetts DET Form-1 is no longer in use.
    - To account for the unavailability of FELA in the residual market effective July 1, 2016 and for revisions to the Admiralty Program:
        - A question was added to allow the employer to select the Admiralty Employers' Liability Limits,
        - A line item was added in the premium calculation for the Admiralty Employers' Liability Increased Limits Charge, and
        - The Balance to Admiralty/FELA Minimum Premium line item was removed.
    - In the premium calculation, the QLMP Adjustment line item was removed because the QLMP credit is applied at audit.
- Section VIII – Applicant's Agreement
    - The applicants will now make their certifications 'under the pains and penalties of perjury'.
    - The certifications were expanded to include any attached Supplemental Applications.
    - The applicant now certifies that he understands that the WCRIBMA and the assigned carrier rely on the information provided, and that they have a continuing responsibility to promptly notify the carrier in the event of specified changes.
    - The applicant's signature section was expanded to capture the name of the signer and their email address.
- Section IX – Agency Information and Producer's Statement
    - The producer's signature section was also expanded to capture the name of the signer and their email address.
- General Changes:

- o The effective date in the footer of the application was changed from January 28, 2008 (Edition 02) to January 1, 2017 (Edition 01)
- o All references to 'the Bureau' have been changed to 'WCRIBMA'.
- o All references to 'the Bureau's website, www.wcribma.org,' have been changed to 'www.WCRIBMA.org.'
- o Some additional, minor editorial changes were made, and they have been highlighted throughout the application.

See **Exhibit B** for a copy of the current Employee Leasing Supplemental Application, Side A (B-1), a highlighted version of the Employee Leasing Supplemental Application with the proposed changes (B-2), and a clean copy of the Employee Leasing Supplemental Application with proposed changes (B-3).
See **Exhibit C** for a copy of the current Employee Leasing Supplemental Application, Side B (C-1), a highlighted version of the Client of Labor Contractor Supplemental Application (f/k/a the Employee Leasing Supplemental Application, Side B) with the proposed changes (C-2), and a clean copy of the proposed Client of Labor Contractor Supplemental Application (C-3).

See **Exhibit D** for the proposed Labor Contractor Supplemental Application.

See **Exhibit E** for the proposed Construction Contractor Supplemental Application.

See **Exhibit F** for the proposed Trucker/Delivery Supplemental Application.

See **Exhibit G** for a copy of the current Massachusetts Exclusion of Coverage for Leased Employees Endorsement – WC200305 (G-1), a highlighted version of the Endorsement with proposed changes (G-2), and a clean copy of the Endorsement with proposed changes (G-3). The following is a list of the revisions that are being proposed to the Endorsement:

- Language was added to clarify that the policy provides coverage for the labor contractor's own staff and any employees they provide to other businesses on a temporary basis.
- Examples of what constitutes 'temporary' are listed on the application.
- Language was added that places the responsibility of obtaining leasing policies for leasing arrangements on the insured employer.
- Notes were added that make this endorsement mandatory on all residual market policies issued to labor contractors and optional on voluntary policies issued to labor contractors.

Impact

The proposed revisions to the Pool Application and the Endorsement, as well as the introduction of the new Supplemental Applications, will (i) have no rate impact; and (ii) result in more thorough collection of information about applicants before assignment and more accurate policies being written for employee leasing companies and labor contractors.

Implementation

The revised Pool Application and the proposed Supplemental Applications will be used for applications for Assigned Risk Pool coverage received on or after January 1, 2017.

The revised Endorsement will be available for use on new and renewal policies effective on or after January 1, 2017. On residual market policies, the Endorsement will be mandatory for all residual market policies issued to labor contractors and for employee leasing companies' policies issued to cover their non-leased staff. On voluntary market policies, the endorsement will be optional for all policies issued to labor contractors and mandatory for employee leasing companies' policies issued to cover their non-leased staff.

MASSACHUSETTS WORKERS' COMPENSATION ASSIGNED RISK POOL
APPLICATION FOR WORKERS' COMPENSATION INSURANCE

MAIL TO: **The Workers' Compensation Rating & Inspection Bureau of Massachusetts**
101 Arch Street, 5th Floor, Boston, MA 02110
(617) 439-9030

IMPORTANT:

For assistance completing this application, refer to the Pool Procedures for New Applications under Residual Market on the Bureau's website, www.wcribma.org.
A separate application must be filed for each legal entity.
This application must be typed or printed in ink and submitted in duplicate to the Bureau.
Under no circumstance will coverage be assigned if: payment or required deposit does not accompany the application; the declination requirements are not met; there is a record of coverage in force for the entity making application; the applicant is in default of premium for prior workers' compensation coverage; or, the applicant has an audit or inspection from a prior workers' compensation policy that remains incomplete due to the applicant's failure to cooperate with the prior insurer.
The earliest possible date coverage can be bound is at 12:01 A.M. the day after the application and required deposit are received in the office of the Bureau.
The undersigned employer has failed to obtain workers' compensation and employers' liability insurance in the voluntary market and hereby applies for such insurance in the Massachusetts Assigned Risk Pool and expressly represents that such insurance is sought in good faith.

I. GENERAL INFORMATION

Requested Effective Date: ____________

1. ______________________________
NAME OF EMPLOYER (Name the sole proprietor, general partner(s) or trustee(s) along with the trade name of the business.)

☐ PENDING

2. ______________________________
FEDERAL EMPLOYERS IDENTIFICATION NUMBER (If pending, attach a copy of the IRS application.)

3. ______________________________
MAILING ADDRESS Number Street City State Zip Phone

4. ______________________________
PRINCIPAL MA LOCATION Number Street City State Zip Phone

5. TOTAL NUMBER OF MA LOCATIONS ____________

6. ______________________________
1st ADDITIONAL MA LOCATION Number Street City State Zip Phone
(If there is more than one additional MA location, attach a list of street addresses and phone numbers. Fully complete Section VI for each location.)

7. ______________________________
LOCATION OF RECORDS Number Street City State Zip Phone

8. LEGAL STATUS ☐ Sole Proprietor ☐ Partnership ☐ Corporation ☐ Trust ☐ Limited Partnership
☐ LLC ☐ LLP ☐ Other (explain) ____________

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II. ELIGIBILITY REQUIREMENTS

To be eligible to obtain assigned risk coverage:

- The employer's application for voluntary Massachusetts workers' compensation coverage must have been rejected by two (2) carriers licensed to write workers compensation in Massachusetts;
- The employer must not be in default of premium for Massachusetts workers' compensation insurance;
- The employer must have complied with all laws, orders, rules and regulations in force and effect relating to the welfare, health and safety of employees; and,
- The employer must not have an audit or inspection on a prior workers' compensation policy that remains incomplete due to the employer's failure to cooperate with the insurer.

1. List the names, representatives, date(s) of discussion, and phone numbers of two insurance companies licensed to write workers' compensation in Massachusetts who have refused to write voluntary coverage for this risk in the past sixty days. Each representative named must be an employee who has authority to bind coverage for the insurance company. A failure to reach such a representative cannot be construed as a refusal to write coverage.

NAME OF INSURANCE COMPANY	FULL NAME OF REPRESENTATIVE	DECLINATION DATE	PHONE

NOTE: If coverage was recently terminated or expired in either the voluntary or assigned risk market, you must attach a copy of the cancellation or nonrenewal notice. The reason for cancellation or nonrenewal must be indicated. If the coverage was in the voluntary market within the past sixty days, the cancellation or nonrenewal will serve as one of the two required declinations. Generally, coverage must be replaced in the voluntary market if voluntary coverage was cancelled or non-renewed at the employer's request.

2. Have you received any offers of voluntary coverage? ☐ YES ☐ NO
If **YES**, attach the offer for coverage, including all multi-line, deductible, or retrospective rating terms.

3. Is there any unpaid workers' compensation premium due from you or any other commonly owned enterprise? ☐ YES ☐ NO
If **YES**, provide the entity name, balance and policy number(s).
If the premium is being disputed, attach an explanation for Bureau consideration.
If an arrangement for payment has been made, attach a copy of the signed agreement.

4. Does the employer have any outstanding audits or inspections on a prior workers' compensation policy? ☐ YES ☐ NO
If **YES**, provide the name of the carrier and the policy number.
If the employer has scheduled an audit, provide the name and telephone number of a contact at the carrier.

III. CORPORATE OFFICERS, SOLE PROPRIETORS, PARTNERS & MEMBERS

If there are more than four Officers, Partners or Members, attach a list including the required information for each additional individual.

For Sole Proprietors, Partners, LLC Members and LLP Partners: List the Names, Titles, Ownership and Duties of all Proprietors, Partners or Members, and indicate whether each is **electing coverage**. Sole Proprietors, Partners and Members are not covered unless they elect coverage. To elect coverage, a letter must be submitted on company letterhead in accordance with MA Regulation 452 CMR 8.07. Refer to the MA WC & EL Insurance Manual, to the Rates Page with Miscellaneous Values, for Sole Proprietors', Partners' and Members' Basis of Premium. In Section VI, include the Basis of Premium for all Sole Proprietors, Partners and Members electing coverage.

For Corporations: List the Name, Title, Ownership, Duties and **actual** Salary of all officers listed in the Corporate Articles of Organization, and indicate whether each has chosen to **exempt** himself from coverage in accordance with MA Regulation 452 CMR 8.06. Corporate officers will be included unless a Form 153 has been submitted to and approved by the MA Department of Industrial Accidents. **The stamped and approved Form 153 must be attached.** Corporate officer salaries may be subject to payroll limitations; refer to the MA WC & EL Insurance Manual, Part One - Rule IX. In Section VI, include the salary, subject to the minimums and maximums, of all nonexempt corporate officers.

NAME	TITLE	% OWNERSHIP	ELECT/EXEMPT	DUTIES	SALARY

IV. INSURANCE RECORD

1. Has the applicant previously had Massachusetts workers' compensation insurance from a licensed insurance company? ☐ YES ☐ NO
2. If **YES,** complete the following for the most recent three years:

INSURANCE COMPANY	POLICY NUMBER	POLICY PERIOD FROM	POLICY PERIOD TO	PREMIUM

3. If **NO**, complete: ☐ New Business ☐ Uninsured ☐ Self Insurance Group ☐ Self Insured
   ☐ Other (explain): ______________________________
4. Was the applicant self-insured within the last twelve months, or was the applicant's expiring policy subject to the Premium Determination Endorsement – Former Self Insurers –1? ☐ YES ☐ NO
   If **YES**, **an audit must be completed before coverage can be bound.**
   Refer to the Pool Procedures for New Applications for details.
   Former members of Self Insurance Groups are not subject to this endorsement.
   If self insured within the last twelve months, provide the termination date: ________________
5. Is the employer in bankruptcy? If YES, attach a copy of the approved bankruptcy filing. ☐ YES ☐ NO
6. Does this entity or any other commonly owned entity have operations in states other than MA? ☐ YES ☐ NO
   If YES, attach a list of employer names, states, carriers and interstate or intrastate ID numbers.
7. Has there been a name change within the last five years? ☐ YES ☐ NO
8. Has there been a merger or consolidation within the last five years? ☐ YES ☐ NO
9. Has there been a sale, transfer or conveyance of ownership interest within the last five years? ☐ YES ☐ NO
10. Did the applicant purchase or otherwise acquire the physical assets of another entity whose operations they took over within the last five years? ☐ YES ☐ NO
11. Have the owners or officers ever had ownership interest in any other entity, either currently or previously existing? ☐ YES ☐ NO

If the answer to 7, 8, 9, 10 or 11 is YES, complete an ERM Form and attach it to this application.

V. BUSINESS OF EMPLOYER

1. Does the employer provide temporary or leased employees to other businesses? ☐ YES ☐ NO
   If **YES**, refer to the Pool Procedures for New Applications for instructions.
2. Does the employer lease employees or regularly have temporary employees supplied to them from another business? ☐ YES ☐ NO
   If **YES**, refer to the Pool Procedures for New Applications for instructions.
3. MA Law provides that the employer is liable for injury of employees of uninsured subcontractors.
   Premium will be charged in the absence of a certificate of insurance from subcontractors.
   Is it anticipated that subcontracted labor will be utilized during the policy term? ☐ YES ☐ NO
   If **YES**, estimate payrolls made to subcontractors without certificates of insurance. $ ________________
   Transfer this amount to Section VI and identify by classification of work performed.
4. Does the employer use independent contractors? ☐ YES ☐ NO
   If **YES**, documentation must be maintained which supports that they are, in fact, independent contractors.
   If such documentation is not available, or if the designated carrier finds evidence of an employment relationship, then premium may be charged as if the individuals were employees.

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V. BUSINESS OF EMPLOYER (continued)

5. Completely describe all operations of the employer. If there are multiple locations, provide a description for each. Completely describe any changes that have taken place in the last three years that might affect the classification of the operation.

VI. MASSACHUSETTS CLASSIFICATIONS, ESTIMATED EXPOSURE AND PREMIUM CALCULATIONS

Attach the four most recently filed Form 941s or DET Form 1s. Provide all information for each location by shift.

Location #	Shift #	Describe The Duties Of Employees	Class Code	Number Of Employees	Estimated Exposure	Rate	Premium

MANUAL PREMIUM	
* Waiver of Our Right To Recover From Others Charge	
* Employers Liability Increased Limits Charge ( )	
* Deductible Credit ( )	
* Experience Rating ( ) or Merit Rating ( )	
* MCCPAP Adjustment ( )	
STANDARD PREMIUM	
* ARAP ( )	
* QLMP Adjustment ( )	
* Balance to Admiralty/FELA Minimum Premium	
* Loss Constant	
Expense Constant	
* Terrorism Premium (Total Payroll / 100 x)	
* Balance to Total Policy Minimum Premium	
** Former Self Insurers Insurance Charge	
TOTAL ESTIMATED PREMIUM	
* DIA Assessment (%)	
TOTAL EST. PREMIUM AND DIA ASSESSMENT	
*** REQUIRED DEPOSIT	

Employers Liability Limit Options (check one):

	Limits	Rate	Minimum
☐	100/100/500	no charge	
☐	100/100/1,000	.50%	$75 minimum
☐	500/500/500	1.00%	$50 minimum
☐	500/500/1,000	1.25%	$75 minimum
☐	1,000/1,000/1,000	2.00%	$75 minimum

VII. DEPOSIT REQUIRED :

1. **Installment Options (check one):**

	Installment Basis	Required Total Est. Premium	Deposit Factor	Additional Payments
☐	Annually	≥ $0	100%	none
☐	Semi-Annually	≥ $5,000	75%	one
☐	Quarterly	≥ $10,000	50%	three
☐	Monthly	≥ $25,000	25%	nine

2. Enclosed is check number ________________ in the amount of $ ________________ .
   Make the check payable to the **Massachusetts Workers' Compensation Assigned Risk Pool** (or "**MWCARP**").

3. Any binding of coverage is conditional until the check has cleared. If the check is found to be non-negotiable, the check will be returned to the employer who will be given ten (10) days to provide the carrier with a bank check or money order for the full amount of the required deposit. Only if sufficient funds are received by the carrier on a timely basis, will coverage be effective as of the tentative binding date on the Notice of Assignment issued by the Bureau.

4. Is the premium being financed? ☐ YES ☐ NO
   If YES, then 100% of the Total Est. Premium and DIA Assessment must be sent with the application along with a signed copy of the finance agreement.

* If applicable. Refer to the Pool Procedures for New Applications and to the Residual Market Premium Algorithm – Appendix F in the MA Manual for details.
** Applies only to Former Self Insurers. Refer to the Pool Procedures for New Applications for details.
*** Calculation of Required Deposit:
(((Total Est. Premium + DIA) – (Expense Constant + Insurance Charge)) x Deposit Factor) + (Expense Constant + Insurance Charge)

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VIII. APPLICANT'S AGREEMENT – PLEASE READ CAREFULLY

By signing this application, I certify that:
(i) I am the employer or have been authorized by the employer to complete this application on its behalf;
(ii) I have read and understand the following statements to which I agree by signing this application; and
(iii) All information provided in this application and on its attachments is true.

In consideration of the issuance of a Notice of Assignment and subsequent policy of insurance, I hereby certify, under the pains and penalties of perjury, that:

1. I made a good faith effort, but failed to obtain coverage through the voluntary MA workers' compensation insurance market;
2. I am not knowingly in default of premium on any MA workers' compensation insurance policy;
3. I have complied and will continue to comply with all laws, orders, rules and regulations in force and effect relating to the welfare, health and safety of employees, including but not limited to:
   a. Allowing the carrier to make a careful inspection of my operation for the purpose of measuring the hazards, making recommendations for the health and safety of employees, and determining the rate or rates which are adequate and reasonable;
   b. Complying with the carriers' reasonable recommendations aimed at controlling or reducing the hazard(s) insured against;
   c. Keeping records of information needed to compute premium and providing the carrier with copies of those records when asked for them; and
   d. Fully cooperating with the carriers' attempts to conduct premium audits or inspections of the premises for loss control purposes.

I understand that the employer's compliance with each of these certifications is material to the issuance of Assigned Risk Pool coverage.

Business Name of Employer   Date   Signature and Title (Sole Proprietor, General Partner, Corporate Officer, Trustee or Member)

CURRENT

NOTICE:
This insurance is being provided through the MASSACHUSETTS WORKERS' COMPENSATION ASSIGNED RISK POOL, and not through the voluntary market. The employer's non-compliance with certifications 1, 2 and 3 (a – d) may, to the extent allowed by Massachusetts law, cause the carrier to initiate a mid-term cancellation.

FRAUD NOTICE:
Massachusetts General Law, Chapter 152, Section 14(3) provides:
"(A)ny person who knowingly makes any false or misleading statement, representation or submission or knowingly assists, abets, solicits or conspires in the making of any false or misleading statement, representation or submission, or knowingly conceals or fails to disclose knowledge of the occurrence of any event affecting the payment, coverage or other benefit for the purpose of obtaining or denying any payment, coverage or other benefit under this chapter; and any person or employer who knowingly misclassifies employees or engages in deceptive employee leasing practices for the purpose of avoiding full payment of insurance premiums ... shall be punished by imprisonment in the state prison for not more than five years or by imprisonment in jail for not less than six months nor more than two and one-half years or by a fine of not less than one thousand nor more than ten thousand dollars, or by both such fine and imprisonment."

IX. AGENCY INFORMATION AND PRODUCER'S STATEMENT

The producer hereby certifies, under the pains and penalties of perjury, that all information provided is true to the best of his/her knowledge and belief and that he/she made a good faith effort to place the coverage in the voluntary market as required by M.G.L., c. 152, Section 65A.

AGENCY
Name (Printed)   Agency Federal Identification Number

ADDRESS
Street   City   State   Zip Code   Telephone

PRODUCER
Name (Printed)   Signature   Date   Agency License Number

MASSACHUSETTS WORKERS' COMPENSATION ASSIGNED RISK POOL
ADDITIONAL INSTRUCTIONS
PLEASE READ CAREFULLY

1. Pool Procedures for New Applications and for Existing Policies can be found in the Residual Market area of the Bureau's website, www.wcribma.org.
2. Applications will not be accepted by FAX machine.
3. An additional or replacement entity cannot be endorsed onto an existing assigned risk policy as a named insured unless an application and check are submitted and coverage is assigned by the Bureau. Refer to the Pool Procedures for New Applications for instructions.
4. The Pool is able to provide coverage only for MA employees. If an employer has operations in any state other than MA, or commences operations in such state after policy inception, application for coverage for those operations must be made to the appropriate Bureau or other agency administering the Residual Market in that state, if voluntary coverage is not available.
5. When a Pool policy has been cancelled twice by the insurer for nonpayment of premium, the employer will lose his payment plan, and payment in full of the remaining policy premium will be required as a condition of reinstatement.
6. When a Pool policy has been cancelled twice at the request of the employer, the producer of record or the finance company, the employer must reapply to the Pool for subsequent coverage after all outstanding balances have been paid.
7. Applications for joint ventures must include a copy of the joint venture agreement.
8. Payrolls and classifications are subject to review by Bureau Staff and may be changed.
9. The Waiver of Our Rights to Recover from Others Endorsement, WC000313, is available to employers who require the endorsement by contract. Refer to the Pool Procedures for New Applications for details.
10. Producers are not agents of the MA Workers' Compensation Assigned Risk Pool and cannot issue Certificates of Insurance.
11. If you have any questions about the rules governing the MA Workers' Compensation Assigned Risk Pool, refer to the Bureau's website, www.wcribma.org. If additional information is required, contact the Workers' Compensation Rating & Inspection Bureau of MA at (617) 439-9030 or write to 101 Arch Street, Boston, MA 02110.

MASSACHUSETTS WORKERS' COMPENSATION ASSIGNED RISK POOL
APPLICATION FOR WORKERS' COMPENSATION INSURANCE

MAIL TO: **The Workers' Compensation Rating & Inspection Bureau of Massachusetts**
101 Arch Street, 5th Floor, Boston, MA 02110
(617) 439-9030

IMPORTANT:

For assistance completing this application, refer to the Pool Procedures for New Applications in the Residual Market section of www.WCRIBMA.org.
A separate application must be filed for each legal entity. This application must be typed or printed in ink.
Under no circumstance will coverage be assigned if: payment or required deposit does not accompany the application; the declination requirements are not met; there is a record of coverage in force for the entity making application; the applicant is in default of premium for prior workers' compensation coverage; or, the applicant has an audit or inspection from a prior workers' compensation policy that remains incomplete due to the applicant's failure to cooperate with the prior insurer.
The earliest possible date coverage can be bound is at 12:01 A.M. the day after the application and required deposit are received in the office of the WCRIBMA.
The undersigned employer has failed to obtain workers' compensation and employers' liability insurance in the voluntary market and hereby applies for such insurance in the Massachusetts Assigned Risk Pool and expressly represents that such insurance is sought in good faith.

I. GENERAL INFORMATION

Requested Effective Date: ______________

1. ______________________________
NAME OF EMPLOYER (Name the sole proprietor, general partner(s) or trustee(s) along with the trade name of the business.)

☐ PENDING

2. ______________________________
FEDERAL EMPLOYERS IDENTIFICATION NUMBER (Do NOT provide a Social Security Number.) (If pending, attach a copy of the IRS application.)

3. ______________________________
MAILING ADDRESS Number Street City State Zip Phone

4. ______________________________
PRINCIPAL MA LOCATION Number Street City State Zip Phone

5. TOTAL NUMBER OF MA LOCATIONS ______________

6. ______________________________
1st ADDITIONAL MA LOCATION Number Street City State Zip Phone
(If there is more than one additional MA location, attach a list of street addresses and phone numbers. Fully complete Section VI for each location.)

7a. ______________ 7b. ______________
WEBSITE ADDRESS YEARS IN BUSINESS

8. ______________________________
LOCATION OF RECORDS Number Street City State Zip Phone

9. LEGAL STATUS ☐ Sole Proprietor ☐ Partnership ☐ Corporation ☐ Trust ☐ Limited Partnership
☐ LLC ☐ LLP ☐ Other (explain) ______________

II. ELIGIBILITY REQUIREMENTS

To be eligible to obtain assigned risk coverage:

- The employer's application for voluntary Massachusetts workers' compensation coverage must have been rejected by two (2) carriers licensed to write workers' compensation in Massachusetts;
- The employer must not be in default of premium for Massachusetts workers' compensation insurance;
- The employer must have complied with all laws, orders, rules and regulations in force and effect relating to the welfare, health and safety of employees; and,
- The employer must not have an audit or inspection on a prior workers' compensation policy that remains incomplete due to the employer's failure to cooperate with the insurer.

1. List the names, representatives, dates of discussion, and phone numbers of two insurance companies from different NAIC carrier groups, who are licensed to write workers' compensation in Massachusetts and who have refused to write voluntary coverage for this risk in the past sixty days.
Each representative named must be an employee who has authority to bind coverage for the insurance company.
A failure to reach such a representative cannot be construed as a refusal to write coverage.

NAME OF INSURANCE COMPANY	FULL NAME OF REPRESENTATIVE	DECLINATION DATE	PHONE

NOTE: If coverage was recently terminated or expired in either the voluntary or assigned risk market, you must attach a copy of the cancellation or nonrenewal notice. The reason for cancellation or nonrenewal must be indicated. If the coverage was in the voluntary market within the past sixty days, the cancellation or nonrenewal will serve as one of the two required declinations. Generally, coverage must be replaced in the voluntary market if voluntary coverage was cancelled or non-renewed at the employer's request.

2. Have you received any offers of voluntary coverage? ☐ YES ☐ NO
If **YES**, attach the offer for coverage, including all multi-line, deductible, or retrospective rating terms.

3. Is there any unpaid workers' compensation premium due from you or any other commonly owned enterprise? ☐ YES ☐ NO
If **YES**, provide the entity name, balance and policy number(s).
If the premium is being disputed, attach an explanation for WCRIBMA consideration.
If an arrangement for payment has been made, attach a copy of the signed agreement.

4. Does the employer have any outstanding audits or inspections on a prior workers' compensation policy? ☐ YES ☐ NO
If **YES**, provide the name of the carrier and the policy number.
If the employer has scheduled an audit, provide the name and telephone number of a contact at the carrier.

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III. CORPORATE OFFICERS, SOLE PROPRIETORS, PARTNERS & MEMBERS

If there are more than four Officers, Partners or Members, attach a list including the required information for each additional individual.

For Sole Proprietors, Partners, LLC Members and LLP Partners: List the Names, Titles, Ownership and Duties of all Proprietors, Partners or Members. Enter "ELECT" to indicate whether each is electing coverage; otherwise, enter "EXEMPT." **Sole Proprietors, Partners and Members are not covered unless they elect coverage. To elect coverage, a letter must be submitted on company letterhead in accordance with MA Regulation 452 CMR 8.07.** Refer to the MA WC & EL Insurance Manual, to the Rates Page with Miscellaneous Values, for Sole Proprietors', Partners' and Members' Basis of Premium. In Section VI, include the Basis of Premium for all Sole Proprietors, Partners and Members electing coverage.

For Corporations: List the Name, Title, Ownership, Duties and actual Salary of all officers listed in the Corporate Articles of Organization. Enter "EXEMPT" to indicate whether each has chosen to waive coverage in accordance with MA Regulation 452 CMR 8.06; otherwise, enter "ELECT." **Corporate officers will be included unless a Form 153 has been submitted to and approved by the MA Department of Industrial Accidents. The stamped and approved Form 153 must be attached.** Corporate officer salaries may be subject to payroll limitations; refer to the MA WC & EL Insurance Manual, Part One - Rule IX. In Section VI, include the salary, subject to the minimums and maximums, of all non-exempt corporate officers.

NAME	TITLE	% OWNERSHIP	ELECT/EXEMPT	DUTIES	SALARY

IV. INSURANCE RECORD

1. Has the applicant previously had Massachusetts workers' compensation insurance from a licensed insurance company? ☐ YES ☐ NO
2. If **YES,** complete the following for the most recent three years:

INSURANCE COMPANY	POLICY NUMBER	POLICY PERIOD FROM	TO	PREMIUM

3. If **NO**, complete: ☐ New Business ☐ Uninsured ☐ Self-Insurance Group ☐ Self-Insured ☐ Other (explain): __________
4. Was the applicant self-insured within the last twelve months, or was the applicant's expiring policy subject to the Premium Determination Endorsement – Former Self Insurers –1? ☐ YES ☐ NO
   If YES, an audit must be completed before coverage can be bound. Refer to the Pool Procedures for New Applications for details. Former members of Self Insurance Groups are not subject to this endorsement.
   If self-insured within the last twelve months, provide the termination date: __________
5. Has the employer received a Stop Work Order? If **YES**, attach a copy so priority can be given to the application. ☐ YES ☐ NO
6. Is the employer in bankruptcy? If **YES**, attach a copy of the approved bankruptcy filing. ☐ YES ☐ NO
7. Does this entity or any other commonly owned entity have operations in states other than MA? ☐ YES ☐ NO
   If **YES**, attach a list of employer names, states, carriers and interstate or intrastate ID numbers.
8. Has there been a name change within the last five years? ☐ YES ☐ NO
9. Has there been a merger or consolidation within the last five years? ☐ YES ☐ NO
10. Has there been a sale, transfer or conveyance of ownership interest within the last five years? ☐ YES ☐ NO
11. Did the applicant purchase or otherwise acquire the physical assets of another entity whose operations they took over within the last five years? ☐ YES ☐ NO
12. Have the owners or officers ever had ownership interest in any other entity, either currently or previously existing? ☐ YES ☐ NO

If the answer to 8, 9, 10, 11, or 12 is YES, complete an ERM Form and attach it to this application.

V. BUSINESS OF EMPLOYER **(Refer to the *Pool Procedures for New Applications* for additional instructions.)**

1. Does the employer lease employees to other businesses? If **YES**, a separate Pool application must be submitted for each leasing arrangement so that separate policies can be established in accordance with 211 CMR 111.00. All applications must be submitted in the employee leasing company's name. To each such application, attach a completed MA Employee Leasing Supplemental Application, along with all required attachments. ☐ YES ☐ NO
2. Does the employer provide employees to other businesses but not consider their arrangements to be employee leasing arrangements in accordance with 211 CMR 111.00? If **YES**, complete and attach a MA Labor Contractor Supplemental Application, along with all required attachments. ☐ YES ☐ NO
3. Does the employer lease employees from or regularly have temporary employees supplied to them from another business? If **YES**, complete and attach a MA Client of Labor Contractor Supplemental Application, along with all required attachments. ☐ YES ☐ NO
4. Does the employer operate a delivery or trucking business? ☐ YES ☐ NO
   If **YES**, complete and attach a MA Trucking/Delivery Supplemental Application, along with all required attachments.
5. Does the employer operate as a general or subcontractor, in either commercial or residential construction operations? ☐ YES ☐ NO
   If **YES**, complete and attach a MA Contractors Supplemental Application, along with all required attachments.
6. Does the employer use independent contractors? ☐ YES ☐ NO
   If **YES**, documentation must be maintained which supports that they are, in fact, independent contractors in accordance with M.G.L. c. 149, s. 148B. If such documentation is not available, or if the designated carrier finds evidence of an employment relationship, then premium may be charged as if the individuals were employees.
7. Provide the employer's revenue for its last fiscal year and the fiscal year-end date: __________

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V. BUSINESS OF EMPLOYER (continued)

8. Completely describe all operations of the employer. If there are multiple locations, provide a description for each.
Completely describe any changes that have taken place in the last three years that might affect the classification of the operation.

9. MA Law provides that the employer is liable for injury of uninsured subcontractors.
Premium will be charged in the absence of a certificate of insurance from subcontractors.
Is it anticipated that subcontracted labor will be utilized during the policy term? ☐ YES ☐ NO

If **YES**, estimate payrolls made to subcontractors without certificates of insurance. $ ____________
Transfer this amount to Section VI and identify by classification of work performed.

VI. MASSACHUSETTS CLASSIFICATIONS, PAYROLL AND PREMIUM CALCULATIONS

Utilize the MWCARP Application Calculator on www.WCRIBMA.org for assistance in determining the premium for this application.
Attach the four most recently filed Form 941s or the Massachusetts equivalent. Provide all information for each location by shift.

Location #	Shift #	Describe the Duties of Employees	Class Code	Number of Employees	Actual Payroll for Past 12 Months	Estimated Payroll for Next 12 Months	Rate	Premium =Estimated Payroll / 100 x Rate

MANUAL PREMIUM	
* Waiver of Our Right To Recover From Others Charge	
* Employers Liability Increased Limits Charge ( )	
* Admiralty Emp. Liab. Increased Limits Charge ( )	
* Deductible Credit ( )	
* Experience Rating ( ) or Merit Rating ( )	
* MCCPAP Adjustment ( )	
STANDARD PREMIUM	
* ARAP ( )	
* Loss Constant	
Expense Constant	
* Terrorism Premium (Total Payroll / 100 x)	
* Balance to Total Policy Minimum Premium	
** Former Self Insurers Insurance Charge	
TOTAL ESTIMATED PREMIUM	
* DIA Assessment (%)	
TOTAL EST. PREMIUM + DIA ASSESSMENT	
*** REQUIRED DEPOSIT	

Employers Liability Limit Options (check one):

☐	100/100/500	no charge	
☐	100/100/1,000	.50%	$75 minimum
☐	500/500/500	1.00%	$50 minimum
☐	500/500/1,000	1.25%	$75 minimum
☐	1,000/1,000/1,000	2.00%	$75 minimum

Admiralty Emp. Liab. Limit Options (if applicable, check one)

☐ $10,000 ☐ $50,000 ☐ $100,000

VII. DEPOSIT REQUIRED :

1. **Installment Options (check one):**

	Installment Basis	Required Total Est. Premium	Deposit Factor	Additional Payments
☐	Annually	≥ $0	100%	none
☐	Semi-Annually	≥ $5,000	75%	one
☐	Quarterly	≥ $10,000	50%	three
☐	Monthly	≥ $25,000	25%	nine

2. Enclosed is check number ______________ in the amount of $ ______________ .
Make the check payable to the **Massachusetts Workers' Compensation Assigned Risk Pool** (or "**MWCARP**").

3. Any binding of coverage is conditional until the check has cleared. If the check is found to be non-negotiable, the check will be returned to the employer who will be given ten (10) days to provide the carrier with a bank check or money order for the full amount of the required deposit. Only if sufficient funds are received by the carrier on a timely basis, will coverage be effective as of the tentative binding date on the Notice of Assignment issued by the WCRIBMA.

4. Is the premium being financed? ☐ YES ☐ NO
If **YES**, then 100% of the Total Est. Premium and DIA Assessment must be sent with the application along with a signed copy of the finance agreement.

* If applicable. Refer to the Pool Procedures for New Applications and to the Residual Market Premium Algorithm – Appendix F in the MA Manual for details.
** Applies only to Former Self Insurers. Refer to the Pool Procedures for New Applications for details.
*** Calculation of Required Deposit:
(((Total Est. Premium + DIA Assessment) – (Expense Constant + Insurance Charge)) x Deposit Factor) + (Expense Constant + Insurance Charge)

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VIII. APPLICANT'S AGREEMENT – PLEASE READ CAREFULLY

By signing this application, I certify under the pains and penalties of perjury that:
- (i) I am the employer or have been authorized by the employer to complete this application and any necessary Supplemental Applications on its behalf;
- (ii) All information provided on this application and on any Supplemental Applications and attachments is true;
- (iii) I understand that the WCRIBMA and the assigned carrier are relying on this information when providing coverage;
- (iv) I understand that I have a continuing obligation to promptly notify the assigned carrier of changes in the type of work conducted, the amount of payroll, the business name, legal status or ownership, or a change in mailing address or business location, and
- (v) I have read and understand the following statements to which I agree by signing this application.

In consideration of the issuance of a Notice of Assignment and subsequent policy of insurance, I hereby certify, under the pains and penalties of perjury, that:

1. I made a good faith effort, but failed to obtain coverage through the voluntary MA workers' compensation insurance market;
2. I am not knowingly in default of premium on any MA workers' compensation insurance policy;
3. I have complied and will continue to comply with all laws, orders, rules and regulations in force and effect relating to the welfare, health and safety of employees, including but not limited to:
   a. allowing the carrier to make a careful inspection of my operation for the purpose of measuring the hazards, making recommendations for the health and safety of employees, and determining the rate or rates which are adequate and reasonable;
   b. complying with the carriers' reasonable recommendations aimed at controlling or reducing the hazard(s) insured against;
   c. keeping records of information needed to compute premium and providing the carrier with copies of those records when asked for them; and
   d. fully cooperating with the carriers' attempts to conduct premium audits or inspections of the premises for loss control purposes.

I understand that the employer's compliance with each of these certifications is material to the issuance of Assigned Risk Pool coverage.

Signature and Title (Sole Proprietor, Partner, Officer, Trustee or Member) Date

Signer's Name (Printed) Signer's Email Address

NOTICE:
This insurance is being provided through the MASSACHUSETTS WORKERS' COMPENSATION ASSIGNED RISK POOL, and not through the voluntary market. The employer's non-compliance with certifications 1, 2 and 3 (a – d) may, to the extent allowed by Massachusetts law, cause the carrier to initiate a mid-term cancellation.

FRAUD NOTICE:
Massachusetts General Law, Chapter 152, Section 14(3) provides:
"(A)ny person who knowingly makes any false or misleading statement, representation or submission or knowingly assists, abets, solicits or conspires in the making of any false or misleading statement, representation or submission, or knowingly conceals or fails to disclose knowledge of the occurrence of any event affecting the payment, coverage or other benefit for the purpose of obtaining or denying any payment, coverage or other benefit under this chapter; and any person or employer who knowingly misclassifies employees or engages in deceptive employee leasing practices for the purpose of avoiding full payment of insurance premiums ... shall be punished by imprisonment in the state prison for not more than five years or by imprisonment in jail for not less than six months nor more than two and one-half years or by a fine of not less than one thousand nor more than ten thousand dollars, or by both such fine and imprisonment."

IX. AGENCY INFORMATION AND PRODUCER'S STATEMENT

The producer hereby certifies, under the pains and penalties of perjury, that all information provided is true to the best of his/her knowledge and belief and that he/she made a good faith effort to place the coverage in the voluntary market as required by M.G.L., c. 152, Section 65A.

AGENCY
Agency Name (Printed) Agency Federal Identification Number

ADDRESS
Street City State Zip Code Telephone

PRODUCER
Producer's Signature Date License Number

Producer's Name (Printed) Producer's Email Address

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MASSACHUSETTS WORKERS' COMPENSATION ASSIGNED RISK POOL
ADDITIONAL INSTRUCTIONS
PLEASE READ CAREFULLY

1. Pool Procedures for New Applications and for Existing Policies can be found in the Residual Market section of www.WCRIBMA.org.
2. Applications will not be accepted by FAX machine.
3. An additional or replacement entity cannot be endorsed onto an existing assigned risk policy as a named insured unless an application and check are submitted and coverage is assigned by WCRIBMA. Refer to the Pool Procedures for New Applications for instructions.
4. The Pool is able to provide coverage only for MA employees. If an employer has operations in any state other than MA, or commences operations in such state after policy inception, application for coverage for those operations must be made to the appropriate organization administering the Residual Market in that state, if voluntary coverage is not available.
5. When a Pool policy has been cancelled twice by the insurer for nonpayment of premium, the employer will lose his payment plan, and payment in full of the remaining policy premium will be required as a condition of reinstatement.
6. When a Pool policy has been cancelled twice at the request of the employer, the producer of record or the finance company, the employer must reapply to the Pool for subsequent coverage after all outstanding balances have been paid.
7. Applications for joint ventures must include a copy of the joint venture agreement.
8. Payrolls and classifications are subject to review by WCRIBMA Staff and may be changed.
9. The Waiver of Our Rights to Recover from Others Endorsement, WC000313, is available to employers who require the endorsement by contract. Refer to the Pool Procedures for New Applications for details.
10. Producers are not agents of the MA Workers' Compensation Assigned Risk Pool and cannot issue Certificates of Insurance.
11. If you have any questions about the rules governing the MA Workers' Compensation Assigned Risk Pool, refer to www.WCRIBMA.org. If additional information is required, contact the WCRIBMA at (617) 439-9030 or write to 101 Arch Street, Boston, MA 02110.

MASSACHUSETTS WORKERS' COMPENSATION ASSIGNED RISK POOL
APPLICATION FOR WORKERS' COMPENSATION INSURANCE

MAIL TO: **The Workers' Compensation Rating & Inspection Bureau of Massachusetts**
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The earliest possible date coverage can be bound is at 12:01 A.M. the day after the application and required deposit are received in the office of the WCRIBMA.
The undersigned employer has failed to obtain workers' compensation and employers' liability insurance in the voluntary market and hereby applies for such insurance in the Massachusetts Assigned Risk Pool and expressly represents that such insurance is sought in good faith.

I. GENERAL INFORMATION

Requested Effective Date: ________________

1. ______________________________
NAME OF EMPLOYER (Name the sole proprietor, general partner(s) or trustee(s) along with the trade name of the business.)

☐ PENDING

2. ______________________________
FEDERAL EMPLOYERS IDENTIFICATION NUMBER (Do NOT provide a Social Security Number.) (If pending, attach a copy of the IRS application.)

3. ______________________________
MAILING ADDRESS Number Street City State Zip Phone

4. ______________________________
PRINCIPAL MA LOCATION Number Street City State Zip Phone

5. TOTAL NUMBER OF MA LOCATIONS ______________________

6. ______________________________
1st ADDITIONAL MA LOCATION Number Street City State Zip Phone
(If there is more than one additional MA location, attach a list of street addresses and phone numbers. Fully complete Section VI for each location.)

7a. ______________________ 7b. ______________________
WEBSITE ADDRESS YEARS IN BUSINESS

8. ______________________________
LOCATION OF RECORDS Number Street City State Zip Phone

9. LEGAL STATUS ☐ Sole Proprietor ☐ Partnership ☐ Corporation ☐ Trust ☐ Limited Partnership
☐ LLC ☐ LLP ☐ Other (explain) ______________________

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II. ELIGIBILITY REQUIREMENTS

To be eligible to obtain assigned risk coverage:

- The employer's application for voluntary Massachusetts workers' compensation coverage must have been rejected by two (2) carriers licensed to write workers' compensation in Massachusetts;
- The employer must not be in default of premium for Massachusetts workers' compensation insurance;
- The employer must have complied with all laws, orders, rules and regulations in force and effect relating to the welfare, health and safety of employees; and,
- The employer must not have an audit or inspection on a prior workers' compensation policy that remains incomplete due to the employer's failure to cooperate with the insurer.

1. List the names, representatives, dates of discussion, and phone numbers of two insurance companies from different NAIC carrier groups, who are licensed to write workers' compensation in Massachusetts and who have refused to write voluntary coverage for this risk in the past sixty days. Each representative named must be an employee who has authority to bind coverage for the insurance company. A failure to reach such a representative cannot be construed as a refusal to write coverage.

NAME OF INSURANCE COMPANY	FULL NAME OF REPRESENTATIVE	DECLINATION DATE	PHONE

NOTE: If coverage was recently terminated or expired in either the voluntary or assigned risk market, you must attach a copy of the cancellation or nonrenewal notice. The reason for cancellation or nonrenewal must be indicated. If the coverage was in the voluntary market within the past sixty days, the cancellation or nonrenewal will serve as one of the two required declinations. Generally, coverage must be replaced in the voluntary market if voluntary coverage was cancelled or non-renewed at the employer's request.

2. Have you received any offers of voluntary coverage? ☐ YES ☐ NO
If **YES**, attach the offer for coverage, including all multi-line, deductible, or retrospective rating terms.

3. Is there any unpaid workers' compensation premium due from you or any other commonly owned enterprise? ☐ YES ☐ NO
If **YES**, provide the entity name, balance and policy number(s).
If the premium is being disputed, attach an explanation for WCRIBMA consideration.
If an arrangement for payment has been made, attach a copy of the signed agreement.

4. Does the employer have any outstanding audits or inspections on a prior workers' compensation policy? ☐ YES ☐ NO
If **YES**, provide the name of the carrier and the policy number.
If the employer has scheduled an audit, provide the name and telephone number of a contact at the carrier.

III. CORPORATE OFFICERS, SOLE PROPRIETORS, PARTNERS & MEMBERS

If there are more than four Officers, Partners or Members, attach a list including the required information for each additional individual.

For Sole Proprietors, Partners, LLC Members and LLP Partners: List the Names, Titles, Ownership and Duties of all Proprietors, Partners or Members. Enter "ELECT" to indicate whether each is electing coverage; otherwise, enter "EXEMPT." **Sole Proprietors, Partners and Members are not covered unless they elect coverage. To elect coverage, a letter must be submitted on company letterhead in accordance with MA Regulation 452 CMR 8.07.** Refer to the MA WC & EL Insurance Manual, to the Rates Page with Miscellaneous Values, for Sole Proprietors', Partners' and Members' Basis of Premium. In Section VI, include the Basis of Premium for all Sole Proprietors, Partners and Members electing coverage.

For Corporations: List the Name, Title, Ownership, Duties and actual Salary of all officers listed in the Corporate Articles of Organization. Enter "EXEMPT" to indicate whether each has chosen to waive coverage in accordance with MA Regulation 452 CMR 8.06; otherwise, enter "ELECT." **Corporate officers will be included unless a Form 153 has been submitted to and approved by the MA Department of Industrial Accidents. The stamped and approved Form 153 must be attached.** Corporate officer salaries may be subject to payroll limitations; refer to the MA WC & EL Insurance Manual, Part One - Rule IX. In Section VI, include the salary, subject to the minimums and maximums, of all non-exempt corporate officers.

NAME	TITLE	% OWNERSHIP	ELECT/EXEMPT	DUTIES	SALARY

IV. INSURANCE RECORD

1. Has the applicant previously had Massachusetts workers' compensation insurance from a licensed insurance company? ☐ YES ☐ NO
2. If **YES,** complete the following for the most recent three years:

INSURANCE COMPANY	POLICY NUMBER	POLICY PERIOD FROM	POLICY PERIOD TO	PREMIUM

3. If **NO**, complete: ☐ New Business ☐ Uninsured ☐ Self-Insurance Group ☐ Self-Insured ☐ Other (explain): __________
4. Was the applicant self-insured within the last twelve months, or was the applicant's expiring policy subject to the Premium Determination Endorsement – Former Self Insurers –1? ☐ YES ☐ NO
   If YES, an audit must be completed before coverage can be bound. Refer to the Pool Procedures for New Applications for details. Former members of Self Insurance Groups are not subject to this endorsement.
   If self-insured within the last twelve months, provide the termination date: __________
5. Has the employer received a Stop Work Order? If **YES**, attach a copy so priority can be given to the application. ☐ YES ☐ NO
6. Is the employer in bankruptcy? If **YES**, attach a copy of the approved bankruptcy filing. ☐ YES ☐ NO
7. Does this entity or any other commonly owned entity have operations in states other than MA? ☐ YES ☐ NO
   If **YES**, attach a list of employer names, states, carriers and interstate or intrastate ID numbers.
8. Has there been a name change within the last five years? ☐ YES ☐ NO
9. Has there been a merger or consolidation within the last five years? ☐ YES ☐ NO
10. Has there been a sale, transfer or conveyance of ownership interest within the last five years? ☐ YES ☐ NO
11. Did the applicant purchase or otherwise acquire the physical assets of another entity whose operations they took over within the last five years? ☐ YES ☐ NO
12. Have the owners or officers ever had ownership interest in any other entity, either currently or previously existing? ☐ YES ☐ NO

If the answer to 8, 9, 10, 11, or 12 is YES, complete an ERM Form and attach it to this application.

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V. BUSINESS OF EMPLOYER (Refer to the *Pool Procedures for New Applications* for additional instructions.)

1. Does the employer lease employees to other businesses? If **YES**, a separate Pool application must be submitted for each leasing arrangement so that separate policies can be established in accordance with 211 CMR 111.00. All applications must be submitted in the employee leasing company's name. To each such application, attach a completed MA Employee Leasing Supplemental Application, along with all required attachments. ☐ YES ☐ NO
2. Does the employer provide employees to other businesses but not consider their arrangements to be employee leasing arrangements in accordance with 211 CMR 111.00? If **YES**, complete and attach a MA Labor Contractor Supplemental Application, along with all required attachments. ☐ YES ☐ NO
3. Does the employer lease employees from or regularly have temporary employees supplied to them from another business? If **YES**, complete and attach a MA Client of Labor Contractor Supplemental Application, along with all required attachments. ☐ YES ☐ NO
4. Does the employer operate a delivery or trucking business? If **YES**, complete and attach a MA Trucking/Delivery Supplemental Application, along with all required attachments. ☐ YES ☐ NO
5. Does the employer operate as a general or subcontractor, in either commercial or residential construction operations? If **YES**, complete and attach a MA Contractors Supplemental Application, along with all required attachments. ☐ YES ☐ NO
6. Does the employer use independent contractors? ☐ YES ☐ NO
   If **YES**, documentation must be maintained which supports that they are, in fact, independent contractors in accordance with M.G.L. c. 149, s. 148B. If such documentation is not available, or if the designated carrier finds evidence of an employment relationship, then premium may be charged as if the individuals were employees.
7. Provide the employer's revenue for its last fiscal year and the fiscal year-end date: __________

V. BUSINESS OF EMPLOYER (continued)

8. Completely describe all operations of the employer. If there are multiple locations, provide a description for each.
Completely describe any changes that have taken place in the last three years that might affect the classification of the operation.

9. MA Law provides that the employer is liable for injury of uninsured subcontractors.
Premium will be charged in the absence of a certificate of insurance from subcontractors.
Is it anticipated that subcontracted labor will be utilized during the policy term? ☐ YES ☐ NO

If **YES**, estimate payrolls made to subcontractors without certificates of insurance. $ ____________________
Transfer this amount to Section VI and identify by classification of work performed.

VI. MASSACHUSETTS CLASSIFICATIONS, PAYROLL AND PREMIUM CALCULATIONS

Utilize the MWCARP Application Calculator on www.WCRIBMA.org for assistance in determining the premium for this application.
Attach the four most recently filed Form 941s or the Massachusetts equivalent. Provide all information for each location by shift.

Location #	Shift #	Describe the Duties of Employees	Class Code	Number of Employees	Actual Payroll for Past 12 Months	Estimated Payroll for Next 12 Months	Rate	Premium =Estimated Payroll / 100 x Rate

MANUAL PREMIUM	
* Waiver of Our Right To Recover From Others Charge	
* Employers Liability Increased Limits Charge ( )	
* Admiralty Emp. Liab. Increased Limits Charge ( )	
* Deductible Credit ( )	
* Experience Rating ( ) or Merit Rating ( )	
* MCCPAP Adjustment ( )	
STANDARD PREMIUM	
* ARAP ( )	
* Loss Constant	
Expense Constant	
* Terrorism Premium (Total Payroll / 100 x)	
* Balance to Total Policy Minimum Premium	
** Former Self Insurers Insurance Charge	
TOTAL ESTIMATED PREMIUM	
* DIA Assessment (%)	
TOTAL EST. PREMIUM + DIA ASSESSMENT	
*** REQUIRED DEPOSIT	

Employers Liability Limit Options (check one):

☐	100/100/500	no charge	
☐	100/100/1,000	.50%	$75 minimum
☐	500/500/500	1.00%	$50 minimum
☐	500/500/1,000	1.25%	$75 minimum
☐	1,000/1,000/1,000	2.00%	$75 minimum

Admiralty Emp. Liab. Limit Options (if applicable, check one)

☐ $10,000 ☐ $50,000 ☐ $100,000

VII. DEPOSIT REQUIRED :

1. **Installment Options (check one):**

	Installment Basis	Required Total Est. Premium	Deposit Factor	Additional Payments
☐	Annually	≥ $0	100%	none
☐	Semi-Annually	≥ $5,000	75%	one
☐	Quarterly	≥ $10,000	50%	three
☐	Monthly	≥ $25,000	25%	nine

2. Enclosed is check number ________________ in the amount of $ ________________ .
Make the check payable to the **Massachusetts Workers' Compensation Assigned Risk Pool** (or "**MWCARP**").

3. Any binding of coverage is conditional until the check has cleared. If the check is found to be non-negotiable, the check will be returned to the employer who will be given ten (10) days to provide the carrier with a bank check or money order for the full amount of the required deposit. Only if sufficient funds are received by the carrier on a timely basis, will coverage be effective as of the tentative binding date on the Notice of Assignment issued by the WCRIBMA.

4. Is the premium being financed? ☐ YES ☐ NO
If **YES**, then 100% of the Total Est. Premium and DIA Assessment must be sent with the application along with a signed copy of the finance agreement.

* If applicable. Refer to the Pool Procedures for New Applications and to the Residual Market Premium Algorithm – Appendix F in the MA Manual for details.
** Applies only to Former Self Insurers. Refer to the Pool Procedures for New Applications for details.
*** Calculation of Required Deposit:
(((Total Est. Premium + DIA Assessment) – (Expense Constant + Insurance Charge)) x Deposit Factor) + (Expense Constant + Insurance Charge)

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VIII. APPLICANT'S AGREEMENT – PLEASE READ CAREFULLY

By signing this application, I certify under the pains and penalties of perjury that:
(i) I am the employer or have been authorized by the employer to complete this application and any necessary Supplemental Applications on its behalf;
(ii) All information provided on this application and on any Supplemental Applications and attachments is true;
(iii) I understand that the WCRIBMA and the assigned carrier are relying on this information when providing coverage;
(iv) I understand that I have a continuing obligation to promptly notify the assigned carrier of changes in the type of work conducted, the amount of payroll, the business name, legal status or ownership, or a change in mailing address or business location, and
(v) I have read and understand the following statements to which I agree by signing this application.

In consideration of the issuance of a Notice of Assignment and subsequent policy of insurance, I hereby certify, under the pains and penalties of perjury, that:

1. I made a good faith effort, but failed to obtain coverage through the voluntary MA workers' compensation insurance market;
2. I am not knowingly in default of premium on any MA workers' compensation insurance policy;
3. I have complied and will continue to comply with all laws, orders, rules and regulations in force and effect relating to the welfare, health and safety of employees, including but not limited to:
   a. allowing the carrier to make a careful inspection of my operation for the purpose of measuring the hazards, making recommendations for the health and safety of employees, and determining the rate or rates which are adequate and reasonable;
   b. complying with the carriers' reasonable recommendations aimed at controlling or reducing the hazard(s) insured against;
   c. keeping records of information needed to compute premium and providing the carrier with copies of those records when asked for them; and
   d. fully cooperating with the carriers' attempts to conduct premium audits or inspections of the premises for loss control purposes.

I understand that the employer's compliance with each of these certifications is material to the issuance of Assigned Risk Pool coverage.

Signature and Title (Sole Proprietor, Partner, Officer, Trustee or Member) Date

Signer's Name (Printed) Signer's Email Address

NOTICE:
This insurance is being provided through the MASSACHUSETTS WORKERS' COMPENSATION ASSIGNED RISK POOL, and not through the voluntary market. The employer's non-compliance with certifications 1, 2 and 3 (a – d) may, to the extent allowed by Massachusetts law, cause the carrier to initiate a mid-term cancellation.

FRAUD NOTICE:
Massachusetts General Law, Chapter 152, Section 14(3) provides:
"(A)ny person who knowingly makes any false or misleading statement, representation or submission or knowingly assists, abets, solicits or conspires in the making of any false or misleading statement, representation or submission, or knowingly conceals or fails to disclose knowledge of the occurrence of any event affecting the payment, coverage or other benefit for the purpose of obtaining or denying any payment, coverage or other benefit under this chapter; and any person or employer who knowingly misclassifies employees or engages in deceptive employee leasing practices for the purpose of avoiding full payment of insurance premiums ... shall be punished by imprisonment in the state prison for not more than five years or by imprisonment in jail for not less than six months nor more than two and one-half years or by a fine of not less than one thousand nor more than ten thousand dollars, or by both such fine and imprisonment."

IX. AGENCY INFORMATION AND PRODUCER'S STATEMENT

The producer hereby certifies, under the pains and penalties of perjury, that all information provided is true to the best of his/her knowledge and belief and that he/she made a good faith effort to place the coverage in the voluntary market as required by M.G.L., c. 152, Section 65A.

AGENCY
Agency Name (Printed) Agency Federal Identification Number

ADDRESS
Street City State Zip Code Telephone

PRODUCER
Producer's Signature Date License Number

Producer's Name (Printed) Producer's Email Address

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MASSACHUSETTS WORKERS' COMPENSATION ASSIGNED RISK POOL
ADDITIONAL INSTRUCTIONS
PLEASE READ CAREFULLY

1. Pool Procedures for New Applications and for Existing Policies can be found in the Residual Market section of www.WCRIBMA.org.
2. Applications will not be accepted by FAX machine.
3. An additional or replacement entity cannot be endorsed onto an existing assigned risk policy as a named insured unless an application and check are submitted and coverage is assigned by WCRIBMA. Refer to the Pool Procedures for New Applications for instructions.
4. The Pool is able to provide coverage only for MA employees. If an employer has operations in any state other than MA, or commences operations in such state after policy inception, application for coverage for those operations must be made to the appropriate organization administering the Residual Market in that state, if voluntary coverage is not available.
5. When a Pool policy has been cancelled twice by the insurer for nonpayment of premium, the employer will lose his payment plan, and payment in full of the remaining policy premium will be required as a condition of reinstatement.
6. When a Pool policy has been cancelled twice at the request of the employer, the producer of record or the finance company, the employer must reapply to the Pool for subsequent coverage after all outstanding balances have been paid.
7. Applications for joint ventures must include a copy of the joint venture agreement.
8. Payrolls and classifications are subject to review by WCRIBMA Staff and may be changed.
9. The Waiver of Our Rights to Recover from Others Endorsement, WC000313, is available to employers who require the endorsement by contract. Refer to the Pool Procedures for New Applications for details.
10. Producers are not agents of the MA Workers' Compensation Assigned Risk Pool and cannot issue Certificates of Insurance.
11. If you have any questions about the rules governing the MA Workers' Compensation Assigned Risk Pool, refer to www.WCRIBMA.org.
    If additional information is required, contact the WCRIBMA at (617) 439-9030 or write to 101 Arch Street, Boston, MA 02110.

MASSACHUSETTS WORKERS' COMPENSATION INSURANCE
EMPLOYEE LEASING SUPPLEMENTAL APPLICATION
SIDE A

The Workers' Compensation Rating and Inspection Bureau of Massachusetts
101 Arch Street, 5th Floor Boston, MA 02110 (617) 439-9030

If you are making application for Assigned Risk Pool coverage, refer to the Pool Procedures For New Applications on www.wcribma.org.
If you are an employee leasing company, you must complete a separate SIDE A for each client to whom you lease employees.
If you lease employees from an employee leasing company, you must complete a separate SIDE B for each leasing company from whom you lease employees.

1. ______________________________ ______________
Name of Employee Leasing Company Leasing Company's FEIN

CLIENT INFORMATION

2. ______________________________ ______________
Name of Client Company - Name of sole proprietor, general partner(s), or trustee(s) must be given with a trade name, if any.

3. ______________________________
Client's FEIN

4. ______________________________
Client's Address

5. Client's Legal Status ☐ Sole Proprietorship ☐ Partnership ☐ Trust ☐ Corporation ☐ Other (explain) ______________

6. Nature of Client's Business ______________________________

7. Client's Insurance Record: Provide the client's workers' compensation insurance record for the most recent three years available.

Insurance Company	Policy Number	Policy Period	Premium

LEASED EMPLOYEES

8. Do you provide the client named above with its entire workforce? ☐ YES ☐ NO

9. Do you have a written contract with the client named above? **IF YES, ATTACH A COPY.** ☐ YES ☐ NO

10. Labor Leased - Provide information about all employees leased by you to the client named above.

class code	duties	number of employees	estimated payroll	estimated premium

11. **Attach a list of all Leased Employees**. The list must include each employee's name, address, duties and estimated annual payroll.

EMPLOYEE LEASING COMPANY'S STATEMENT

By signing this application, I certify, under the pains and penalties of perjury, that (i) I am an officer or owner of the employee leasing company and authorized to complete this application; (ii) I have read and understand the following statement to which I agree by signing this application; and (iii) All information provided in this application is true.

As an employee leasing company who operates in Massachusetts, I have read and understand Massachusetts Division of Insurance Regulation 211 CMR 111. I understand that my violation of 211 CMR 111.04 - .05 shall be considered fraud or material misrepresentation and grounds for cancellation or nonrenewal.

____
Name of Employee Leasing Company Date Signature and Title (Sole Proprietor, General Partner Corporate Officer or Trustee)

AGENCY'S AND PRODUCER'S STATEMENT

The producer hereby certifies, under the pains and penalties of perjury, that all information provided in this application is true to the best of his/her knowledge and belief.

____
Name of Agency Date Signature of Producer

CURRENT

WCRIBMA
THE WORKERS' COMPENSATION RATING AND INSPECTION BUREAU OF MASSACHUSETTS

MASSACHUSETTS WORKERS' COMPENSATION ASSIGNED RISK POOL
EMPLOYEE LEASING SUPPLEMENTAL APPLICATION

If you are making application for Assigned Risk Pool coverage, refer to the *Pool Procedures for New Applications* on **www.WCRIBMA.org**.
If you lease employees to other businesses, complete a separate Pool Application and a separate Employee Leasing Supplemental Application for each client to whom you lease employees.
If you lease employees from another business, complete a Client of Labor Contractor Supplemental Application.

EMPLOYEE LEASING COMPANY INFORMATION

From Part I of the Employee Leasing Company's Application for Assigned Risk Pool Coverage.

1. Employee Leasing Company Name: ______________________________
2. a. FEIN: ______________________ b. Website: ______________________

CLIENT COMPANY INFORMATION

3. Client Company Name: ______________________________
   The name of the Sole Proprietor, General Partner(s) or Trustee(s) must be given with the trade name, if any.
4. Address: ______________________________
5. a. FEIN: ______________________ b. Website: ______________________
6. Legal Status: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Trust ☐ LLC ☐ Other ______________
7. Nature of Client's Business: ______________________________
8. Client's Insurance Record: Provide the client's current or most recent workers' compensation insurance policy information.

Insurance Company	Policy Number	Policy Period	Premium

LEASED EMPLOYEES

9. Do you provide the client named above with its entire workforce? ☐ YES ☐ NO
10. Do you have a written contract with the client named above? **IF YES, ATTACH A COPY.** ☐ YES ☐ NO
11. Labor Leased: Provide information about all employees leased by you to the client named above. Attach if necessary.

Class Code	Duties	Number of Employees	Estimated Payroll	Estimated Premium

12. **ATTACH A LIST OF ALL LEASED EMPLOYEES.** The list must include each employee's name, address, duties and estimated annual payroll.
    NOTE: The employee count and the payroll by classification on the Pool Application, the Supplemental Application and the attached list of employees must agree.

EMPLOYER STATEMENT: As an owner or officer of an employee leasing company who operates in Massachusetts, I have read and understand Massachusetts Division of Insurance Regulation 211 CMR 111.00. I understand that my violation of 211 CMR 111.04-.05 shall be considered fraud or material misrepresentation and grounds for cancellation or nonrenewal.

EMPLOYER & PRODUCER STATEMENTS: I understand that this Employee Leasing Supplemental Application is being submitted as an attachment to the employer's Massachusetts Assigned Risk Pool Application for Workers' Compensation Insurance and is part of that application. By signing this application, I am stating that I am the employer or have been authorized by the employer to complete this application, and I have read, understand and confirm that the Applicant's Agreements, the Fraud Notice, and the Producer's Statement agreed to on the Pool Application are applicable to this form as well.

EMPLOYER'S SIGNATURE (Sole Proprietor, Partner, Officer, Member or Trustee)	**DATE**	**PRODUCER'S SIGNATURE**	**DATE**

DRAFT

WCRIBMA
THE WORKERS' COMPENSATION RATING AND INSPECTION BUREAU OF MASSACHUSETTS

MASSACHUSETTS WORKERS' COMPENSATION ASSIGNED RISK POOL

EMPLOYEE LEASING SUPPLEMENTAL APPLICATION

If you are making application for Assigned Risk Pool coverage, refer to the *Pool Procedures for New Applications* on **www.WCRIBMA.org**.
If you lease employees to other businesses, complete a separate Pool Application and a separate Employee Leasing Supplemental Application for each client to whom you lease employees.
If you lease employees from another business, complete a Client of Labor Contractor Supplemental Application.

EMPLOYEE LEASING COMPANY INFORMATION

From Part I of the Employee Leasing Company's Application for Assigned Risk Pool Coverage.

1. Employee Leasing Company Name: ____________________
2. a. FEIN: ____________________ b. Website: ____________________

CLIENT COMPANY INFORMATION

3. Client Company Name: ____________________
The name of the Sole Proprietor, General Partner(s) or Trustee(s) must be given with the trade name, if any.
4. Address: ____________________
5. a. FEIN: ____________________ b. Website: ____________________
6. Legal Status: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Trust ☐ LLC ☐ Other ____________
7. Nature of Client's Business: ____________________
8. Client's Insurance Record: Provide the client's current or most recent workers' compensation insurance policy information.

Insurance Company	Policy Number	Policy Period	Premium

LEASED EMPLOYEES

9. Do you provide the client named above with its entire workforce? ☐ YES ☐ NO
10. Do you have a written contract with the client named above? **IF YES, ATTACH A COPY.** ☐ YES ☐ NO
11. Labor Leased: Provide information about all employees leased by you to the client named above. Attach if necessary.

Class Code	Duties	Number of Employees	Estimated Payroll	Estimated Premium

12. **ATTACH A LIST OF ALL LEASED EMPLOYEES.** The list must include each employee's name, address, duties and estimated annual payroll.
NOTE: The employee count and the payroll by classification on the Pool Application, the Supplemental Application and the attached list of employees must agree.

EMPLOYER STATEMENT: As an owner or officer of an employee leasing company who operates in Massachusetts, I have read and understand Massachusetts Division of Insurance Regulation 211 CMR 111.00. I understand that my violation of 211 CMR 111.04-.05 shall be considered fraud or material misrepresentation and grounds for cancellation or nonrenewal.
EMPLOYER & PRODUCER STATEMENTS: I understand that this Employee Leasing Supplemental Application is being submitted as an attachment to the employer's Massachusetts Assigned Risk Pool Application for Workers' Compensation Insurance and is part of that application. By signing this application, I am stating that I am the employer or have been authorized by the employer to complete this application, and I have read, understand and confirm that the Applicant's Agreements, the Fraud Notice, and the Producer's Statement agreed to on the Pool Application are applicable to this form as well.

EMPLOYER'S SIGNATURE (Sole Proprietor, Partner, Officer, Member or Trustee) **DATE**	**PRODUCER'S SIGNATURE** **DATE**

DRAFT

MASSACHUSETTS WORKERS' COMPENSATION INSURANCE
EMPLOYEE LEASING SUPPLEMENTAL APPLICATION
SIDE B

The Workers' Compensation Rating and Inspection Bureau of Massachusetts
101 Arch Street, 5th Floor Boston, MA 02110 (617) 439-9030

If you are making application for Assigned Risk Pool coverage, refer to the Pool Procedures For New Applications on www.wcribma.org.
If you are an employee leasing company, you must complete a separate SIDE A for each client to whom you lease employees.
If you lease employees from an employee leasing company, you must complete a separate SIDE B for each leasing company from whom you lease employees.

1. ______________________________ ______________________________
Name of Client Company Client Company's FEIN

EMPLOYEE LEASING COMPANY INFORMATION

2. ______________________________
Name of Employee Leasing Company

3. ______________________________
Employee Leasing Company's FEIN

4. ______________________________
Employee Leasing Company's Address

LABOR PROVIDED

5. Do you have a written contract with the employee leasing company named above? **IF YES, ATTACH A COPY.** ☐ YES ☐ NO

6. The employee leasing company from whom you lease employees is required by Massachusetts Regulation 211 CMR 111 to purchase and maintain a separate workers' compensation insurance policy for the employees they lease to you. **ATTACH EVIDENCE OF SUCH INSURANCE**.

7. Labor Leased - Provide information about all employees leased to you by the employee leasing company named above.

class code	duties	number of employees	estimated payroll	estimated premium

8. Do you obtain your entire workforce from the employee leasing company named above? ☐ YES ☐ NO
If NO, provide evidence of workers' compensation insurance coverage for the employees you pay directly.

9. If you no longer lease employees from the employee leasing company named above, provide the termination date. ______________________

10. Do you use the services of any other employee leasing companies? ☐ YES ☐ NO
If YES, complete a separate Supplemental Employee Leasing Application - Side B for each, **AND ATTACH**.

EMPLOYER'S STATEMENT

By signing this application, I certify, under the pains and penalties of perjury, that (i) I am an officer or owner of the client company and authorized to complete this application; and (ii) All information provided in this application is true.

____
Business Name of Employer Date Signature and Title (Sole Proprietor, General Partner, Corporate Officer or Trustee)

AGENCY'S AND PRODUCER'S STATEMENT

The producer hereby certifies, under the pains and penalties of perjury, that all information provided in this application is true to the best of his/her knowledge and belief.

____
Name of Agency Date Signature of Producer

CURRENT

WCRIBMA
THE WORKERS' COMPENSATION RATING AND INSPECTION BUREAU OF MASSACHUSETTS

MASSACHUSETTS WORKERS' COMPENSATION ASSIGNED RISK POOL
CLIENT OF LABOR CONTRACTOR SUPPLEMENTAL APPLICATION

If you are making application for Assigned Risk Pool coverage, refer to the *Pool Procedures for New Applications* on **www.WCRIBMA.org**.
If you regularly have employees provided to you by another business, whether from an employee leasing company, PEO, staffing agency, or temporary employment agency, complete a separate Client of Labor Contractor Supplemental Application for each company from whom you obtain employees.

EMPLOYER INFORMATION
From Part I of the Client Company's Application for Assigned Risk Pool Coverage.

1. Client Name: ______________________________
2. a. FEIN: ______________________ b. Website: ______________________

LABOR CONTRACTOR INFORMATION

3. Labor Contractor Company Name: ______________________________
4. a. FEIN: ______________________ b. Website: ______________________
5. Do you have a written contract with the labor contractor named above? **IF YES, ATTACH A COPY.** ☐ YES ☐ NO
6. The labor contractor is required to provide workers' compensation insurance for the employees they provide to you.
ATTACH EVIDENCE OF SUCH INSURANCE.

EMPLOYEES PROVIDED

7. Employees Obtained: Supply information about all employees provided to you for the past 12 months by the labor contractor named above.

Duties	# of Employees	Estimated Payroll / Cost of Service

8. What type of services does the above labor contractor provide to your organization?
   - ☐ Employee Leasing
   - ☐ Professional Employment Organization (PEO)
   - ☐ Long Term Staffing (more than 6 months)
   - ☐ Temporary to Permanent Hire by the Client
   - ☐ Placement Services (client pays employees)
   - ☐ Special Assignment or Project Work (with a defined end date)
   - ☐ Special Assignment or Project Work (with no defined end date)
   - ☐ Provide Supplemental Help for Seasonal Business Increases
   - ☐ Provide Temporary Replacements for Absent Employees
   - ☐ Provide Skilled Professionals during Skill Shortages
   - ☐ Other (describe in detail): ______________________________
9. Explain how frequently you obtain employees from the labor contractor named above and how long you expect the arrangement to last.
____
10. Do you obtain your entire workforce from the labor contractor named above? ☐ YES ☐ NO
11. If you no longer obtain employees from the labor contractor named above, provide the termination date. ______________
12. Do you regularly use the services of any other labor contractors? ☐ YES ☐ NO
If YES, complete a separate Client of Labor Contractor Supplemental Application for each, **AND ATTACH**.

EMPLOYER & PRODUCER STATEMENTS: I understand that this Client of Labor Contractor Supplemental Application is being submitted as an attachment to the employer's Massachusetts Assigned Risk Pool Application for Workers' Compensation Insurance and is part of that application.
By signing this application, I am stating that I am the employer or have been authorized by the employer to complete this application, and I have read, understand and confirm that the Applicant's Agreements, the Fraud Notice, and the Producer's Statement agreed to on the Pool Application are applicable to this form as well.

EMPLOYER'S SIGNATURE (Sole Proprietor, Partner, Officer, Member or Trustee)	DATE	PRODUCER'S SIGNATURE	DATE

DRAFT

WCRIBMA
THE WORKERS' COMPENSATION RATING AND INSPECTION BUREAU OF MASSACHUSETTS

MASSACHUSETTS WORKERS' COMPENSATION ASSIGNED RISK POOL
CLIENT OF LABOR CONTRACTOR SUPPLEMENTAL APPLICATION

If you are making application for Assigned Risk Pool coverage, refer to the *Pool Procedures for New Applications* on **www.WCRIBMA.org**.
If you regularly have employees provided to you by another business, whether from an employee leasing company, PEO, staffing agency, or temporary employment agency, complete a separate Client of Labor Contractor Supplemental Application for each company from whom you obtain employees.

EMPLOYER INFORMATION
From Part I of the Client Company's Application for Assigned Risk Pool Coverage.

1. Client Name: ______________________________
2. a. FEIN: ____________________ b. Website: ____________________

LABOR CONTRACTOR INFORMATION

3. Labor Contractor Company Name: ______________________________
4. a. FEIN: ____________________ b. Website: ____________________
5. Do you have a written contract with the labor contractor named above? **IF YES, ATTACH A COPY.** ☐ YES ☐ NO
6. The labor contractor is required to provide workers' compensation insurance for the employees they provide to you.
ATTACH EVIDENCE OF SUCH INSURANCE.

EMPLOYEES PROVIDED

7. Employees Obtained: Supply information about all employees provided to you for the past 12 months by the labor contractor named above.

Duties	# of Employees	Estimated Payroll / Cost of Service

8. What type of services does the above labor contractor provide to your organization?
   - ☐ Employee Leasing
   - ☐ Professional Employment Organization (PEO)
   - ☐ Long Term Staffing (more than 6 months)
   - ☐ Temporary to Permanent Hire by the Client
   - ☐ Placement Services (client pays employees)
   - ☐ Special Assignment or Project Work (with a defined end date)
   - ☐ Special Assignment or Project Work (with no defined end date)
   - ☐ Provide Supplemental Help for Seasonal Business Increases
   - ☐ Provide Temporary Replacements for Absent Employees
   - ☐ Provide Skilled Professionals during Skill Shortages
   - ☐ Other (describe in detail): ______________________________
9. Explain how frequently you obtain employees from the labor contractor named above and how long you expect the arrangement to last.
____
10. Do you obtain your entire workforce from the labor contractor named above? ☐ YES ☐ NO
11. If you no longer obtain employees from the labor contractor named above, provide the termination date. ____________________
12. Do you regularly use the services of any other labor contractors? ☐ YES ☐ NO
If YES, complete a separate Client of Labor Contractor Supplemental Application for each, **AND ATTACH**.

EMPLOYER & PRODUCER STATEMENTS: I understand that this Client of Labor Contractor Supplemental Application is being submitted as an attachment to the employer's Massachusetts Assigned Risk Pool Application for Workers' Compensation Insurance and is part of that application.
By signing this application, I am stating that I am the employer or have been authorized by the employer to complete this application, and I have read, understand and confirm that the Applicant's Agreements, the Fraud Notice, and the Producer's Statement agreed to on the Pool Application are applicable to this form as well.

EMPLOYER'S SIGNATURE (Sole Proprietor, Partner, Officer, Member or Trustee)	**DATE**	**PRODUCER'S SIGNATURE**	**DATE**

DRAFT

WCRIBMA

THE WORKERS' COMPENSATION RATING AND INSPECTION BUREAU OF MASSACHUSETTS

MASSACHUSETTS WORKERS' COMPENSATION ASSIGNED RISK POOL

LABOR CONTRACTOR SUPPLEMENTAL APPLICATION

If you provide employees to other businesses but do not consider them to be employee leasing arrangements as defined by 211 CMR 111.03, then complete a Labor Contractor Supplemental Application. Where space restricts a complete answer, attach responses on a separate sheet of paper.
Massachusetts Regulation 211 CMR 111.03 defines an employee leasing arrangement as an "arrangement whereby one business entity provides workers to another business entity under a contract that retains for the lessor a substantial portion of personnel management functions, such as payroll, direction and control of workers, and the right to hire and fire those workers provided by such lessor; provided, however, that the leasing arrangement is long term and not an arrangement to provide the lessee temporary help services during seasonal or unusual conditions such as temporary skill shortages or temporary special assignments and projects."
Note: Any arrangements to provide labor that are not "*temporary help services during seasonal or unusual conditions such as temporary skill shortages or temporary special assignments and projects*" shall be considered employee leasing arrangements, and each such arrangement will need to be insured on a separate policy in accordance with 211 CMR 111.04.

1. Employer Name: ____________________
2. a. FEIN: ____________________ b. Website: ____________________
3. # of W-2's issued last year: ____________________ # of 1099's issued last year: ____________________
4. Do you hire day laborers? ☐ YES ☐ NO

   If YES, how are they paid? ____________________
5. Do you provide group transportation for your employees? ☐ YES ☐ NO
6. Do you provide any services or materials other than *people* to your clients? ☐ YES ☐ NO

   If YES, describe the services or materials provided.____________________

   ____
7. Indicate ALL services you provide:
   - ☐ Employee Leasing
   - ☐ Professional Employment Organization (PEO)
   - ☐ Long Term Staffing (more than 6 months)
   - ☐ Temporary to Permanent Hire by the Client
   - ☐ Placement Service (client pays employees)
   - ☐ Special Assignment or Project Work (with no defined end date)
   - ☐ Special Assignment or Project Work (with a defined end date)
   - ☐ Provide Supplemental Help for Seasonal Business Increases
   - ☐ Provide Temporary Replacements for Absent Employees
   - ☐ Provide Skilled Professionals during Skill Shortages
   - ☐ Other (describe in detail): ____________________
8. **ATTACH** any contracts, brochures, and promotional materials utilized by your organization.
9. **ATTACH** a complete list of your clients for the past 6 months, and for each client, provide:
   The client's name and address;
   The nature of the client's business and the job descriptions of the employees provided;
   The number of employees provided and how often/frequently they were provided;
   The start and end dates of the arrangement; and
   A description of the circumstances under which employees were provided. **

* *In Massachusetts, PEOs are required to obtain employee leasing policies for their employees.*

** *Examples of circumstances under which employees may have been provided: Temporary to permanent hire by the client; covering for employee absences or leave; filling temporary skill shortages; staffing for a seasonal increase in business; staffing for a special temporary assignment or project; or meeting daily staffing needs.*

EMPLOYER & PRODUCER STATEMENTS: I understand that this Labor Contractor Supplemental Application is being submitted as an attachment to the employer's Massachusetts Assigned Risk Pool Application for Workers' Compensation Insurance and is part of that application. By signing this application, I am stating that I am the employer or have been authorized by the employer to complete this application, and I have read, understand and confirm that the Applicant's Agreements, the Fraud Notice, and the Producer's Statement agreed to on the Pool application are applicable to this form as well.	
EMPLOYER'S SIGNATURE **DATE** (Sole Proprietor, Partner, Officer, Member or Trustee)	**PRODUCER'S SIGNATURE** **DATE**

DRAFT

WCRIBMA
THE WORKERS' COMPENSATION RATING AND INSPECTION BUREAU OF MASSACHUSETTS

MASSACHUSETTS WORKERS' COMPENSATION ASSIGNED RISK POOL

CONSTRUCTION CONTRACTOR SUPPLEMENTAL APPLICATION

Where space restricts a complete answer, attach responses on a separate sheet of paper.

DRAFT

1. Employer Name: ____________________
2. a. License Type: ____________________ b. License #: ____________________
3. a. # of W-2's issued last year: ____________________ b. # of 1099's issued last year: ____________________
4. Does the applicant use day laborers? ☐ YES ☐ NO If Yes, how are they paid? ____________________
5. Attach a list of the five largest jobs performed by the employer within the past year, including the jobsite addresses, a description of the work performed, and the dollar value of each.
6. Estimated percentage of work completed last year by: Self & Employees: _____% Subcontractors: ____% (Must total 100%.)
7. Provide the total number of subcontractors used over the last year: ____________________
8. Describe the type(s) of work the applicant subcontracted out: ____________________
____
____
9. Do you have workers' compensation certificates of insurance on file for each subcontractor used? ☐ YES ☐ NO
If NO, you must include the payroll of each subcontractor without a certificate in Section VI of your coverage application.
10. Does the applicant use any individuals who perform the work themselves and have no employees? ☐ YES ☐ NO
If Yes, documentation must be maintained which supports that those individuals are independent contractors in accordance with M.G.L. c. 149, s. 148B. If such documentation is not available, or if the designated carrier finds evidence of an employment relationship, then premium may be charged as if the individuals were employees.
11. If the applicant has no employees and does not use subcontractors, answer the following:
a. How is the work performed? ____________________
b. Who performs the work? ____________________
c. Why do you need workers' compensation insurance? ____________________
12. Percentage of Operations (Must total 100%.): General Contractor*: ____________% Subcontractor*: ___________%
Other: _________% Explain 'other' in detail: ____________________
13. Indicate the % of work conducted in each of the following categories. (Each line must total 100%.)
New Construction ______% + Additions to Existing Construction ______% + Remodel/Repair ______% = 100%
Commercial Construction ______% + Residential Construction ______% = 100%
Interior Construction ______% + Exterior Construction ______% = 100%
14. If external construction is performed, what is the maximum height at which you will work? ____________________
15. Is the applicant involved in "Wrap Up" or "Owner Controlled Insurance Projects"? ☐ YES ☐ NO
If YES, attach a list of all such projects you are involved in now or may be involved in within the next year.

* Definitions: Subcontractor – Contractor who is hired by a General Contractor and not directly by the owner.
General Contractor – Contractor who is hired directly by the owner for new or renovation projects. They may perform the work or subcontract it out.

EMPLOYER & PRODUCER STATEMENTS: I understand that this Contractor Supplemental Application is being submitted as an attachment to the employer's Massachusetts Assigned Risk Pool Application for Workers' Compensation Insurance and is part of that application. By signing this application, I am stating that I am the employer or have been authorized by the employer to complete this application, and I have read, understand and confirm that the Applicant's Agreements, the Fraud Notice, and the Producer's Statement agreed to on the Pool application are applicable to this form as well.	
EMPLOYER'S SIGNATURE **DATE** (Sole Proprietor, Partner, Officer, Member or Trustee)	**PRODUCER'S SIGNATURE** **DATE**

101 ARCH STREET 5TH FLOOR, BOSTON, MASSACHUSETTS 02110
(617) 439-9030, FAX (617) 439-6055, www.wcribma.org

WCRIBMA
THE WORKERS' COMPENSATION RATING
AND INSPECTION BUREAU OF MASSACHUSETTS

MASSACHUSETTS WORKERS' COMPENSATION ASSIGNED RISK POOL

TRUCKER/DELIVERY SUPPLEMENTAL APPLICATION

Where space restricts a complete answer, attach responses on a separate sheet of paper.

1. Employer Name: ____________________

2. a. FEIN: ____________________ b. US DOT #: ____________________

3. a. Commercial Auto Carrier: ____________________ b. Commercial Auto Policy #: ____________________

4. Do you or your employees operate out of a base terminal* in Massachusetts? ☐ YES ☐ NO

   a. If YES, (1) provide the terminal address(es) in MA, and (2) attach a list of all employees assigned to each terminal:

   ____

   b. If No, do you or your employees spend a majority of time* driving in any one state? ☐ YES ☐ NO
   If YES, attach a list of employees including the state of majority driving time for each employee.
   If NO, attach a list of employees including the state of residence for each employee.

5. How many of your MA drivers are independent owner-operators (i.e., own or lease their vehicles)? ____________________

   a. If greater than zero, provide a list of all such MA drivers' names, home addresses and vehicle registration numbers.

   b. Do you have an equipment lease agreement with your employees or owner-operators? ☐ YES ☐ NO
   If YES, attach a signed copy of each equipment lease agreement.

   c. # of W-2's issued last year: ____________________ # of 1099's issued last year: ____________________

   d. Do you have workers' compensation certificates of insurance on file for each such MA driver? ☐ YES ☐ NO
   If NO, you must include the payroll of every driver without a certificate in Section VI of your coverage application.

In Massachusetts, Occupational Accident Insurance Coverage is not recognized as a substitute for Workers' Compensation.

6. How are the drivers compensated? ☐ Hourly ☐ By the mile ☐ By the load ☐ By the package ☐ Other – explain:

   ____

7. Indicate operations provided by applicant:
   - ☐ Delivery of goods/merchandise owned by employer. Type of goods: ____________________
   - ☐ General trucking
   - ☐ Parcel or package delivery limited to 100 lbs. or less.
   - ☐ Towing w/out repair (repair < 50% gross revenue)
   - ☐ Towing w/repair (repair > 50% gross revenue)
   - ☐ Contract carrier directly for retail store(s). No general trucking. Provide a copy of the contract(s).
   - ☐ Contract carrier for US Postal Service. No general trucking. Provide a copy of the contract.
   - ☐ Other – explain: ____________________

* Definitions:
Base Terminal – A permanent location with central loading docks and/or storage facilities where a trucker regularly goes to load, unload, store or transfer freight.
State of Majority of Driving Time – State where trucker spends more time driving in or through than any other state. Must be verifiable.

EMPLOYER & PRODUCER STATEMENTS: I understand that this Trucker/Delivery Supplemental Application is being submitted as an attachment to the employer's Massachusetts Assigned Risk Pool Application for Workers' Compensation Insurance and is part of that application. By signing this application, I am stating that I am the employer or have been authorized by the employer to complete this application, and I have read, understand and confirm that the Applicant's Agreements, the Fraud Notice, and the Producer's Statement agreed to on the Pool application are applicable to this form as well.

EMPLOYERS' SIGNATURE (Sole Proprietor, Partner, Officer, Member or Trustee)	DATE	PRODUCER'S SIGNATURE	DATE

DRAFT

101 ARCH STREET 5TH FLOOR, BOSTON, MASSACHUSETTS 02110
(617) 439-9030, FAX (617) 439-6055, www.wcribma.org

MASSACHUSETTS EXCLUSION OF COVERAGE FOR LEASED EMPLOYEES ENDORSEMENT (EMPLOYEE LEASING COMPANY)

This policy applies only with respect to those of your employees not leased to a client company under an "employee leasing arrangement" as defined in Massachusetts Regulation 211 CMR 111:00.

CURRENT

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective Policy No. Endorsement No.
Insured Premium

Insurance Company Countersigned by____

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MASSACHUSETTS EXCLUSION OF COVERAGE FOR LEASED EMPLOYEES ENDORSEMENT (LABOR CONTRACTORS)

This policy applies only with respect to those of your employees who are not leased to a client company under an "employee leasing arrangement" as defined in Massachusetts Regulation 211 CMR 111.00.

This policy provides coverage for the insured labor contractor's own staff and any employees provided on a temporary basis during seasonal or unusual conditions, including by way of example and without limitation:

- To cover employee absences or leaves from which the permanent employee will return to work, such as maternity leave, vacation, or jury duty.
- To fill temporary skill shortages for a specified period of time.
- To temporarily staff for seasonal workload for a specified period of time.
- To staff a special assignment or project for a specified period of time where the employee(s) will be terminated or reassigned upon completion.
- To cover temp-to-hire or probationary hiring situations.

If, at any time, the insured employer enters into an employee leasing arrangement as defined in Massachusetts Regulation 211 CMR 111.00, then it is the responsibility of the insured employer to purchase and maintain a separate policy providing standard workers' compensation and employers' liability insurance for those leased employees, as required by Massachusetts Regulation 211 CMR 111.04.

DRAFT

Note:

1. This endorsement must be attached to every policy where the named insured is an employee leasing company, as defined in Massachusetts Regulation 211 CMR 111.00, to restrict coverage to the leasing company's non-leased employees.
2. This endorsement must be attached to every residual market policy where the named insured is a labor contractor to restrict coverage to the labor contractor's non-leased employees.
3. This endorsement may be attached to a voluntary policy where the named insured is a labor contractor to restrict coverage to the labor contractor's non-leased employees.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective | Policy No. | Endorsement No.
Insured | | Premium

Insurance Company | Countersigned by ____

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MASSACHUSETTS EXCLUSION OF COVERAGE FOR LEASED EMPLOYEES ENDORSEMENT (LABOR CONTRACTORS)

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DRAFT

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Insured Premium

Insurance Company Countersigned by ____________________

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