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.

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? 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? 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. ☐ YES ☐ NO
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

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

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	

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)

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

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.