



# WISCONSIN WORKER'S COMPENSATION INSURANCE POOL

APPLICATION MUST BE PRINTED IN INK OR TYPED AND SIGNED BY APPLICANT AND PRODUCER.

FOR BUREAU USE ONLY

**MAIL TO:**

WISCONSIN WORKER'S COMPENSATION INSURANCE POOL  
P.O. BOX 3080  
MILWAUKEE, WI 53201-3080  
(262) 796-4592

**DELIVER TO:**

20700 SWENSON DRIVE  
SUITE 100  
WAUKESHA, WI 53186

**FILE #:**

**CARRIER:**

**EFF DATE:**

**ALL QUESTIONS MUST BE COMPLETED, OR INDICATED IF "NOT APPLICABLE".**

THE UNDERSIGNED EMPLOYER IS UNABLE TO PURCHASE WORKER'S COMPENSATION AND EMPLOYER'S LIABILITY INSURANCE FOR LIABILITY UNDER THE WISCONSIN WORKER'S COMPENSATION LAW AND HEREBY APPLIES FOR THE DESIGNATION OF AN INSURANCE COMPANY TO PROVIDE INSURANCE IN ACCORDANCE WITH THE WISCONSIN WORKER'S COMPENSATION INSURANCE POOL.

1. APPLICANT NAME (ENTER COMPLETE LEGAL NAME OF EMPLOYER)		2. MAILING ADDRESS (INCLUDING ZIP CODE)		FEIN
TELEPHONE # (INCLUDING AREA CODE)	3. LEGAL STATUS			4. REQUESTED EFFECTIVE DATE (MM/DD/YY)
FAX # (INCLUDING AREA CODE)	<input type="checkbox"/> INDIVIDUAL	<input type="checkbox"/> LIMITED LIABILITY CO	DATE BUSINESS BEGAN (MM/DD/YY)	
	<input type="checkbox"/> PARTNERSHIP	<input type="checkbox"/> OTHER:		
	<input type="checkbox"/> CORPORATION			

**NOTE: THE EFFECTIVE DATE OF INSURANCE IS GOVERNED BY THE RULES OF THE WISCONSIN WORKER'S COMPENSATION POOL. APPLICATIONS SHOULD BE SUBMITTED AT LEAST 15 DAYS PRIOR TO THE REQUESTED EFFECTIVE DATE.**

**5. LOCATIONS OF ALL WISCONSIN WORK PLACES (Show principal location first)**

#	STREET, CITY, COUNTY, STATE, ZIP CODE	
PAYROLL OFFICE ADDRESS (STREET, CITY, STATE & ZIP)		CONTACT PERSON AND TELEPHONE # (INCLUDING AREA CODE)

**6. NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS**

**7. SUPPLEMENTAL INFORMATION**

EXPLAIN ALL "YES" RESPONSES IN REMARKS	YES	NO	EXPLAIN ALL "YES" RESPONSES	YES	NO
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT/WATERCRAFT?			12. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME?		
2. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?			13. HAS THERE BEEN A NAME CHANGE, CONSOLIDATION, MERGER OR OWNERSHIP CHANGE DURING THE PAST THREE YEARS? IF YES, GIVE PREVIOUS NAME AND DATE OF CHANGE. CONTACT POOL ABOUT AN ERM-14.		
3. ANY WORK SUBLET WITHOUT CERTIFICATES OF INSURANCE?					
4. IS A FORMAL SAFETY PROGRAM IN OPERATION?			14. ARE THERE OPERATIONS IN STATES OTHER THAN WISCONSIN? IF YES, COMPLETE THE FOLLOWING AS THE POLICY CANNOT PROVIDE COVERAGE IN THOSE STATES. (IF SELF-INSURED OR UNINSURED, INDICATE UNDER INSURANCE CARRIER.)  STATE:  LOCATION:  INS CARRIER:		
5. DO YOU EMPLOY DRIVERS?					
6. DO EMPLOYEES TRAVEL OUT OF STATE?					
7. ARE ATHLETIC TEAMS SPONSORED?					
8. ARE EMPLOYEE HEALTH PLANS PROVIDED?					
9. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS/SUBSIDIARY?					
10. ARE YOU IN CHAPTER 11 BANKRUPTCY?					
11. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?					

**8. INSURANCE RECORD**

1. HAS THERE BEEN PREVIOUS WORKER'S COMPENSATION INSURANCE COVERAGE IN WISCONSIN?  YES  NO  
IF NO, COMPLETE:  NEW BUSINESS  SELF-INSURED  OTHER (EXPLAIN):

2. INSURANCE RECORDS -- THREE PREVIOUS YEARS:

INSURANCE COMPANY	FROM	POLICY PERIOD TO	POLICY NUMBER



# WISCONSIN WORKER'S COMPENSATION INSURANCE POOL INSTRUCTIONS FOR COMPLETING ACORD 133 WI APPLICATION

WISCONSIN COMPENSATION RATING BUREAU  
P.O. BOX 3080  
MILWAUKEE, WI 53201-3080  
TELEPHONE (262) 796-4592, FAX (262) 796-4423  
LOCATED AT: 20700 SWENSON DRIVE, SUITE 100  
WAUKESHA, WI 53186

The numbers on this instruction sheet correspond to the numbered sections on ACORD 133 WI, Wisconsin Worker's Compensation Insurance Pool application. Attach extra sheets to the application if you need space when filling out Sections 6, 7 & 12.

## **GENERAL**

File the application and all required attachments. Make a copy and keep it for your records.

Failure to fully answer all questions, attach required payroll verification forms or supplemental applications, remit proper form or amount of deposit premium and/or include required signatures may result in a delay in coverage.

The effective date of coverage is normally 12:01a.m. on the day following receipt of the application at Wisconsin Compensation Rating Bureau. Coverage may also be bound on a future date if so requested. Only the Pool can bind coverage. No agent has binding authority. **Pool Coverage is never effective retroactively.**

## **SECTION 1. APPLICANT NAME**

Show the complete legal name of the employer(s). If the applicant is a proprietorship, a partnership, or a limited liability company, the full name(s) of general partners must be included in addition to all applicable trade names. Include the business telephone number, fax number, and the applicant's Federal Employers Identification Number.

The insured named first on the policy Information Page is given certain rights and responsibilities by the language of the policy contract. If more than one applicant is listed on the application, the one intended to receive these rights and responsibilities should be named first.

## **SECTION 2. MAILING ADDRESS**

Show the applicant's complete and exact mailing address.

## **SECTION 3. LEGAL STATUS**

Check the box to designate the legal status of the applicant. If you check "other", please identify the type of organization. If there is more than one applicant, clearly identify the legal status of each.

## **SECTION 4. REQUESTED EFFECTIVE DATE**

The effective date of coverage is determined by the Wisconsin Pool rules. Coverage will be bound at 12:01am the day following receipt of the complete application, all applicable supplementary forms and appropriate deposit premium; or on the requested effective date, whichever date is later. If the applications and deposit premium are personally delivered to the Bureau, coverage may not be earlier than the day following Bureau receipt. Indicate the date business began for the applicant in the state of Wisconsin.

## **SECTION 5. LOCATIONS OF ALL WISCONSIN WORK PLACES**

Enter the physical address of all permanent Wisconsin locations from which the applicant operates. Enter the company name and physical address of the location where payroll records are maintained. For any location, a post office box is not an acceptable address. Include the name and telephone number of the person to contact regarding the applicant's payroll records.

## **SECTION 6. NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS**

Completely describe the business or operations of the applicant. This information is needed to establish proper classification code assignments. Do not simply include the wording for a classification code.

If the applicant is a service organization, describe the nature and details of the operation.

If the applicant is a merchant, describe the products sold and any operations that involve the preparation of merchandise for sale and indicate if sales are retail or wholesale (if both, give percentage of each).

If the applicant is a manufacturer, list the raw materials, processes, and products manufactured.

If the applicant is a contractor, describe the type of construction, erection or repair work performed and the type of equipment used. Describe the nature of any sub-contract arrangements.

(Continued)

## **SECTION 7. SUPPLEMENTAL INFORMATION**

Answer all questions by checking yes or no. Provide any additional details or clarification as required. Please attach a separate sheet of paper to explain any "Yes" responses needing clarification.

## **SECTION 8. INSURANCE RECORD**

Provide the previous record of worker's compensation insurance coverage for the applicant.

## **SECTION 9. CORPORATE OFFICERS, SOLE PROPRIETORS, PARTNERS, OR MEMBERS OF A LIMITED LIABILITY COMPANY**

List the name of each executive officer, sole proprietor, partner(s), general partner(s) or each member of a limited liability company. Indicate whether coverage for each individual is elected or rejected. Include title, percentage of ownership, applicable code, remuneration and duties.

Executive officers of a corporation are automatically covered under Wisconsin law; however, any two officers of a corporation having not more than ten stockholders are allowed to non-elect coverage under the law. The payroll, subject to individual minimum or maximum limitations as shown on the state rate pages, for all covered executive officers must be included in the "total payroll" and used to calculate estimated annual premium. Sole proprietors, partners and members of a limited liability company are not covered under Wisconsin law; however, the sole proprietor, partners and members of a limited liability company may elect to be included as an employee, if actively engaged in the operation of the business and the insurer is notified of the election to be included. The fixed payroll amount, as shown on the state rate pages, for covered sole proprietors, partners and members of a limited liability company must be included in the "total payroll" and used to calculate estimated annual premium. Any sole proprietor, partner or member who elected to be an employee under this section may withdraw that election upon 30 days prior written notice to the insurance carrier and the Wisconsin Compensation Rating Bureau. Please note that the non-election or election of coverage will be continued on all renewal policies, unless changes are requested at time of renewal.

**\* IMPORTANT: PLEASE ATTACH SIGNED "NON ELECTION" OR "ELECTION" FORMS TO THIS APPLICATION.**

## **SECTION 10. RATING INFORMATION SECTION**

Separately list class code, classification phraseology, number of employees, an accurate estimate of the annual payroll, the rate and calculated premium. For any estimated annual premium in excess of \$2,000 a percentage of the annual premium may be calculated as the deposit premium. Payroll verification such as Federal Employer forms 940, 941, 942, or 943 should be attached when submitting any application. A new employer must submit a notarized letter stating there was no payroll in the past.

## **SECTION 11. PREMIUM PAYMENT REQUIREMENTS**

Premium, payable to the Wisconsin Compensation Rating Bureau, may be made by agencies, cashiers or certified checks, money order or a check of a premium finance company. The estimated annual premium or proper deposit premium must be received before an assignment of coverage can be made.

If the premium is financed, the full financed amount must be received before assignment of coverage can be made. Attach a copy of the signed premium finance agreement.

## **SECTION 12. SPECIAL NEEDS**

Additional information may be requested before an assignment of coverage can be made. Please note that when requesting Other States Coverage, ACORD Form 136 (Wisconsin Limited Other States Coverage) must be completed and submitted with the initial application.

## **SECTION 13. APPLICANT'S STATEMENT**

The application is incomplete unless it has been signed by an individual: (i) certifying the accuracy of the information given to the agent, and used to complete the application, and (ii) agreeing to comply with basic provisions of the Wisconsin Worker's Compensation Insurance Pool. The individual signing the application must be the sole proprietor if the applicant is a proprietorship, a partner if the applicant is a partnership, a member if the applicant is a limited liability company, or an executive officer if the applicant is a corporation.

## **SECTION 14. STATEMENT OF LICENSED AGENT OR PRODUCER OF RECORD**

In signing this application, the agent certifies that: (1) I am a licensed intermediary agent of the state of Wisconsin, (2) I have read the Wisconsin Worker's Compensation Insurance Pool rules, explained the provisions to the applicant, and have included in this application all required information given to me by the applicant. In the event the policy is terminated or a change is made resulting in a return of premium to the insured, I agree to return the unearned commission.

**Please review the information below, and pay particular attention to the items that pertain to you.**

- 1) Attach a copy of Non Resident license if you are an agent from another state.
- 2) The producer does not represent the servicing carrier nor the Pool, in any way, has no authority to bind coverage, change, alter or terminate coverage.
- 3) The application may be signed by an out of state agent to whom the Wisconsin Office of Commissioner of Insurance has issued a non-resident license.
- 4) If you are not an agent licensed in the state of Wisconsin, or do not have a non-residents license in the state of Wisconsin, you may not submit the application. The insured should submit an application without an agent.
- 5) Include the complete agent/agency name and mailing address, telephone number, fax number, Federal Employers Identification Number or Social Security Number and Producers Wisconsin License number.
- 6) Commissions will not be paid unless you sign the application.