

Form SI-12 Rev. 8/01/2006	ARKANSAS WORKERS' COMPENSATION COMMISSION SELF-INSURANCE DIVISION 324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-2783 / 1-800-622-4472	SI-12
Ark. Code Ann. §11-9-404 & AWCC Rule 099.05		

APPLICATION FOR MEMBERSHIP IN A GROUP

Name of Group Self-Insurer: Arkansas Self-Insurance Trust	
Name of Applicant:	Telephone Number ()
	Facsimile Number ()
Mailing Address:	
City, State, and Zip Code:	Years in Business:
Application is for: <input type="checkbox"/> Individual <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other (please specify)	Federal Employer Identification Number (FEIN):
Nature of Business:	
PHYSICAL LOCATIONS: List physical address, city, state, and zip code - (If more locations, please list on a separate page and attach.)	
1.	
2.	
3.	
4.	
5.	
6.	
Name of officers, owners or partners, and addresses	
(First name)	(MI) (Last name) (Title) (Address) Include for Coverage
1.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	<input type="checkbox"/> Yes <input type="checkbox"/> No

NOTICE: THE INFORMATION IN ITEMS 1 - 5 BELOW IS CONFIDENTIAL

1. Number of employees working for applicant in Arkansas at this time _____
2. Arkansas workers' compensation and employer's liability insurance coverage prior to effective date carried by: _____

3. What is the expiration date of applicant's current workers' compensation coverage? _____
4. List the class codes and descriptions used on the applicant's existing or previous workers' compensation policy.

If the applicant is a new entity, skip this step and proceed with number 5. (Attach an additional sheet if more space is needed)

MANUAL CODE	DESCRIPTION

5. Please complete the following, based on the preparation of the proposed group policy

NO. OF EMPLOYEES	MANUAL CODE	CLASSIFICATION	PAYROLL	RATE PER \$100	ANNUAL PREMIUM
Totals			\$		\$
Experience Modifier _____			Experience Modifier Discount		\$
Premium Size Discount _____%			Premium Size Discount		\$
Front-End Discount _____%			Front-End Discount ASIT Charge		\$
			Total projected premium to be paid for the policy period		\$

6. We hereby formally apply for continuing membership in the above named group, to be effective at 12:01 A.M. _____, 2 _____, and if accepted by the group's duly authorized representative, do hereby designate and appoint the named manager of the Group as our agent-in-fact in all matters relating to the workers' compensation laws and/or employer's liability.

We further agree as follows:

- A. To accept and be bound by the provisions of the Arkansas workers' compensation laws.
- B. That, by application and reference, the terms and provisions of the Group Indemnity Agreement and/or Amendment thereto filed, or any renewal Indemnity Agreement which may hereafter be filed with the Arkansas Workers' Compensation Commission are hereby adopted, approved, ratified and confirmed by us: and, further, we agree to assume all of the obligations set forth therein, including, but not limited to, our joint and several liabilities for payment of any lawful awards against any member of the Group.
- C. To abide by the rules and regulations of the Trustees of the Group and to conform to the terms of the agreements they may enter into with any authorized third party administrator as long as we remain a member of the group.
- D. We agree to give at least thirty (30) days written notice to the Group prior to our withdrawal as a member. In the event, of any changes in ownership, corporate structure, legal entity, nature of business or if any locations are to be added or deleted, we agree to so notify the Group immediately. The Group will give written notice thirty (30) days prior to cancellation or expulsion of any member.

(Name of applicant)

(Printed Name of authorized officer of Applicant)

(Signature of authorized officer of Applicant)

(Title of officer)

State of Arkansas

County of _____ }
_____ }

Subscribed and sworn to me by _____ on this _____
day of _____, 2_____.

Notary Public

My Commission Expires: _____

The application and supporting documents of _____ have been properly received and noted. Said applicant is hereby approved and accepted for membership in the Group effective the _____ day of _____, 2_____.

Arkansas Self-Insurance Trust _____
(Name of Group)

By: _____
Chairman, Board of Trustees

Date of Signing



ARKANSAS SELF-INSURANCE TRUST WORKERS' COMPENSATION INSURANCE APPLICATION

Administered By: Midwest Risk Management Services, Inc.

5502 Walsh Lane, Ste 103

Rogers, AR 72758

Tele: (479) 271-7475

Toll Free: (800) 440-7475

Fax: (479) 271-7141

Website: www.midwestrisk.net

E-mail: mbohannon@mrmsi.com

1. Legal Name _____
2. d.b.a. or a.k.a. _____
3. Physical Address _____
City _____ State _____ Zip _____
4. Billing Address _____
City _____ State _____ Zip _____
5. Administrator _____
Telephone _____ Fax _____
E-mail _____
6. Describe ownership and type of facility (individual, partnership, corporation, etc.)

7. Expiration date of your current program _____
8. Experience modifier (if known) _____
9. Provide the following information estimated for the next twelve months.

For Nursing Homes:

<u>Code</u>	<u>Classification</u>	<u>No. of Employees</u>	<u>Estimated annual payroll</u>
8810	Clerical	_____	_____
8829	Convalescent	_____	_____

For Retirement Homes Only:

<u>Code</u>	<u>Classification</u>	<u>No. of Employees</u>	<u>Estimated annual Payroll</u>
8810	Clerical (Administrator)	_____	_____
8824	Health Care Employees (Physicians, nurses, therapists, aids, orderlies, Activities Director)	_____	_____
8825	Food Service Employees (Prepare or serve)	_____	_____
8826	All Other (Housekeeping, laundry, salespersons, van drivers, security, maintenance)	_____	_____

EXHIBIT A
TO
TRUST AGREEMENT

APPLICATION FOR MEMBERSHIP
AND PARTICIPATION AGREEMENT FOR THE
ARKANSAS SELF-INSURANCE TRUST

LEGAL NAME OF APPLICANT: _____

LEGAL NATURE OF APPLICANT: _____

(e.g., corporation, partnership, individual)

NAME OF FACILITY: _____

ADDRESS: _____

INSURANCE COVERAGE NOW CARRIED BY: _____

The above-named applicant (the "Applicant") hereby formally applies for continuing membership for workers' compensation coverage in the ARKANSAS SELF-INSURANCE TRUST (the "Trust"), to be effective 12:01 a.m. on _____, _____, until proper termination or any permitted withdrawal. If accepted for membership, the Applicant does hereby through its duly authorized representative, constitute and appoint the Trust, and its authorized representatives to act as the Applicant's agent in all matter relating to the Trust Agreement of the Trust (the "Trust Agreement") and the workers' compensation laws, rules and regulations of the State of Arkansas.

In furtherance of the foregoing and both for now and at all times during which the Applicant is a member of the Trust, in the event this application is approved, the Applicant hereby agrees as follows:

A. To accept and be bound by each of the terms, conditions and provisions of the Trust Agreement, Bylaws, and Operating Regulations of the Trust and the workers' compensation laws of the State of Arkansas, particularly, without limitation, those governing group self-insurance organizations and membership therein. In this regard, the Applicant specifically authorizes the Board of Trustees to enter into and carry out the terms of the Trust Agreement on its behalf.

B. By this reference, the terms, conditions and provisions of the Trust Agreement as amended from time to time and filed with the Arkansas Workers' Compensation Commission (the "AWCC") are hereby adopted, approved, ratified and confirmed by the Applicant. That the Applicant further agrees to assume all of the obligations set forth therein, including, but not limited to joint and several liability with all members of the Trust for payment of any lawful awards against any member of the Trust and being bound, jointly and severally, with each member of the Trust to comply with the provisions of Arkansas Code Annotated §11-9-101, et seq. In the event the Applicant fails to pay any premium or lawful assessment within the time frame set by the Board of Trustees or the Fund Manager, the Applicant agrees to pay all costs of the collection thereof, including reasonable attorneys' fees. It is understood, however, that the Trust will procure on behalf of the Trust re-insurance coverage, with attachment points and coverage limits to be determined in the sole discretion of the Board of Trustees, to help protect the financial integrity and stability of the Trust.

C. During all times which the Applicant is a member of the Trust, to abide by the rules and regulations, contractual provisions, and all other requirements governing the Trust and its members as set forth in the Trust Agreement, Bylaws, Operating Regulations and other Trust documents as they presently exist or may hereafter be amended, and to further conform to the Arkansas Workers' Compensation Law regarding membership in self-insured groups, and the terms and agreements which may be entered into with any authorized service companies for so long as the Applicant remains a member of the Trust.

D. In the event of any changes in the Applicant's corporate or business structure, ownership or legal name or entity, or if any locations are to be added to or deleted from this coverage, the Applicant agrees to provide immediate written notice thereof to the Fund Manager at the following address or at such other address as may be specified subsequent hereto by the Trust or the Fund Manager:

Midwest Risk Management Services, Inc.

5502 Walsh Lane, Suite 103

Rogers, Arkansas 72758

E. Except as otherwise provided in the Trust Agreement, the Applicant shall not withdraw from membership until it has been a member of the Trust

for three (3) full calendar years. Should the Applicant desire to withdraw from membership thereafter, it will give written notice at least one hundred twenty (120) days prior to cancellation, that such cancellation will be effective at the end of the fiscal year.

F. The Applicant understands and agrees that (1) coverage under this membership shall be for Arkansas employers only; (2) the Wage Declaration Schedule and/or Renewal Certificates, when completed and returned to the Trust, will become a part of this Agreement; and (3) upon approval of this Application for Membership, this application shall be deemed to be the Participation Agreement required by the Trust Agreement.

G. The Applicant further makes the following representations and warranties regarding this Application: (1) the Applicant has delivered herewith, if available, the latest fiscal year audit or financial statement as well as any other information requested by the Trust or the Fund Manager; (2) the Applicant has met all eligibility requirements and the information provided to the Trust and the Fund Manager for purposes of this Application is accurate and not misleading; (3) the person signing this Application for Membership has full authority to legally bind and contract on behalf of the Applicant; and (4) enclosed with this Application is the initial annual contribution to the Trust, or such other installment amount, as established by the Fund Manager, in the amount of \$_____.

NAME OF APPLICANT

AUTHORIZED REPRESENTATIVE

REPRESENTATIVE CAPACITY

STATE OF ARKANSAS _____

COUNTY OF _____

Subscribed and sworn to before me this _____ day of _____, 20_____. Witness my hand and official seal.

Notary Public

My Commission Expires:

DO NOT WRITE BELOW - FOR TRUST USE ONLY

COVERAGE AGREEMENT

_____ is hereby approved for membership in the Trust, the terms and provisions of which are incorporated herein by reference. Receipt is acknowledged of the amount of \$_____.

Approved this _____ day of _____, 20_____.

MIDWEST RISK MANAGEMENT SERVICES, INC., as Fund
Manager of the Arkansas Self-Insurance Trust

Authorized Signature

FINANCIAL AFFIDAVIT

The information contained in the accompanying financial statements is true and correct to the best of my/our knowledge, and accurately reflects the financial condition of

Legal Name of Applicant

Further, I/We declare there has been no material lessening in the net worth or significant alteration of the current ratio of _____
Legal Name of Applicant

Since _____
Date of attached Financial Statements

Signature Title Date

Signature Title Date

I hereby certify that I have witnessed the signature/s of _____

and _____ on this _____ day of _____, 200_____

Notary Public

Seal