

Kentucky Associated General Contractors Self Insurers' Fund

P.O. Box 436949 * Louisville, KY 40253-6949 * (502) 245-2007

**STANDARD WORKERS' COMPENSATION &
EMPLOYERS' LIABILITY INSURANCE POLICY**

Policy No:	Policy Period:	Coverage Provided By: Kentucky AGC/SIF
Named Insured and Address:		Agent:
FEIN Number: Your Legal Status Is:		

ANNUAL RATIFICATION OF JOINT AND SEVERAL LIABILITY

As an **Owner** or **Officer** of all Named Insureds, as stated on the most recent Application for Membership (coverage) on the above policy number through the Kentucky AGC/SIF, I acknowledge and affirm my understanding of, and obligation to, the following statement:

The Named Insured/s' workers' compensation and employers liability insurance coverage has *BEEN PLACED WITH A WORKERS COMPENSATION SELF-INSURED GROUP WHICH IS REGULATED BY THE KENTUCKY OFFICE OF INSURANCE AND HAS RECEIVED A CERTIFICATE OF FILING FROM THE COMMONWEALTH OF KENTUCKY. CLAIMS AGAINST GROUP MEMBERS ARE COVERED BY THE SELF-INSURED GROUP INSURANCE GUARANTY ASSOCIATION, BUT ARE NOT COVERED BY THE KENTUCKY INSURANCE GUARANTY ASSOCIATION. GROUP MEMBERS SHALL BE ASSESSED IN THE EVENT OF INSOLVENCY OF THE WORKERS' COMPENSATION GUARANTY ASSOCIATION.*

Additionally, I acknowledge and affirm my understanding of, and obligation to, the provisions of the Workers' Compensation and Employers' Liability policy assumed in the Application for Membership to the Kentucky AGC/SIF at the inception of the named insured's coverage and the provisions of the Kentucky AGC/SIF's Workers' Compensation and Employers' Liability Insurance written policy, the Indemnity Agreement or any amendment thereto by which group members jointly and severally bind themselves to pay their workers' compensation liability in accordance with Kentucky Insurance Laws and Regulations governing self-insured groups, terms of the Information Page, and any revisions made hereto. .

Signed: _____
(Owner or Officer)

Position: _____

Print Name: _____

Date: _____