

Policy #: _____
(for Fund Office use only)

APPLICATION FOR MEMBERSHIP TO THE

KENTUCKY ASSOCIATED GENERAL CONTRACTORS SELF INSURERS' FUND (KY AGC/SIF)

P.O. BOX 436949 * LOUISVILLE, KY 40253-6949 *

Phone: (502) 245-2007 * Fax: (502) 245-6062 * Website: www.kyagcsif.com

(FOR WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY COVERAGE ONLY)

APPLICANT NAME (ALL ENTITIES): _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE: () _____ FAX: () _____

CHECK ONE: CORPORATION ____ PARTNERSHIP ____ SOLE PROPRIETOR ____ LLC ____

FED EMP. ID#: _____ KY EMP. ID #: _____ SIC CODE: _____

NATURE OF BUSINESS: _____

LIST OWNERS, PARTNERS, MEMBERS OR CORPORATE OFFICERS

1. NAME _____	TITLE _____
2. NAME _____	TITLE _____
3. NAME _____	TITLE _____
4. NAME _____	TITLE _____

W/C INSURANCE COVERAGE IS CURRENTLY CARRIED BY: _____

I (we), and the company(s) for which I am the authorized agent do hereby formally apply for membership to the above named Fund for Kentucky workers' compensation coverage to be bound at 12:01 A.M. on _____, **20**____, and if my membership is accepted by the Fund's duly authorized representatives, and in consideration of coverage provided by the Fund do hereby designate and appoint the Fund, its Administrators, and its Trustees to act as my/our agents in all matters relating to The Kentucky Workers' Compensation Laws, and/or Employers' Liability and I (we) further agree to be bound by the following:

1. All provisions of:
 - a. The Kentucky Workers' Compensation Laws (KRS, Chapter 342)
 - b. The applicable Kentucky Insurance Laws and Regulations governing self-insured groups (Specifically, but not limited to KRS, Chapter 304.50)
 - c. The Kentucky Associated General Contractors Self Insurers' Fund Workers' Compensation and Employers' Liability Policy and Information Page. (Your Policy and an Information Page will be provided to you if your application is accepted.)
 - d. The Kentucky Associated General Contractors Self Insurers' Fund's Agreement and Declaration of Trust and any subsequent Amendments (Copy available upon written request)
 - e. 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. I (we) further acknowledge that:

THIS 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 SELF-INSURED GROUP.

f. Any legal action taken by the Fund's duly authorized representatives.

2. The actions and policies adopted by the Trustees of the Fund.

3. I (we) and the Company(s) for which I am the authorized agent also agree:

- a. To pay my/our premium, audited premium or lawful assessment within thirty (30) days of the date the same shall become due.
- b. To pay all costs of any collection of monies due the Fund together with the maximum rate of interest allowed by law including reasonable attorney fees incurred in such collection.
- c. To notify the Fund immediately of any changes in corporate, partnership, sole proprietor, LLC, or any other legal entity structure, including location and/or address changes.
- d. That coverage in the State of Kentucky shall be exactly in accordance with the terms and conditions of the Fund’s written Information Page and Policy.
- e. That “Other” States coverage shall be exactly in accordance with the terms and conditions of the Fund’s written Information Page and Policy, and I (we), and the Company(s) for which I am the authorized agent, understand that Other States coverage is ONLY offered if the insured uses Regularly Employed Kentucky Employees. A Regularly Employed Kentucky Employee is defined as: An employee who is a resident of Kentucky and/or employed by a resident Kentucky employer, or is hired from a resident Kentucky Union Hall, and performs work within the scope of said employment for said employer for a minimum period of eight (8) hours in the Commonwealth of Kentucky PRIOR to performing any work in any other state, EXCLUDING Florida, Illinois, New Jersey and New York, with said period evidenced by payroll records from said employer. This statement shall not conflict with KRS 342.670 (1), (a,b,c or d).
- f. That the membership and coverage is continuing unless terminated by either the member or the Fund in accordance with Kentucky Insurance Laws and Regulations governing self-insured groups.

Witness to Applicant Signature

Name of Applicant

Name (Witness)

By: _____
Signature/Title

Address (Witness)

Date: _____

Date: _____

_____ is a member in good standing with one of the following

sponsoring **Trade Associations** which must be checked:

- AGC of Kentucky _____
- AGC of Western Kentucky _____
- Builders Exchange of Kentucky _____
- Home Builders Association of Kentucky _____ (Local # _____)
- Kentucky Association of Highway Contractors _____
- Kentucky Association of Plumbing, Heating & Cooling Contractors _____
- Kentucky Crushed Stone Association _____

AND IS HEREBY APPROVED FOR MEMBERSHIP IN THIS FUND AND COVERAGE IS EFFECTIVE AT 12:01 A.M. ON THIS THE _____ day of _____, 20_____.

By: _____
Fund Administrator

WARNING

Any person or entity who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

REQUIRED INFORMATION

PLEASE BE ADVISED THAT THE FOLLOWING INFORMATION MUST BE PROVIDED IN ORDER FOR THE FUND OFFICE TO CONTINUE WITH THE PROCESSING OF THIS ACCOUNT.

EFFECTIVE DATE: _____ SIC CODE: _____

FEIN NUMBER: _____ UNEMPLOYMENT ID NUMBER: _____

FIRM NAME: _____

P.O. BOX: _____

PHYSICAL ADDRESS: _____

CITY, STATE, ZIP: _____

AREA CODE AND PHONE NUMBER: _____

PERSON(S) TO CONTACT

REGARDING PAYROLL AND PREMIUM: _____

REGARDING CLAIMS: _____

SAFETY ENGINEER: _____

IS A SAFETY PROGRAM IN OPERATION AT THIS TIME? YES ___ NO ___

IF YES, PLEASE DESCRIBE:

DATE BUSINESS STARTED: _____ CURRENT CARRIER: _____

ANNUAL PREMIUM: _____ EXPERIENCE MODIFICATION: _____

INSURANCE AGENCY (IF APPLICABLE): _____

INSURANCE AGENT: _____ PHONE/FAX NUMBER: _____

ADDRESS: _____

AGENCY ASSOCIATION MEMBERSHIP (CHECK ONE): AGC ___ BX ___ HBK ___ KHC ___ KPHC ___

KCS ___ WKC ___

HOW CONTACTED:

REQUIRED INFORMATION (continued)

1) IS THIS ACCOUNT DOING BUSINESS AS ANY OTHER NAMES OR ENTITIES?

YES ___ NO ___ IF YES, PLEASE LIST: _____

2) IF THERE IS MORE THAN ONE ENTITY, ARE THE FINANCIAL RECORDS MAINTAINED SEPARATELY? YES ___ NO ___

3) EXACTLY HOW SHOULD THE POLICY READ? (IS IT DBA OR INC., ETC.)

4) ARE THERE ANY ADDITIONAL LOCATIONS THAT ARE ACTIVE UNDER THIS CURRENT POLICY?

YES ___ NO ___ IF YES, PLEASE LIST: _____

5) ARE THERE ANY ADDITIONAL COMPANIES THAT ARE COVERED UNDER THIS CURRENT POLICY? YES ___ NO ___

IF YES, PLEASE LIST:

6) (IF THIS BUSINESS IS A SOLE PROPRIETORSHIP/PARTNERSHIP/LLC) DO THE OWNER/PARTNER(S) WISH TO BE INCLUDED/EXCLUDED? IF THEY WANT TO BE INCLUDED THEN WE NEED AN ELECTION NOTICE WITH ORIGINAL SIGNATURES.

INCLUDED ___ EXCLUDED ___

7) (IF THIS BUSINESS IS A CORPORATION) DO THE OFFICERS WANT TO BE INCLUDED OR EXCLUDED? IF EXCLUDED WE WILL NEED AN ORIGINAL FORM-4 REJECTION NOTICE.

INCLUDED ___ EXCLUDED ___

8) WHICH ASSOCIATION WILL THE ACCOUNT JOIN OR ARE THEY A MEMBER OF?

- AGC OF KENTUCKY (AGC) ___

- AGC OF WESTERN KENTUCKY (WKC) ___

- BUILDERS EXCHANGE OF KENTUCKY (BX) ___

- HOMEBUILDERS ASSOCIATION OF KENTUCKY (HBK) ___ (Local # ___)

- KENTUCKY ASSOCIATION OF HIGHWAY CONTRACTORS (KHC) ___

- KENTUCKY ASSOCIATION OF PLUMBING, HEATING & COOLING CONTRACTORS (KPHC) ___

- KENTUCKY CRUSHED STONE ASSOCIATION (KCS) ___

9) DO WE HAVE ALL OF THE ORIGINAL FORMS SUCH AS THE:

- KY AGC/SIF APPLICATION ___ (ORIGINAL SIGNATURES REQUIRED)

- STATEMENT OF NET WORTH ___ (ORIGINAL SIGNATURES REQUIRED)

10) WHAT IS THE ESTIMATED NUMBER OF EMPLOYEES? _____

11) WHAT IS THE PROPOSED EFFECTIVE DATE? ASAP? _____

WE MUST HAVE THE CHECK AND THE ABOVE INFORMATION BEFORE WE CAN BIND COVERAGE!!!

> PLEASE SIGN & DATE BELOW <

(AGENT/OWNER)

(COMPANY)

(DATE)