

## APPLICATION FOR MEMBERSHIP IN APARTMENT & BUILDING MANAGERS SELF INSURED WORK COMP FUND

Applicant Name			
Mailing Address (Street No. and Name)			
City, State ZIP Code			
Phone # (    )	Fax # (    )	Federal Tax ID#	Date Coverage Begins:
Description of business:			
Location and names of operations other than the above:			
Michigan Employment Security Commission number:			
Number of employees regularly employed in Michigan:			
Total payroll for all Michigan employees for the past year:			
Above company has been in existence in the state of Michigan since:			

List all names of partners, corporate officers, or directors:

Name	Office/Title
Name	Office/Title
Name	Office/Title
Name	Office/Title

1. Are you a division or subsidiary of a parent corporation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please explain
2. Years under present ownership:			
3. Does your business have locations or job sites outside the state of Michigan?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please explain
4. Do any of the company's employees travel outside the state of Michigan on business of the employer member?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please explain
5. Current workers' compensation carrier:			

**PLEASE NOTE: If you answered yes to question #3, your company may have potential liability that will not be covered by this group self-insurer. You are cautioned to make appropriate arrangements to obtain the necessary insurance to cover those exposures.**

Explanations: (Attach additional sheets if necessary)

# APARTMENT & BUILDING MANAGERS SELF INSURED WORK COMP FUND

**Complete this section if there are any affiliated companies that will be insured under this group.** The signature of the corporate officer of these affiliated companies indicates that the companies named on this form are jointly and severally liable in regard to all of the terms and conditions as described in this application.

Company		
Mailing Address (Street No. and Name)		
City, State ZIP Code		
Phone #	Fax #	Federal Tax ID#
Description of business:		
Location and names of operations other than the above:		
Michigan Employment Security Commission number:		
Number of employees regularly employed in Michigan:		
Total payroll for all Michigan employees for the past year:		
Above company has been in existence in the state of Michigan since:		
<b>SIGNATURE OF CORPORATE OFFICER:</b>		

Company		
Mailing Address (Street No. and Name)		
City, State ZIP Code		
Phone #	Fax #	Federal Tax ID#
Description of business:		
Location and names of operations other than the above:		
Michigan Employment Security Commission number:		
Number of employees regularly employed in Michigan:		
Total payroll for all Michigan employees for the past year:		
Above company has been in existence in the state of Michigan since:		
<b>SIGNATURE OF CORPORATE OFFICER:</b>		

Company		
Mailing Address (Street No. and Name)		
City, State ZIP Code		
Phone #	Fax #	Federal Tax ID#
Description of business:		
Location and names of operations other than the above:		
Michigan Employment Security Commission number:		
Number of employees regularly employed in Michigan:		
Total payroll for all Michigan employees for the past year:		
Above company has been in existence in the state of Michigan since:		
<b>SIGNATURE OF CORPORATE OFFICER:</b>		

**APPLICANT NAME:** \_\_\_\_\_

**WAGE AND LOSS HISTORY DATA SHEET**

Estimated annual payrolls by specific industry code (S.I.C.) classification:

Class Code	Classification	Estimated Annual Payroll

**CLAIMS EXPERIENCE**

Accident experience for twelve months preceding this application:

Number of deaths:
Number of permanent and total disabilities:
Number of cases of specific loss:
Number of injuries causing 7 or more days of disability:

Claims experience over the past five years:

From	To	Gross Payroll	Paid Claims	Reserves	Total Incurred

Losses in excess of \$10,000 over the past five years:

Date	Injury	Total Amount	Open or Closed

# APARTMENT & BUILDING MANAGERS SELF INSURED WORK COMP FUND

STATEMENT OF FINANCIAL CONDITION OF: (APPLICANT) \_\_\_\_\_

Attach annual report, audited financial report, or report prepared for other regulatory agencies

**Financial Statement: (Required by the Michigan Department of Consumer & Industry Services)**

Please provide a copy of your most current balance sheet or have your bookkeeper complete and sign the form below. Information stated below is confidential and will be viewed only by the fund administrator and Bureau.

Current Year: \_\_\_\_\_ 20 \_\_\_\_\_

## STATEMENT OF ASSETS & LIABILITIES

<b>Assets:</b>		
Current Assets		
Cash on Hand in Banks	\$	
Stocks & Bonds		
Notes & Accounts Receivable		
Inventories		
Other Current Assets		
<b>Total Current Assets</b>		
Other Assets		
Properties, Building & Equipment	\$	
Good Will		
Other		
<b>Total Other Assets</b>	\$	
<b>Total Assets</b>		\$
<b>Liabilities:</b>		
Current Liabilities		
Accrued Payroll	\$	
Trade Accounts Payable		
Notes Payable, short-term		
Taxes Payable		
<b>Total Current Liabilities</b>		\$
Other Liabilities		
Notes Payable, long-term	\$	
Mortgages Payable		
Bonds Payable		
<b>Total Other Liabilities</b>	\$	
<b>Total Liabilities</b>		\$
<b>Capital</b>		
Capital Stock	\$	
Paid in Surplus		
Retained Earnings		
<b>Total Capital</b>	\$	
<b>Total Capital &amp; Liabilities</b>		\$
Signature		
Mailing Address (Street No. and Name)		
City, State ZIP Code		Phone # (     )

The Applicant hereby certifies, warrants and represents that the financial statement included herewith and signed by the Applicant and the payroll information provided herein are accurate and true as of the date of this application and that the Applicant will provide \_\_\_\_\_ (name of group) (the "Group") with such other information required to qualify the Applicant with the applicable state authorities or other such persons designated by the Group. The Applicant warrants and represents that the Applicant will report all payroll of any kind, whether paid in cash, by check, or any other method, to the Group periodically, when requested, and agrees to make available all pertinent records at such reasonable times as requested.

We hereby formally apply for workers' disability compensation self-insurer coverage in the Group, to be effective 12:01 a.m. on the effective date given by the Michigan Bureau of Workers' Disability Compensation on the application and Form 650, following acceptance by the board of trustees or their designated representative. With acceptance and approval of the application, the Applicant hereby constitutes and appoints the Group and/or its designated representative to act on the Employer's behalf as agent and/or attorney in fact.

We further agree as follows:

(a) That we will accept and be bound by the provisions of the Michigan Workers' Disability Compensation Act of 1969, as amended.

(b) That, by this reference, the terms, and provision of the Indemnity Agreement and/or Amendments thereto filed or which may hereafter be filed with the Michigan Bureau of Workers' Disability Compensation are hereby adopted, approved, ratified and confirmed by us; and further, we agree to assume all of the obligations set forth therein, including our joint and several liabilities for payment of any lawful awards against any member of the Group; and in the event we fail to pay any premium or lawful assessment within thirty (30) days of the date the same shall become due, we will pay all costs of the collection thereof, including reasonable attorney fees.

(c) That we will abide by the rules and regulations of the Group and will conform to the terms of the agreements the Group may enter into with any authorized service company as long as we remain a member of the Group.

(d) That, in the event of any changes in our corporate structure, or in our legal entity, or if any locations are to be added to or deleted from the coverage, we agree to notify the Group at the office of the \_\_\_\_\_ (name of service company), or at the offices of the Group's Administrator.

(e) That should we desire to cancel our coverage, we will give the Group written notice at least thirty (30) days prior to the cancellation.

(f) That coverage under this membership shall be for Michigan operations only.

(g) That the Wage Declaration Schedule and/or Renewal Certificates, when completed and returned to us by the Group, shall become part of this agreement.

(h) That in consideration for the privilege of being a self-insurer, we hereby agree that we will discharge our liability for compensation to injured employees or their dependents in accordance with the requirements of the Michigan Workers' Disability Compensation Act of 1969, as amended.

(i) That we will promptly furnish to the Bureau of Workers' Disability Compensation all reports which it may lawfully require under the Michigan Workers' Disability Compensation Act of 1969, as amended.

(j) That in case of insolvency we shall make our records available to an agent of the Group.

We affirm all information submitted as being true and understand that the information in this application or otherwise submitted will be the basis for determining eligibility to participate in the Group. We understand and agree that any misrepresentation on this application will permit the Group to cancel our coverage.

We understand that completing this application and/or paying a deposit and/or paying an entire annual premium does not guarantee, nor does it imply, that coverage will be provided on the date requested. Coverage is effective only when and if the application is approved by both the \_\_\_\_\_ (name of Group) and the Michigan Department of Consumer & Industry Services.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Title: (Owner, Partner, or Corporate Officer)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Accepted by:

The above application is hereby approved for membership in APARTMENT ASSOCIATION SELF-INSURED WC FUND \_\_\_\_\_

Signed this \_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_

By: \_\_\_\_\_  
Group Administrator

**GROUP SELF-INSURER**