North Dakota
Workforce Safety
& Insurance
Putting Safety to Work

WSI

APPLICATION FOR INSURANCE

EMPLOYER SERVICES / PHS DIVISION
SFN 5556 (092008)

1600 EAST CENTURY AVENUE, SUITE 1
PO BOX 5585
BISMARCK ND 58506-5585
Telephone 1-800-777-5033
Fax 701-328-3750
TTY (hearing impaired) 1-800-366-6888
Fraud and Safety Hotline 1-800-243-3331
www.WorkforceSafety.com

PLEASE TYPE OR PRINT USING BLACK OR BLUE INK

FOR WSI USE ONLY				
Employer Account Number	*Effective Date of Coverage*	*Expiration Date - Payroll Period*	SIC Code	NAICS

GENERAL INFORMATION

Legal Name of Entity or Individual	Trade Name of Business or DBA (if different from legal name)

Web Site Address	Federal Employer I.D. Number	Unemployment Account Number

First Date employee(s) worked or are expected to work in ND	Date Operations will begin/began in ND

Will you be utilizing the services of a Professional Employer Organization (PEO) or employee leasing company? ☐ Yes ☐ No

If yes, please provide their business name :

Will you be using a Temporary Staffing Agency? ☐ Yes ☐ No

If yes, please provide their business information:

Name	Address

City	State	Zip

Your Mailing Address: (However if you will be utilizing the services of a Professional Employer Organization or employee leasing company, please provide their mailing address here.)

Attention To

Address	Suite/Apt

PO Box	City	State	Zip

Your Business Address: ☐ Same as mailing address above

Address	Suite/Apt #	PO Box

City	County	State	Zip

North Dakota Locations: Enter address of other North Dakota Locations if different from the Mailing Address above. No PO Boxes please. (additional sheets may be attached)

Address	City	State	Zip	Phone

Contact Person:

First Name	Middle Initial	Last Name

Title	Email

Phone	Cell Phone	Fax

APPLICATION FOR INSURANCE

Legal Name of Entity or Individual

Outside Accountant:

First Name	Middle Initial	Last Name

Phone	Email

REASON FOR APPLYING

Please indicate your reason for applying for insurance coverage:

- ☐ New or existing business and are now requesting workers' compensation insurance coverage
- ☐ Change of Entity

CHANGE OF ENTITY

If you have indicated a change of entity, please indicate your change below:

- ☐ Purchase
- ☐ Reorganization
- ☐ Merger
- ☐ Other _____

Complete if applicable.

Date of Acquisition	What percent of the business did you acquire?

Prior Owner's Name(s)	Prior Business Name

Prior Workers' Comp Account Number (if known)	Prior Business Address

TYPE OF ENTITY

Choose the entity type that most closely describes your business:

- ☐ Individual
- ☐ Limited Liability Partnership
- ☐ Corporation
- ☐ Cooperative
- ☐ Association
- ☐ Nonprofit Corporation
- ☐ General Partnership
- ☐ Limited Liability Company
- ☐ Sub-S Corporation
- ☐ Limited Partnership
- ☐ Government

COMPLETE IF YOU ARE AN OUT-OF-STATE CORPORATION OR AN OUT-OF-STATE COOPERATIVE ASSOCIATION

State of Incorporation	Date of Incorporation

TYPE OF BUSINESS

Choose the item that best describes the principal activity of your business (choose only one.):

- ☐ Accommodation and Food Service
- ☐ Administrative and Support and Waste Management and Remediation Services
- ☐ Agriculture, Forestry, Fishing and Hunting
- ☐ Arts, Entertainment, and Recreation
- ☐ Construction
- ☐ Education Services
- ☐ Finance and Insurance
- ☐ Health Care and Social Assistance
- ☐ Information
- ☐ Management of Companies and Enterprises
- ☐ Manufacturing
- ☐ Mining
- ☐ Professional, Scientific, and Technical Services
- ☐ Public Administration
- ☐ Real Estate and Rental and Leasing
- ☐ Retail Trade
- ☐ Transportation
- ☐ Utilities
- ☐ Warehousing
- ☐ Wholesale Trade
- ☐ Other _____

If Business Type is Construction, check all that apply:

- ☐ Road Construction
- ☐ Steel Construction
- ☐ Building Construction
- ☐ Other _____

If Business Type is Transportation, check all that apply:

- ☐ Over The Road Transportation
- ☐ Gravel/Dirt Transportation
- ☐ Grain Transportation
- ☐ Other _____

Are you leased on to another transportation company? ☐ Yes ☐ No

If yes, please indicate leasing company name:

APPLICATION FOR INSURANCE

Legal Name of Entity or Individual

NAME(S) OF OWNERS, PARTNERS, CORPORATE OFFICERS

Name	Title	Address	Home Phone	Soc. Sec. No.	% Owned	Is Coverage Desired?
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

EMPLOYER(S) OPTIONAL COVERAGE: (additional sheets may be attached) **Coverage for the owner, partner or corporate officers of a business corporation is optional.** Check coverage boxes above, if coverage is desired. An employer electing optional coverage will be charged an annual premium based upon the maximum taxable payroll cap. An optional coverage contract will be sent to you. Coverage becomes effective upon WSI's receipt of that completed, signed contract.

EMPLOYER'S SPOUSE AND/OR CHILDREN COVERAGE: You must list the spouse and all children under the age of 22 of the employer(s) who have received or will receive compensation from your business. **COVERAGE FOR SPOUSE AND CHILDREN UNDER AGE 22 IS PROVIDED BY SPECIAL CONTRACT ONLY.** Spouse - Premium calculated on wage cap amount. Children 21 and under for payroll period - Premium based on actual wages. Children 22 and older for payroll period - Actual wages would be reported along with the other employees. **Coverage becomes effective upon WSI's receipt of a completed, signed optional coverage contract.** (additional sheets may be attached)

Name of Family Member	Soc. Sec. No.	Date of Birth	Relationship	Class Code	Actual Wages	Estimated Wages	Is Coverage Desired?
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

EMPLOYEE ACTIVITY AND ESTIMATED 12-MONTH PAYROLL (additional sheets may be attached)

Describe each unique type of work performed within the business (e.g., clerical office, janitorial, traveling personnel, etc.) List the number of employees engaged in that type of work and estimate the payroll which will be expended for each in the next 12 months. If you need assistance, contact Employer Services for more information at (701) 328-3800 or 1-800-777-5033.

Place Where Work Is Performed	Description of Work Performed	Number of Employees (not including owners)	Estimated payroll (include room and board allowance)

EXTRATERRITORIAL COVERAGE

Do you anticipate having any North Dakota based employee(s) that will travel outside ND for work? ☐ Yes ☐ No

Do you intend to cover your ND based employee(s) under your WSI policy while temporarily working outside ND?
☐ Yes ☐ No

If yes, please indicate those state(s) in which your ND based employee(s) will be working.

If no, do you have separate coverage in the state(s) where the employee(s) will be working? ☐ Yes ☐ No

PENALTY FOR FILING FALSE PAYROLL WITH WORKFORCE SAFETY & INSURANCE

North Dakota law provides that any employer who willfully misrepresents to WSI the amount of payroll upon which compensation premium is based is guilty of a Class A misdemeanor. If the premium owing exceeds $500, the employer is guilty of a Class C felony. The employer is also civilly liable to WSI in the amount of THREE (3) times the difference between the premium paid and the amount that should have been paid.

I acknowledge that I have read this Fraud Warning and understand that failing to secure workers' compensation coverage, filing a false payroll report, or willfully misrepresenting the amount of payroll is a criminal offense. I understand that WSI is relying upon the truth of my statements on this application. I CERTIFY THAT I HAVE NOT FILED ANY FALSE PAYROLL INFORMATION, NOR MADE ANY FALSE STATEMENT, NOR KNOW OF ANY FALSE STATEMENT MADE IN CONNECTION WITH THIS APPLICATION.

I declare that the payroll information entered on this report is true, correct, and accurately reflects the identity of owners or officers, and earnings of all covered employees. I have read and understand this Fraud Warning.

Signature of owner/officer	Printed Name	Date

Title	Phone	Email