DIVISION OF WORKERS' COMPENSATION

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

APPLICATION FOR MEMBERSHIP IN THE

_____
(Trust Fund Name)

Name & dba _____

☐ Corporation ☐ Co-Partnership ☐ Individual

Mailing Address _____
(Number) (Street) (City) (State) (ZIP Code)

Location Address _____
(Number) (Street) (City) (State) (ZIP Code)

Nature of business _____ FEIN Number _____

List partners or corporate officers:

_____
(Name) *(Title)*

_____
(Name) *(Title)*

_____
(Name) *(Title)*

_____
(Name) *(Title)*

Insurance Coverage is now carried by: _____

We hereby formally apply for continuing membership for workers' compensation self-insurance coverage in the above-named Trust, to be effective 12:01 A.M. _____, _____, and, if accepted by its duly authorized representative, do hereby constitute and appoint (if applicable, Service Company) _____ _____ to act as Administrators of the Trust and as our agents-in-fact in all matters relating to the Workers' Compensation Law.

We further agree as follows:

(a) To accept and be bound by the provisions of the Missouri Workers' Compensation Act

(b) That, by this reference, the terms and provisions of the Indemnity Agreement and/or Amendments thereto filed or which may hereafter be filed with the Missouri Division of Workers' 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 trust; 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 attorneys' fees

(c) To abide by the rules and regulations of the trustees of the trust and to conform to the terms of the agreements they may enter into with any authorized service company as long as we remain a member of the trust

(d) That, in the event of any changes in corporate structure, or in legal entity, or if any locations are to be added to or deleted from this coverage, we agree to immediately notify (Name of the Trust Fund or Service Company)

_____

(Address) _____.

(e) That should we desire to cancel our coverage, we will give notice in accordance with the terms and conditions established by the trust

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

(g) That the Wage Declaration Schedule and/or Certificates, when completed and returned to us by (Service Company) _____, become a part of this agreement.

_____
(Typed Name of Applicant)

_____
(Title) (Owner, Partner, Corporate Officer)

_____
(Signature of Applicant)

WITNESSES:

(1) _____
(Typed Name)

_____
(Signature)

_____
(Address)

(2) _____
(Typed Name)

_____
(Signature)

_____
(Address)

_____
(Corporate President)

_____
(Date)

The above applicant is a member of _____ and is hereby approved for membership in this trust, and coverage is effective the _____ day of _____, _____.

Signed this _____ day of _____, _____

By: _____
(Fund Administrator or Trustee)

_____

Name of Trust Fund

Effective _____ to _____

Member Name _____

Address _____ City _____ State _____ ZIP _____

Present coverage _____ No. Locations _____ No. Employees _____

Own or operate aircraft? _____ Details _____

Premium Estimate by Class

Code	Classification	Estimated Next Year Payroll	Rate Per $100	Estimated Premium
	TOTALS			

Experience Modification _____

Standard Premium _____

Experience

From	To	Gross Payroll	Total Losses

Losses over $10,000 past 5 years

Date	Injury	Total Amount	Open or Closed