



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? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, please provide their business name :				
Will you be using a Temporary Staffing Agency? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> 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		

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 Merger

Reorganization 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:

<input type="checkbox"/> Individual	<input type="checkbox"/> Cooperative	<input type="checkbox"/> General Partnership	<input type="checkbox"/> Limited Partnership
<input type="checkbox"/> Limited Liability Partnership	<input type="checkbox"/> Association	<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Government
<input type="checkbox"/> Corporation	<input type="checkbox"/> Nonprofit Corporation	<input type="checkbox"/> Sub-S Corporation	

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.):

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

If Business Type is Construction, check all that apply:

<input type="checkbox"/> Road Construction	<input type="checkbox"/> Building Construction
<input type="checkbox"/> Steel Construction	<input type="checkbox"/> Other _____

If Business Type is Transportation, check all that apply:

<input type="checkbox"/> Over The Road Transportation	<input type="checkbox"/> Grain Transportation
<input type="checkbox"/> Gravel/Dirt Transportation	<input type="checkbox"/> Other _____

Are you leased on to another transportation company? Yes No

If yes, please indicate leasing company name:

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?
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> 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?
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> 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	