

<i>For WSI use only</i>				
Employer account number	Effective date of coverage	Expiration date - payroll period	NAICS	
SECTION 1 – General business information				
Legal name of entity or individual		Trade name of business or DBA (if different from legal name)		
Website address	Federal Tax ID	Unemployment account number		
First date employee(s) worked or are expected to work in ND		Date operations will begin/began in ND		
Attention				
Business mailing address (street address)		Suite/apartment	PO Box	
City	State	ZIP code		
Physical business address, if different than mailing address		Suite/apartment		
City	State	ZIP code		
Contact information				
Contact (first name)		(Last name)		
Title	Email address			
Telephone number	Cell phone number	Fax number		
North Dakota locations - Provide address of other ND locations if different from the mailing address above. No PO boxes please. (additional sheets may be attached)				
Address	City	State	ZIP code	Telephone number
SECTION 2 – Third party information				
Accountant (first name)		(Last name)		
Telephone number	Email address			
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 information				
Name		Address		
City	State	ZIP code		
SECTION 3 – Reason for applying				
Please indicate reason for applying for insurance coverage				
<input type="checkbox"/> New or existing business now requesting workers' compensation insurance coverage				
<input type="checkbox"/> Change of entity				

Form continued on next page. Please submit all pages to WSI.

Legal name of entity or individual

SECTION 4 – 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 business name	Prior business address	
City	State	ZIP code
Prior owner's name(s)	Prior workers' compensation account number (if known)	

SECTION 5 – Type of entity

Choose the entity type that most closely describes your business

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

Complete if entity is an out-of-state corporation or an out-of-state cooperative

State of incorporation	Date of incorporation
------------------------	-----------------------

SECTION 6 – Parent company – complete following section if entity has a parent company. If not, skip to section 7.

Federal Tax ID	Business name		
Business address	City	State	ZIP code
Contact person	Contact telephone number	Effective date	Expiration date

Legal name of officer(s) of parent company

Name	Title	Home address, city, state, ZIP code	Home telephone number	Social Security number	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

SECTION 7 – Legal name of owners, partners, corporate officers

Name	Title	Home address, city, state, ZIP code	Home telephone number	Social Security number	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

Form continued on next page. Please submit all pages to WSI.

Legal name of entity or individual

Employer's spouse and/or children coverage

- You must list the employer's spouse and all of the employer's children under the age of 22 who have received or will receive compensation from your business. (Additional sheets may be attached)
- Coverage for the spouse and children under age 22 is provided by special contract only.
- Spouse – the premium is calculated on the wage cap amount.
- Children under the age of 22 for payroll period – the premium is based on actual wages.
- Children 22 and older for payroll period – wages should be reported along with the other employees.
- Coverage becomes effective upon WSI's receipt of a completed, signed elective coverage contract.

Name of family member	Social Security number	Date of birth	Relationship	Class code	Estimated wages	Is coverage desired?
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 8 – 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 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)

SECTION 9 – Temporary and incidental coverage

Extraterritorial coverage – as a general rule, extraterritorial coverage extends to incidental operations lasting fewer than 30 days in a state where the employer has no other significant contacts with that state and those operations do not require the employer to purchase workers' compensation insurance under the laws of that state.

Reciprocal coverage – WSI currently has reciprocal agreements with seven states: Idaho, Montana, Oregon, South Dakota, Utah, Washington, and Wyoming. These reciprocal agreements allow your ND employees to work in those states on a temporary basis without purchasing workers' compensation coverage in that jurisdiction. The reciprocal agreements for each state vary and may include exclusions. These agreements must be requested by the employer and be approved before becoming effective.

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, indicate the state(s) 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

SECTION 10 – Fraud warning

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 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 declare that all information entered on this report is true, correct, and accurate.

Signature of owner/officer	Printed name	Date
Title	Telephone number	Email address

SECTION 11 – Additional information or comments