WSI
North Dakota Workforce Safety & Insurance

APPLICATION FOR INSURANCE

EMPLOYER SERVICES / PHS DIVISION
SFN 5556 (04/2018)

1600 E Century Ave, Ste 1
PO Box 5585
Bismarck ND 58506-5585
Telephone 800-777-5033
Fax 701-328-3750
TTY (hearing impaired) 800-366-6888
Fraud and Safety Hotline 800-243-3331
www.workforcesafety.com

For WSI use only			
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)	PO Box	
City	State	ZIP code
Physical business address, if different than mailing address		
City	State	ZIP code

Contact information

Contact (First name)	(Last name)	
Title	Email address	
Telephone number	Other telephone 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? ☐ Yes ☐ No

If yes, please provide their business and contact information

Name	Address	
City	State	ZIP code
PEO contact name	Contact email address	

Legal name of entity or individual

Contact telephone number	Client ID

SECTION 3 – *Reason for applying*

Please indicate reason for applying for insurance coverage

☐ New or existing business now requesting workers' compensation insurance coverage
☐ Change of entity
☐ Volunteer/Vocational/Inmate coverage

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 ☐ Other
☐ Tribal ☐ Township ☐ Professional Corporation

Complete if out-of-state entity

State of incorporation	Date of incorporation

SECTION 6 – *Parent company – compete 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	Email address	Home address, city, state, ZIP code	Home telephone number	Social Security number*	Effective date	Is coverage desired
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

If coverage is desired describe work to be performed

Legal name of entity or individual

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

Name	Title	Email address	Home address, city, state, ZIP code	Home telephone number	Social Security number*	Effective date	Is coverage desired
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

If coverage is desired describe work to be performed

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	Date became a family member	Is coverage desired?
							☐ Yes ☐ No
							☐ Yes ☐ No

If coverage is desired describe work to be performed

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.

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

Legal name of entity or individual

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
Name of individual completing this form	Telephone number	Email address

SECTION 11 – *Additional information or comments*

* In compliance with the Federal Privacy Act of 1974, disclosure of the Social Security number on this form is mandatory pursuant to N.D.C.C. § 65-05-02. The Social Security number is used for identification and verification purposes. Failure to provide this information may result in a delay in processing your request.