

**KANSAS INSURANCE DEPARTMENT**

**INDIVIDUAL APPLICATION FOR MEMBERSHIP  
IN A GROUP FUNDED WORKERS' COMPENSATION POOL**

GENERAL INFORMATION

(Please type all information)

- 1. Member's Name \_\_\_\_\_
- 2. Address (City, State, Zip Code and Phone Number)  
\_\_\_\_\_
- 3. \_\_\_\_\_
- 4. FEIN \_\_\_\_\_
- 5. Type: Individual, Limited Partnership, Co-Partnership, Corporation  
\_\_\_\_\_
- 6. Name of Business \_\_\_\_\_  
Type of Business \_\_\_\_\_

List of Principals

- | 7. NAME | ADDRESS (City, State, Zip Code) | Title |
|---------|---------------------------------|-------|
| _____   | _____                           | _____ |
| _____   | _____                           | _____ |
| _____   | _____                           | _____ |
| _____   | _____                           | _____ |
| _____   | _____                           | _____ |

- 8. Chartered under the laws of the State of \_\_\_\_\_ Date \_\_\_\_\_
- 9. Date of commencement of business in Kansas \_\_\_\_\_
- 10. Date of registration in the office of Secretary of State, in a foreign corporation \_\_\_\_\_
- 11. List affiliates or subsidiaries and divisions to be included in the group funded workers' compensation pool. (Shown below or attach list)

NAME	BUSINESS ADDRESS (City, State, Zip Code)	TYPE OF BUSINESS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

12. If applicant is a subsidiary, name parent company

NAME	ADDRESS (City, State, Zip Code)	TITLE

13. Loss history for last three completed years

	Year Ending:	Year Ending:	Year Ending:
A. Number of accidents requiring Medical attention only			
B. Number of accidents requiring lost time of more than 7 days			
C. Total paid claims	\$ _____	\$ _____	\$ _____
D. Outstanding reserves	\$ _____	\$ _____	\$ _____
E. Total incurred losses (Paid and Reserves)	\$ _____	\$ _____	\$ _____
F. Fatalities in that last 3 years	No _____	Yes _____	Number _____

If Yes, explain:

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14. Self-Insured Locations (Shown below or attach list)

List of Names and Locations of Each Operation to be Covered Under Self-Insurance Program in Kansas	Nature of Operations According to Industry Pursued or Products Manufactured	Average Number of Employees	
		Production	Office/Sales



17. What medical facilities are available to your employees?

A. First Aid\_\_\_\_ Local Clinic\_\_\_\_ In Plant Staff\_\_\_\_ Hospital\_\_\_\_

B. Do you employ a full time doctor/nurse? Yes\_\_\_\_ No\_\_\_\_

C. Explain:

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18. Financial Status (Use Attached Form)

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IMPORTANT: Your most current certified financial statement must be attached.

**AFFIDAVIT**

COUNTY \_\_\_\_\_

STATE \_\_\_\_\_

I, \_\_\_\_\_, the undersigned, being the  
\_\_\_\_\_ of the \_\_\_\_\_  
(Title) (Name of Applicant)

\_\_\_\_\_, swear (or affirm) that to the best of my knowledge and belief, the  
statements contained in the application, including any accompanying documents, are true and complete.

BY: \_\_\_\_\_

Sworn before me this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_

\_\_\_\_\_  
(Notary Public)

My commission expires \_\_\_\_\_

**IMPORTANT:**  
**ALL MEMBERS AND POTENTIAL MEMBERS**  
**PLEASE READ CAREFULLY.**

The Applicant or Member Hereby Acknowledges That:

1. The "Pool" is a self-insured Workers' Compensation pool established pursuant to K.S.A. 44-581.
2. The pool is not an insurance company, and is not governed by the same regulations and is not subject to the same supervision by the Kansas Insurance Department as an insurance company would be.
3. The pool is not a member of, and its member are not eligible for any benefits from the Kansas Insurance Guaranty Association.
4. The member will be JOINTLY AND SEVERALLY LIABLE with every other employer who is a member of the pool for any unpaid claims and liabilities of the pool if the pool becomes insolvent.
5. The pool covers only Kansas Operations, including incidental coverage in other states.
6. The member will comply with all provisions of K.S.A. 44-581, et. seq., the Kansas Workers' compensation law, all rules and regulations of the pool, and all lawful orders of the Commissioner of Insurance.
7. That the member will promptly pay all premiums, taxes and assessments due as a member of the pool.
8. That the member will give to the pool notice prior to withdrawal from the pool, as required by the pool bylaws.
9. That the member will neither ask for nor receive credit from the trustees for payment of premium.

This is to certify that the above conditions have been explained to me, and I understand and acknowledge them.

APPLICANT

\_\_\_\_\_  
NAME

BY: \_\_\_\_\_  
(Corporate Officer, Partner, Owner)

TITLE: \_\_\_\_\_

DATE: \_\_\_\_\_