

RISK MANAGEMENT SERVICES

a division of Christian Brothers Services

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WORKERS' COMPENSATION APPLICATION

Entity Name _____

Address _____ City _____ State _____ Zip _____

Contact Person _____ Phone _____ Fax _____

E-mail _____ Federal Employers ID _____

Unemployment ID # _____ Department of Labor # _____

Description of Operations

Please complete the following sections, checking all applicable boxes.

Educational Institutions

Community Services

<input type="checkbox"/> ALTERNATIVE SCHOOL # of Students _____ <input type="checkbox"/> SPECIAL EDUCATION SCHOOL # of Students _____ <input type="checkbox"/> DAY CARE # of Students _____ <input type="checkbox"/> PRE-SCHOOL # of Students _____ <input type="checkbox"/> ELEMENTARY SCHOOL # of Students _____ <input type="checkbox"/> JUNIOR HIGH SCHOOL # of Students _____ <input type="checkbox"/> HIGH SCHOOL # of Students _____ <input type="checkbox"/> UNIVERSITY/COLLEGE # of Students _____ <input type="checkbox"/> NOVITIATE/SEMINARY # of Students _____ <input type="checkbox"/> OTHER _____ # of Students _____	<input type="checkbox"/> CHURCH <input type="checkbox"/> FOOD PANTRY/SOUP KITCHEN <input type="checkbox"/> THRIFT/SECOND-HAND STORE <input type="checkbox"/> Clothing <input type="checkbox"/> Furniture <input type="checkbox"/> Appliances <input type="checkbox"/> GIFT SHOP <input type="checkbox"/> RETREAT HOUSE/CENTER <input type="checkbox"/> Religious Retreatants <input type="checkbox"/> Lay Retreatants <input type="checkbox"/> SOCIAL CENTER <input type="checkbox"/> CAMP <input type="checkbox"/> Day Camp <input type="checkbox"/> Overnight Camp <input type="checkbox"/> OTHER _____
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Health & Psychological Services

Homes for the Religious - Private

<input type="checkbox"/> COUNSELING/MENTAL HEALTH CENTER Approx. # of Annual Visits _____ <input type="checkbox"/> MEDICAL CLINIC Approx. # of Annual Visits _____ <input type="checkbox"/> DENTAL CLINIC Approx. # of Annual Visits _____ <input type="checkbox"/> OTHER _____ Approx. # of Annual Visits _____	<input type="checkbox"/> CONVENT # of Residents _____ <input type="checkbox"/> MONASTERY # of Residents _____ <input type="checkbox"/> NURSING RETIREMENT HOME # of Residents _____ <input type="checkbox"/> INFIRMARY # of Residents _____ <input type="checkbox"/> OTHER _____ # of Residents _____
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ANTICIPATED CHANGES IN OPERATIONS

Describe any changes in the nature of your business which may occur during the year, including any new construction which may take place.

GENERAL INFORMATION

- A. Number of paid/salaried employees: Lay _____ Religious _____
- B. Number of lay volunteers: _____ Total estimate volunteer hours annually: _____
- C. Number of non-paid/non-stipend Religious employees: _____
- D. Number of paid Religious employees: _____

The Risk Pooling Trust has a volunteer endorsement on the Workers' Compensation policy that extends to both religious and lay volunteer individuals. Your organization can elect to provide Workers' Compensation coverage for religious and/or lay volunteer individuals. **Wisconsin is excluded** from the endorsement and Workers' Compensation coverage cannot be provided to lay volunteer or religious individuals.

- * **If you should elect to provide Workers' Compensation coverage which may include full payment of all medical expenses, rehabilitation, and compensation for wages lost from their regular employment for your lay volunteers and/or religious individuals, you will be required to assess a salary at time of audit.**
- * **If you should elect not to provide Workers' Compensation coverage for your lay volunteers, the Medical Payments portion of the Liability coverage, if provided by the Risk Pooling Trust, may pay for medical bills caused by injuries sustained in the volunteer's services of the Beneficiary which are not covered by the volunteer's Health carrier(s) up to a limit of \$15,000, and that this coverage will not compensate the volunteer for wages lost from their regular employment.**
- * **Liability coverage and/or Health Benefits Coverage may exclude and/or deny payment of medical expenses when the injury/illness is the result of a religious member or volunteer working and/or performing services on behalf of your organization.**

- E. Do you employ anyone under the age of 16? Yes No
- F. Do you employ anyone over the age of 60? Yes No
- G. Do you require pre-employment physicals? Yes No
- H. Do you have a Safety Program in operation? Yes No
- I. Are certificates of insurance required from sub-contractors?..... Yes No

J. Do you own, operate, or lease any air/watercraft? Yes No

K. Do your employees travel out of state on business? Yes No

L. Do your employees travel out of the country on business? Yes No

* If the answer is **YES** to J or K, please attach an explanation of the:

(A) States/countries involved

(B) Number of employees who travel

(C) Length of time spent in other states/countries.

SALARY INFORMATION

Payroll State	Job Code Classification	# of Employees	Brief Description of Duties	Annual Gross Salaries

1. Please provide us with your organization’s current **Experience Modification Factor:** _____

2. It is a requirement that we obtain your organization’s Workers’ Compensation Loss experience for **no less than 3 years** from your current/prior carrier(s).

Your loss experience is (please check one):

- Attached.
- Requested from carriers and will be forthcoming.
- We have not carried Workers’ Compensation coverage for the past three to five years.
- This is a new business/operation and the first request for Workers’ Compensation coverage.

Signed _____ Date _____

Title _____