NON-BINDING WORKERS COMPENSATION APPLICATION

Phone: (989) 695-5770 Fax (989) 625-1326 www.fsgeneral.com

Restaurant / Tavern Workers comp rate $2.50! Can be endorsed to the package with NO money down!

Date	Effective Date	☐ Direct Bill	☐ EFT

☐ Ownership ☐ Sole Proprietor ☐ Corporation ☐ Partnership ☐ LLC

Applicant				Agency	
DBA				Agent Name	
Address				Telephone	Fax
City	State	Zip	Inspection Contact		Telephone
Describe The Type Of Business				Federal Emp. ID#	
Location: Street, City, County, State, Zip Code					

Rating Information

Class Code	Categories, Duties, Classifications	Employees Full	Employees Part	Estimated Annual Renumeration

If Coverage Is Desired, All Payrolls Not Excluded, Must Be Included In Rating Information Section Of Application.

Individuals Included/Excluded

Name	Duties	Title	% Owner	Include	Exclude
				☐	☐
				☐	☐
				☐	☐

Employers Liability Limit 500/500/500 On All Policies

Previous Carrier	Premium $
Losses in the past three years? Yes ☐ No ☐	Please Attach Loss Runs.

General Agent's Signature _____ DATE _____

WORKERS' COMPENSATION REJECTION FORM – MICHIGAN

Individual or Partners and Corporations

Insured _____

INDIVIDUALS OR PARTNERS

I (We), the undersigned, as partners, spouse, child or parent in the employer's family do not desire coverage under the Michigan Workers' Compensation Act.

As of the date of execution of this notice, the undersigned has not suffered any injury or disability that has been unreported to his employer and Insurance Company in the course of his employment that would compensate under the Michigan Workers' Disability Compensation Act.

I (We), the undersigned, agree to hold Badger Mutual Insurance Company harmless from and against all loss and expense because of injury or death sustained in my (our) employment.

Dated this day of , , to be effective , .

_____

(Name and Title) **Signature**

_____

(Name and Title) **Signature**

CORPORATION

I (We), and employee(s), officer(s), stockholder(s) of a corporation which has not more than 10 stockholders and each individually own at least 10% of the stock of the corporation, with the consent of the corporation, as approved by the corporation board of directors do elect to be excluded from the coverage afforded by the Michigan Workers' Disability Compensation Act.

As of the date of execution of this notice, the undersigned has not suffered any injury or disability that has been unreported to his employer and Insurance Company in the course of his employment that would compensate under the Michigan Workers' Disability Compensation Act.

I (We), the undersigned, agree to hold Badger Mutual Insurance Company harmless from and against all loss and expense because of injury or death sustained in my (our) employment.

Dated this day of , , to be effective , .

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(Name and Title) **Signature**

_____

(Name and Title) **Signature**