CAMComp

safety pays!

Construction Association of Michigan
Workers' Compensation Plan
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APPLICATION FOR PARTICIPATION IN THE
CONSTRUCTION ASSOCIATION OF MICHIGAN WORKERS' COMPENSATION PLAN (CAM-COMP)

Name ____
Corporation ( ) Limited Liability Co. ( ) Co-Partnership ( ) Individual ( )

Address ____
Number Street City County State Zip

Nature of business ____

Federal ID # ________________________

List all names of partners, corporate officers or directors:

(Name)	(Title)	(% of Ownership)
(Name)	(Title)	(% of Ownership)
(Name)	(Title)	(% of Ownership)
(Name)	(Title)	(% of Ownership)

Is this applicant an employee leasing company? __Yes __No
If yes, list all entities where employees are placed, the names of the entities and their % of ownership. These entities must participate in the group.

(Entity)	(Name of Owner)	(% of Ownership)
(Entity)	(Name of Owner)	(% of Ownership)
(Entity)	(Name of Owner)	(% of Ownership)
(Entity)	(Name of Owner)	(% of Ownership)

Application is hereby made for continuing participation for workers' disability compensation self-insurance coverage in the CAM-COMP Plan. We acknowledge coverage will be effective 12:01 A.M. on the date inserted on the reverse of this contract after endorsed and accepted by its duly authorized representative, the State of Michigan, and excess carrier. We do hereby constitute and appoint CAM-COMP or its designated representative as our agents-in-fact in all matters relating to the Michigan law and/or Employers Liability coverage. We further agree as follows:

(a) To accept and be bound by the provisions of the Michigan Workers' Disability Compensation Act and the rules and regulations of the bureau.

(b) That, upon acceptance as a participant the terms and provisions of the Indemnity Agreement, CAM-COMP Bylaws, the Memorandum of Coverage, Operating Procedures and/or Workers' Disability Compensation Act are hereby adopted, approved, ratified and confirmed by us, and further, we agree to assume all of the obligations set forth therein, including our joint and several liabilities for payment of any lawful awards against any participant in the Plan; and in the event we fail to pay any premium or lawful assessment within fifteen (15) days of the date the same shall become due we will pay all costs of the collection thereof, including actual attorney's fee.

(c) To abide by the Bylaws, rules and regulations of the Trustees of the Plan and to conform to the terms of the agreements they enter into with any representative or other such agents as long as we remain a participant in the Plan.

(d) That, in the event of any change of corporate structure, or in legal entity, or if any locations are to be added to or deleted from this coverage, we agreed to notify CAM-COMP, or the designated representative, in writing immediately of the change.

(e) That the Plan shall pay all awards, including awards made by the Michigan Bureau of Workers' Disability Compensation in accordance with the laws of the State of Michigan plus all related expenses.

(f) That we will remain participants in said Plan for each succeeding year unless our self-insurers certificate and/or Plan Participation is canceled or terminated by the Michigan Bureau of Workers' Disability Compensation or the Trustees of the Plan, or we have resigned, withdrawn from or been terminated by the Plan.

(g) That should we desire to cancel our coverage, we will give written notice at least 30 days prior to cancellation and that the Plan will give written notice at least 20 days prior to cancellation should they desire to cancel our coverage.

(h) That coverage under the Plan shall be for Michigan operations only.

(i) That the Wage Declaration Schedule, successive wage disclosures and/or Renewal Certificates, when completed and returned to us by CAM-COMP, their designated representative or agent shall become a part of this agreement.

(j) "That sales or insurance agents" through which a participant's application is received are not agents of the Plan for purposes of this Application Form. The term "agent" when used herein is intended to exclude such sales agents or insurance brokers who are solely permitted solicitors for Plan Membership.

The Application hereby certifies that the Member, Owner, Partner or Corporate Officer signing below for applicant is authorized to enter into this transaction, the signatory has personal knowledge of the finances of the Applicant, the financial statement attached hereto and signed by Applicant is accurate and true as of the date of this Application to the best of Applicant's knowledge and belief, and that Applicant will provide Construction Association of Michigan Workers' Compensation Plan with such other information required to qualify Applicant with the applicable State authorities. Applicant warrants and represents it will report all payroll of any kind whether paid in cash, check or any other method to CAM-COMP and/or to the designated representative or agent of the Plan periodically when requested and agreed to make available all pertinent records at such reasonable times as requested.

Our classification, code numbers and payrolls are as follows:

Classification	Manual Code	Estimated Payroll	Rate Per $100 Payroll	Estimated Annual Premium
				*

Manual Premium ____________________________

Experience Modification Effective ____________________________

Standard Premium ____________________________

Our Prior Loss and Payroll Experience is as follows:

Policy Year from-to	Payroll	Paid Indemnity	Medical	Reserved Indemnity/Medical	Total Incurred Losses
					*

______________________________ (Type-Name of Applicant)

______________________________ (Title) Member, Owner, Partner, Corporate Officer

______________________________ (Signature of Applicant)

WITNESSES:

(1) ______________________________
(Type Name)

____
(Signature)

____
(Address & Phone)

(2) ______________________________
(Type Name)

____
(Signature)

____
(Address & Phone)

The above applicant is a member of the Construction Association of Michigan Workers' Compensation Plan and is hereby approved for participation in this Plan, and coverage is effective the ____day of ________________, ______

Signed this ____day of ________________, ______

By: ______________________________
(Plan Administrator or Trustee)

* add additional pages as necessary