



FARMERS INSURANCE POOL
 3357 39th St SW, Suite 1
 Fargo, North Dakota 58104
 Ph. 701-271-9183 • Toll Free 888-217-5100
 Fax 701-356-0010
 www.farmersinsurancepool.com

WORKERS' COMPENSATION INSURANCE DAIRY APPLICATION

Applicant (Legal Entity that pays the payroll): _____

Contact Person: _____ Telephone # _____

Mailing Address: _____ Cell # _____

_____ Fax # _____

Farm Address (if different from Mailing Address): _____

E-mail Address: _____

Entity Type: Individual Partnership Corporation Other _____

Federal Employer ID # _____ **(Required)**

Unemployment ID # (If applicable) _____ -OR- Are you Exempt? _____

List Ownership and Percentage of Ownership Below:

Corporations: List owners with 5% or more of voting stock and number of shares owned.

Partnerships: List each General Partner and their share in the profits.

Other: If no voting stock, list members of the Board of Directors or comparable governing body.

Requested Effective Date* of Policy: _____/_____/_____

**Coverage not bound until approved by Insurance Company* Month / Day / Year

Normal Anniversary Rating Date (the policy effective date from your current policy): _____

If application is approved, please circle your preferences below:

1. Premium Payment Schedule (circle one): Monthly • Quarterly • Semi-Annual • Annual

2. Payment Option (circle one): Check-Off of Premium through Dairy Cooperative • Direct Bill

ESTIMATE OF PAYROLL BY CLASSIFICATION

(Please provide your best estimate for payroll)

<u>Classification</u>	<u>Code</u>	<u>Estimated Payroll - From the Effective Date above to Dec 31st</u>
General Farm Labor.	0006	\$ _____
Machine Shop	3632	\$ _____
Clerical (NOC).	8810	\$ _____
Other: _____ .. _____		\$ _____

The Limits of the Employer's Liability Insurance are:

\$1,000,000 each accident / \$1,000,000 by disease policy limit / \$1,000,000 by disease each employee

*Don't Forget to **Answer** the Questions and **Sign** the Application on the Back*

<p>RETURN THE FOLLOWING WITH THIS APPLICATION:</p> <p><input type="checkbox"/> 5-Year Loss History (See attached letter)</p> <p><input type="checkbox"/> Election of Coverage Form</p> <p><input type="checkbox"/> Contract Authorization Form</p>

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Briefly describe your farm operation:

Grain: Yes No Crops Grown: _____

- Do you sell any hay, corn, soybeans, or other crops? _____
- If “Yes”, what percentage of your revenue does this include? _____ %
- Of the crops grown, what percentage is used by the Dairy Operation? _____ %

Dairy Information:

A. <u>Livestock</u>	<u>Number</u>	B. <u>Milking Parlor</u>	<u># of Stalls</u>	C. <u>Type of Barn</u>	<u># of Stalls</u>
Milking Cows	_____	Herringbone	_____	Free Stall	_____
Heifers	_____	Parallel	_____	Tie Stall	_____
Dry Cows	_____	Stanchion	_____	Loafing	_____
Steers	_____				

- How many times do you milk each day? _____
- Number of farm sites? _____ Distance between sites? _____
- Do you switch any cows? (Tie Stall) _____
- Do you have a manure pit or slurry store? _____
Do you perform work on the pumps / pump your own pit? _____
- TMR mixer (either stationary or wagon)? _____
- Please check all that apply:
Silage Bunkers Commodity Sheds Upright Silos On-site Grain Storage
- Have you recently expanded your operation? _____ If “Yes”, please explain:

- Do you have a dedicated person who handles safety & compliance? _____
- I market my milk through: _____
- Who services your farm equipment? _____
- Who performs maintenance on your milking equipment? _____

Type of Labor for your Operation:

<u>Employees</u>	<u># of Employees</u>	<u>Type of Labor Performed</u>
Full Time	_____	_____
Part Time	_____	_____
Seasonal.	_____	_____
Family	_____	_____

Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and (NY: substantial) civil penalties. (Not applicable in CO, HI, NE, OH, OK, OR, TN OR VT; IN DC, LA, ME and VA. Insurance benefits may also be denied).

Signature of Applicant _____ **Date:** _____



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TO: New Applicant for Workers' Compensation Insurance

FROM: Brenda Lang, CEO

RE: Statement of Prior Workers' Comp Coverage

PLEASE INCLUDE ONE OF THE FOLLOWING WITH YOUR APPLICATION AS IT APPLIES TO YOU:

- **If you have carried** workers' comp insurance coverage before, please contact your agent and request a 5-year loss history. Please provide this history with your application to the Farmers Insurance Pool.
- **If you have NOT carried** workers' comp insurance before, then include a separate sheet of paper that states the following;

"Due to the fact that I have never had workers' compensation insurance coverage in the past, I do not have a loss history to provide."

Please sign this statement and return with the application forms.

Thank you!

WORKERS' COMPENSATION ELECTION OF COVERAGE

Minnesota Workers' Compensation law (Minn. § Stat. 176.041) exempts coverage for the following employed persons and their spouses, parents or children (regardless of age or wage rate):

1. An individual owner of a business (a Sole Proprietorship).
2. Partners of a Partnership.
3. Executive officers of a Family Farm Corporation.
4. Managers of Limited Liability Companies in which the LLC has:
 - 10 or fewer members (i.e., owners)
 - Less than 22,880 hours of payroll in the previous calendar year,
 - If both are applicable, only managers who own at least 25% membership interest are excluded and must elect to be included.

I N C L U D E	E X C L U D E	<ul style="list-style-type: none"> List the name(s) of: the Sole Proprietor, All Partners, All Executive Officers, or Managers of LLC. Indicate by checking the appropriate box whether each person is to remain excluded for coverage or whether coverage is desired. 	Title

SIGNATURE _____ **TITLE** _____ **DATE** _____

I N C L U D E	E X C L U D E	<ul style="list-style-type: none"> List the name(s) of: spouse, parents or children of those people listed in the section above. Indicate by checking the appropriate box whether each person is to remain excluded for coverage or whether coverage is desired. 	Relationship

SIGNATURE _____ **TITLE** _____ **DATE** _____

Named Insured: _____

Policy Number: _____



Return Original to:
 Farmers Insurance Pool • 3357 39th St SW, Ste 1 • Fargo, ND 58104
 Toll Free at (888) 217-5100 or 271-9183

ELECTION OF COVERAGE

Understanding Who Is Covered and Who is Not Covered on a Workers' Compensation Insurance Policy

When electing coverage for an Owner/Partner/Officer or Family Member there are *minimum* payroll amounts that must be met to calculate premiums.

Policy Year	Sole Prop/Partner/Officer Minimum Payroll	Family Member Minimum Payroll
2010	\$19,760/yr -or- \$380/week	\$13,260/yr -or- \$255/week
2011	\$22,360/yr -or- \$430/week	\$13,676/yr -or- \$263/week

To calculate premium, divide payroll by 100 then multiply by class code rate.
For further information about the minimum payroll amounts, please contact the Pool.

Sole Proprietorship

If your entity is a "Sole Proprietorship", the following people are EXCLUDED from Workers' Comp Coverage unless you choose to endorse any of these people onto the policy:

- The Policy Owner
- Owner's Spouse
- Owner's Parents
- Owner's Immediate Children (regardless of age and including stepchildren)

Partnership

If your entity is a "Partnership", the following people are EXCLUDED from Workers' Comp Coverage unless the partners choose to endorse any of these people onto the policy:

- The Partners
- Partners' Spouses
- Partners' Parents
- Partners' Immediate Children (regardless of age and including stepchildren)

Family Farm Corporation

The following people are EXCLUDED from Workers' Comp Coverage in a Family Farm Corporation unless the Corporation chooses to endorse any of these people onto the policy:

- Any Executive Officer: (Pres, VP, Secretary, Treasurer, CEO, CFO, etc.)
- Officers' Spouses
- Officers' Parents
- Officers' Immediate Children (regardless of age and including stepchildren)





Patron Number

Date for Notice of Assignment

ASSIGNMENT OF PRODUCER INCOME

I, _____, of _____,

a Producer and Patron of the _____,
(Name of Cooperative)

of _____ do hereby transfer and assign to:
(City and State)

the **Farmers Insurance Pool of 3357 39th St S, Ste 1; Fargo, North Dakota 58104**, the Sum of:

\$ _____ on a _____ basis
(Choose one: Monthly, Quarterly, Semi-Annual, or Annual)

beginning _____, 20____ and continuing until revoked in writing, out
of amount due and payable for products marketed by or through said cooperative.

It is hereby agreed that amounts due and payable by said cooperative shall mean and include only
net proceeds in excess of the following:

- (a.) All assignments, transfers, liens or encumbrances with respect to the proceeds which have legal priority over this assignment.
- (b.) All setoffs or claims of said cooperative against the patron whether arising or maturing prior to, or after the effective date hereof.
- (c.) A reasonable service charge which said cooperative reserves the right to charge for processing this assignment.
- (d.) Patronage credits allocated or paid by said cooperative to the patron prior to or after the effective date hereof.

(Date)

(Patron Signature)

ACCEPTANCE

_____ hereby acknowledges receipt of the above
(Name of Cooperative)

Assignment and consents to the same in accordance with the provisions set forth above.

(Date)

(Cooperative Manager)



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ENTRANCE/EXIT CRITERIA

WORKERS' COMPENSATION INSURANCE

ENTRANCE CRITERIA

New members will be subject to the following Entrance Criteria:

- ▶ Is a Minnesota Grain/Row Crop Operation or Dairy Producer
- ▶ Over 50% of Gross Payroll in Classification Codes:
 - 0006 - General Farm; or
 - 0008 - Hand Cultivation; or
 - 3732 - Machine Shop
- ▶ Loss Ratio less than 50%
- ▶ No more than one loss in the three-year period over \$5,000

Notwithstanding the above criteria, all potential applicants must meet the membership guidelines of the Farmers Insurance Pool's by-laws.

Any classification or new operation, other than those currently in the program, will not be added without prior consent of the Farmers Insurance Pool and Insurance Company.

AUDIT CRITERIA

Any member of the Pool who has a loss ratio of 60% or greater, based upon a five year average, and one loss over \$5,000, may have a loss control survey completed during the next growing season. The findings of this review will be reported to the Board of Directors as to their annual findings with reference to which members of the Pool, if any, are subject to these audit provisions. A written report shall be provided confirming that these loss control surveys have been completed for each Pool member in question, and which are subject to these audit criteria on an annual basis.

These audit criteria shall not limit and/or eliminate the responsibilities of the insurer with reference to the targeting of loss control dollars or other obligations that they may have to the Pool as a result of other agreements. Failure to provide a loss survey pursuant to this audit procedure shall not limit the Pool's ability to enforce the Exit Criteria as set forth herein.

EXIT CRITERIA

Each spring, the Pool will request and analyze loss information on all members. Individual loss ratios will be compiled on all members for where a member's losses exceed \$5,000 during the past year. Loss Ratio is defined as Total Incurred Losses divided by the Total Paid Premium.

(continued on reverse)

EXIT CRITERIA CONTINUED:

Criteria for Exit from the Pool is as follows:

- Loss ratio greater than 60% within the last five years; AND
- More than two losses over \$7,500.

There will be a two-year waiting period before re-application can be made to the Pool.

AUTHORITY OF INSURANCE COMPANY

The above referenced criteria are those established by the Board of Directors of the Farmers Insurance Pool. It is recognized that the Insurance Company has the authority to refuse to provide coverage as part of the Pool to any individual member independent of the above referenced Entrance and or Exit Criteria.

AUDIT REQUIREMENTS

By February 1st, the insured will be required to submit a year-end Audit Report that will be mailed by the end of December. This form will require that copies of tax form 943 or 941(s) accompany it. Without the Audit Report and copies of tax form(s), the insured may be subject to a Physical Audit; and will also be responsible for the costs of any such review. Failure to provide these audit reports may also be cause for exit from this Pool.