

**MEMBERSHIP APPLICATION AND INDEMNITY AGREEMENT
LOUISIANA INDEPENDENT BUSINESS ASSOCIATION
AND
EMPLOYERS SELF INSURERS FUND**

The Applicant hereby formally applies for continuing membership and for workers' compensation self-insurance coverage in the Employers Self Insurers Fund and for membership in the Louisiana Independent Business Association to be effective 12:01 A.M. on the approved effective date shown. The Applicant duly authorizes the administrator of said Fund, as attorney-in-fact, in all matters relating to The Louisiana Workers' Compensation Act and Employers Liability. The Applicant agrees to the following upon acceptance to Membership:

- (a) Applicant accepts and agrees to be bound by the provisions of the Louisiana Workers' Compensation Act;
- (b) Applicant accepts and agrees to be bound by the terms and provisions of the *Agreement and Declaration of Trust* of Employers Self Insurers Fund (hereafter the "*Trust*") and any and all Amendments thereto adopted or which may hereafter be adopted by the Board of Trustees of the Fund, (copies of which will be provided to Applicant upon request), which are hereby adopted, approved, ratified and confirmed by Applicant.
- (c) Applicant does hereby assume and agree to be bound by all of the terms and conditions of this *Membership Application and Indemnity Agreement*, and any and all Amendments thereto adopted or which may hereafter be adopted by the Board of Trustees of the Fund.
- (d) Upon acceptance as a member by the Fund, member will receive a copy of an agreement entitled "Employers Self Insurers Fund Indemnity Protection" (the "*Indemnity Agreement*"), and by execution of this application, member accepts and agrees to be bound *in solido* for all obligations of Employers Self Insurers Fund contained in the *Indemnity Agreement*, and any and all amendments thereto adopted or which may hereafter be adopted by the Board of Trustees of the Fund.
- (e) The execution of this document and agreement to all of the terms of the *Membership Application and Indemnity Agreement*, *The Indemnity Agreement* and the *Trust*, and any and all amendments to either (collectively referred to as the Agreement) shall be continuing and will apply as though a new Agreement were issued on each annual fund year anniversary - as shown in the Workers' Compensation Coverage Declarations - that the Agreement is in force unless Applicant gives written notice of cancellation in accordance with subparagraph (l) below;
- (f) Applicant does hereby understand and agree that it is liable *in solido* for the payment of any lawful awards against any member of the Fund to the extent such awards are within the Indemnity Protection afforded pursuant to the Trust.
- (g) In the event of a Fund deficit, Applicant does hereby agree to pay any premium or lawful assessment, which may be levied on Fund members in a manner acceptable to the Department of Insurance by the Board of Trustees of the Fund, when any such premiums or lawful assessments become due;
- (h) Applicant agrees to pay all costs of collection of premiums and/or assessments, including reasonable attorney's fees. Interest shall accrue and be payable on any past due premiums or assessments at the maximum rate of interest allowed by law.
- (i) Applicant hereby agrees to abide by the rules and regulations of the Board of Trustees of the Fund, and to conform to the terms of the agreements they may enter into with any authorized service company as long as Applicant remains a member of the Fund;
- (j) In the event of any changes in Applicant's corporate or business structure, or in the event any locations are to be added or deleted from Applicant's business operations, Applicant shall notify the Fund, in writing, immediately of any such changes, additions or deletions;
- (k) The Indemnity Protection provided under this membership shall be for Applicant's Louisiana operations only; Applicant agrees to remain a member in good standing of the Louisiana Independent Business Association for as long as Applicant's participation in the Fund continues.

- (l) Applicant agrees to promote, respond to, and learn from the safety programs adopted by the Fund, and understands that failure to do so will result in cancellation by the Fund of the Workers' Compensation and Employers Liability Indemnity Protection afforded by the Fund to Applicant;
- (m) Applicant agrees to accurately complete and promptly return all payroll reporting forms required by the Fund, and to fully and timely comply with all payroll audits required by the Fund.
- (n) In accordance with the limitations and conditions of Louisiana Revised Statutes 23:1196, Applicant will allow ESIF, and or its agents, to examine and audit all records that relate to this Agreement. These records shall include but shall not be limited to: ledgers, journals, registers, vouchers, contracts, tax reports, payroll and disbursement records, and programs for storing and retrieving data. Any such audit shall be conducted during regular business hours during the period of this Agreement and within 3 years from the date of its termination.
- (o) Information developed by the audit will be used to determine annual or final premium. Insurance rate service organizations have the same rights as ESIF under these provisions.
- (p) In the event Applicant desires to cancel or terminate its Indemnity Protection through the Fund, Applicant does hereby agree to give written notice to the Fund at least 30 days prior to the effective date of cancellation or termination;
- (q) In the event the Fund requires a security deposit from any member, the Board of Trustees of the Fund shall be authorized: to (1) apply such security deposit to any unpaid premiums or other charges due by the member to the Fund; and (2) apply such security deposit to the Fund member's applicable share of any deficit experienced by the Fund in any year.
- (r) In the event the Fund experiences a surplus in any given year or Fund year, the Board of Trustees of the Fund is authorized to apply the Applicant's share of any such surplus to liquidate any Fund deficit in any other Fund year.
- (s) The person signing this Membership Application as, or on behalf of, the Applicant certifies that he/she has the authority to execute this agreement as, or on behalf of the Applicant.
- (t) In the event any premium or lawful assessment is not paid when due and collection becomes required by the fund, Applicant agrees to pay the cost of collection, including reasonable attorney fees.
- (u) Applicant hereby acknowledges that it is aware that the Fund is not a participant in The Louisiana Insurance Guaranty Association and acknowledges that it has a positive net worth, is financially solvent and capable of assuming the obligations set forth in the Indemnity Agreement, including the ability to fund any assessment.

This Agreement may be executed in counterparts by each member employer of Employers Self Insurers Fund, and the several parts constitute one and the same instrument.

WITNESS THE EXECUTION OF THIS APPLICATION AND INDEMNITY AGREEMENT

COMPANY NAME

WITNESSED BY (Other than Agent)

By (Signature of Owner, Partner, or Corporate Officer)

DATE

(PRINT NAME)

AGENT/SALESMAN SIGNATURE

Approved and Accepted by the Board of Trustees of Employers Self Insurers Fund

This _____ day of _____, 20__.

Authorized Signature

MEMBERSHIP ACKNOWLEDGEMENT

1. The Employers Self Insurers Fund (ESIF) Workers' Compensation coverage is a program sponsored by A Non Profit Trade Association, and is exclusively for its membership.
2. To participate, membership must be kept active in the Louisiana Independent Business Association. Members who do not pay their annual Association dues are removed from participation eligibility.
3. The ESIF Workers' Compensation program is preferred risk. Only members who are concerned with employee safety and who meet the strict underwriting requirements of ESIF may participate.
4. Before coverage can be provided, each applicant must meet the approval of the Board of Trustees.
5. Members must agree to cooperate with safety councils and loss control representatives in meeting safety recommendations.
6. ESIF must make a profit before any dividends are declared and distributed.
7. Due to the nature of self-insurance Workers' Compensation, additional premium may be billed in the event that losses exceed the Loss Fund, as group self insurance is assessable.
8. To protect the financial integrity of the Fund, and in compliance with state regulatory authority, excess Workers Compensation insurance has been purchased.
9. Members who do not cooperate or comply with Safety Inspections and Loss Control recommendations may be subject to cancellation
10. In compliance with state requirements and required notice, members with excessive losses may be cancelled at any time.
11. The Expense Constant is due in full at the beginning of each fund year.
12. The indemnity protection sought in this application is not effective until applicant's membership in the Fund is approved and accepted by the Board of Trustees of Employers Self Insurers Fund.
13. The information provided by Applicant and its accuracy is a substantial factor in ESIF's determination on acceptance of Applicant as a member of the Fund and is a cause of ESIF's agreement thereto. If inaccurate information is provided and accurate information would have resulted in ESIF not having agreed to accept Applicant as a member of the Fund, then ESIF's consent and acceptance of Applicant is vitiated and Applicant will not be entitled to the benefits provided under the Agreement.

My signature hereon acknowledges that I have read and understand the above terms of participation in ESIF, and certifies that the information provided by Applicant is true and correct.

ACCEPTANCE/REJECTION OF COVERAGE
(TO BE SUBMITTED WITH EVERY APPLICATION)

Louisiana law allows sole proprietors, partners and bona fide executive officers of a corporation, each owning not less than ten (10%) percent of the stock therein to accept or reject Workers' Compensation Coverage for himself/themselves. EACH SOLE PROPRIETOR, PARTNER, OR SUCH EXECUTIVE OFFICER MUST SIGN FOR ACCEPTANCE OR REJECTION OF COVERAGE BELOW.

LIST SOLE PROPRIETOR, PARTNERS, OR CORPORATE OFFICERS AND PERCENTAGES OF OWNERSHIP:

- | | |
|---------------------|---------------------|
| 1. Name: _____ (%) | 3. Name: _____ (%) |
| Title: _____ | Title: _____ |
| 2. Name: _____ (%) | 4. Name: _____ (%) |
| Title: _____ | Title: _____ |

ACCEPTANCE

I/We, the undersigned do hereby agree to pay the prescribed premium in exchange for Workers' Compensation Coverage through the Employers Self Insurers Fund.

- | | |
|---------------------|---------------------|
| 1. Signature: _____ | 3. Signature: _____ |
| 2. Signature: _____ | 4. Signature: _____ |

**- OR -
REJECTION**

I/We the undersigned do hereby elect to reject and be exempt from Workers' Compensation Coverage through the Employers Self Insurers Fund.

- | | |
|---------------------|---------------------|
| 1. Signature: _____ | 3. Signature: _____ |
| 2. Signature: _____ | 4. Signature: _____ |

The Above Election To Accept Or Reject Workers' Compensation Coverage Will Be Effective On The Inception Date Of Coverage Through The Fund And Will Remain In Effect For The Duration Of The Member's Membership In The Fund, Unless Rescinded In Writing By The Parties Making The Election. This election may only be made once each fund year at renewal or upon qualifying change in corporate ownership or structure.

Producer

Code	Sub Code

Applicant Information

Name/Address/Phone / Fax		
<input type="checkbox"/> Individual	<input type="checkbox"/> Corporation	Years In Business
<input type="checkbox"/> Partnership	<input type="checkbox"/> Other	
Employers ID	Rating NCCI ID	
	Issue Date	

LOCATIONS - PHYSICAL	Phone #: ()	Fax #: ()
1		
2		
3		

Rating Information					
Class Code	Categories, Duties, Classifications	No. of Employees	Estimated Annual Remuneration	Rate	Estimated Annual Premium

1. Workers' Compensation: Statutory Benefits	Total Manual Premium	
2. Employers Liability	Exp. Mod.	
	Total Manual	
Base Limits Included:	Discount	
Bodily Injury by Accident	\$1,000,000.00 Each Accident	Est. Ann. Premium
Bodily Injury by Disease	\$1,000,000.00 Policy Limit	Deposit
Bodily Injury by Disease	\$1,000,000.00 Each Employee	Expense Constant (Payable Annually)
Remarks:	Annual Service Fee (Payable Monthly \$180.00)	180.00
	Annual Membership Fee (Payable Monthly 192.00)	16.00
	Minimum Deposit	

INDIVIDUALS INCLUDED / EXCLUDED (Refer to Acceptance/Rejection of Coverage Form)								
Partners, Officers, Relatives to be included or excluded. (Include an owners, officers, partner exclusion form)								
	Name	Date of Birth	Title / Relationship	Ownership %	Duties	Inc./Exc.	Class Code	Remuneration
1								
2								
3								
4								
5								

PRIOR CARRIER INFORMATION / LOSS HISTORY							
Provide information for the past 5 years and use the remarks section for loss details					Attach Loss Runs		
Year	Carrier & Policy Number		Annual Premium	Mod	# Claims	Amount Paid	Reserve
	Co:						
	Pol:						
	Co:						
	Pol:						
	Co:						
	Pol:						
	Co:						
	Pol:						

NATURE OF BUSINESS / DESCRIPTION OF OPERATIONS
 Give comments and descriptions of business operations and products manufacturing-raw materials, processes, product, equipment, contractor type of work, sub-contracts, mercantile, merchandise, customers, deliveries, service type, location, farm-acreage, animals, machinery, sub contracts

GENERAL INFORMATION (explain all "yes" responses)	Yes	No	(explain All "Yes" responses)	Yes	No
1. Does Applicant own, operate or lease aircraft/watercraft?			15. Are athletic teams sponsored?		
2. Operations involving Hazardous Material?			16. Are physicals required after offers of employment are made?		
3. Any work performed underground or above 15 feet?			17. Any other insurance with this insurer?		
4. Any work performed on barges, vessels, docks, bridge over water?			18. Any prior coverage declined/cancelled/non-renew? (past 3 yrs)		
5. Is applicant engaged in any other type of business?			19. Are employee health plans provided?		
6. Are sub-contractors used? (if more than 50% explain below)			20. Is there an interchange with any other business/subsidiary?		
7. Any work sublet without certificates of insurance?			21. Do you lease employees to other employers?		
8. Is a formal safety program in operation?			22. Do any employees predominately work at home?		
9. Is there a Drug Free Workplace Program in place?			23. Any group transportation provided?		
10. Any employees under 16 or over 60 years of age?			Inspection Name:		
11. Any part time or seasonal employees?				Contact Phone:	
12. Is there any volunteer or donated labor?			Accounting Name:		
13. Any employees with physical handicaps?				Contact Phone:	
14. Do employees travel out of state?			Claims Name:		
Remarks:				Contact Phone:	

The above represents a true and accurate report of our company's workers' compensation claims experience to the best of my knowledge.