

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

APPLICATION FOR PARTICIPATION IN GROUP SELF-INSURANCE PLAN					
Submit this form to the Workers' Compensation Board, Self-Insurance Office, 20 Park Street, Albany, New York 12207					
1. NAME OF EMPLOYER GROUP:					
2. NAME OF EMPLOYER:					
3. DBA (if applicable):					
4. ADDRESS (Principal Office):					
5. PHONE NO. (including Area Code): () ()			6. FAX NO. (including Area Code): () ()		
7. FEDERAL EMPLOYER IDENTIFICATION NUMBER:		8. NYS U.I. EMPLOYER REGISTRATION NUMBER:		9. REQUESTED EFFECTIVE DATE OF PARTICIPATION:	
10. NATURE OF BUSINESS:			STANDARD INDUSTRIAL CLASSIFICATION CODE (SIC)		
11. WHAT COMPANY NOW IS CARRYING YOUR COMPENSATION INSURANCE?					
Report full payrolls for all employees. Include interstate, maritime, homeworkers, value of meals and lodging, etc., received by employees and sub-contractors' employee's payrolls unless compensation is definitely provided by sub-contractors. No payroll caps are to be applied when developing annual contributions.					
12 CLASS NO.	13 DESCRIPTION	14 NO OF EMPLOYEES	15 FULL ANNUAL PAYROLL	16 CIRB MANUAL RATE PER \$100 PAYROLL	17 CIRB MANUAL PREMIUM ((15+\$100) x 16)
TOTAL		18	18.	TOTAL CIRB MANUAL PREMIUM	20.
				EXPERIENCE MOD	21.
				SUBTOTAL (20 X 21)	22.
23a. DESCRIPTION OF ADJUSTMENTS TO PROPOSED CONTRIBUTIONS:			RATE	AMOUNT	
NYS WCB ASSESSMENTS (PAID BY TRUST FUND)					
TRUST DISCOUNT					
OTHER (SPECIFY)					
OTHER (SPECIFY)					
TOTAL ADJUSTMENTS TO CONTRIBUTIONS			23b.	23c.	
TOTAL ANNUAL CONTRIBUTIONS (23c APPLIED TO 22)					24.
25. IF A CORPORATION...		a. Enter date when incorporated		b. Under laws of what state?	
				c. If not a New York Corporation, enter date of registration in New York State. / /	
d. IF APPLICANT HAS ANY OF THE FOLLOWING (CHECK ALL THAT APPLY)					
PARENT		Yes <input type="checkbox"/>	No <input type="checkbox"/>	PARENT'S PERCENTAGE OF STOCK OWNERSHIP _____ %	
AFFILIATE		Yes <input type="checkbox"/>	No <input type="checkbox"/>	IF YES TO ANY, PLEASE SPECIFY AND ENTER NAME AND ADDRESS.	
SUBSIDIARIES		Yes <input type="checkbox"/>	No <input type="checkbox"/>		
SUCCESSOR TO ANOTHER BUSINESS		Yes <input type="checkbox"/>	No <input type="checkbox"/>		
CERTIFICATIONS ON REVERSE SIDE TO BE COMPLETED BY AUTHORIZED OFFICIAL OF EMPLOYER AND GROUP SELF-INSURER.					

26. IF A PARTNERSHIP... (a) Name all partners and designate whether they are General (G), Special (S), Limited (L), Other.

Name	G	S	L	Specify Other

(b) Enter date when partnership was established. / / Report additional partners on an attached sheet.

27. IF A SOLE PROPRIETORSHIP..... Indicate home address of proprietor.

CERTIFICATION BY PARTICIPATING EMPLOYER

The undersigned hereby affirms, under the penalties of perjury, that (s)he is Title

of , the participating employer named above; that the entity does not lease or is the lessor of any person(s) or is a member of any Professional Employee Organization, Leasing Company or other entity; that the number of employees, payroll information and all other information submitted on this application is true and accurate.

Printed or Typed Name of Company Official Signature Date Signed / /

CERTIFICATION BY GROUP SELF-INSURER

STATE OF NEW YORK

COUNTY OF , being duly sworn, says:

That (s)he is the of the Name of Authorized Official

Title Name of Employer Group

and is duly authorized to execute this affidavit of certification on behalf of said Group Self-Insurer.

That this EMPLOYER'S participation will continue to be effective until ten days after a written notice of termination is served on the EMPLOYER and filed with the Chair, Workers' Compensation Board, by the Self-Insurer. That the adjustments to the annual contributions listed on the front accurately reflect the contributions to be billed and collected from the participating employer. That (s)he acknowledges that the listed adjustments to the participating employer's contributions may be subject to an audit of the group self-insurer and/or the participating employer's records. That all employees of this EMPLOYER will be covered under the Workers' Compensation Law by the Group Self-Insurer.

Signature of Authorized Official

Sworn to before me this day of 20

Signature of Notary Public

FOR WORKERS' COMPENSATION BOARD ONLY USE

Approved

Disapproved

Director of Licensing

Date

JOINDER AND INDEMNIFICATION AGREEMENT

This Agreement is entered into on this day of , 2004 by and between the **Elite Contractors Trust of New York** (the 'Group Self Insured Trust') and the undersigned employer located in the State of New York (the 'Employer').

1. The Group Self Insured Trust accepts the Employer as a Participating Member, and agrees to provide coverage for all obligations of the Employer under the Workers' Compensation Law, pursuant to the terms and conditions of the Trust Agreement, Joinder and Indemnification Agreement, and By-Laws of the Group Self Insured Trust.
2. The Employer agrees to become a Participating Member of the Group Self Insured Trust, and accepts all of the duties and obligations of membership pursuant to the terms and conditions of the Trust Agreement, Joinder and Indemnification Agreement, and By-Laws of the Group Self Insured Trust.
3. In particular, the Employer understands, acknowledges and agrees that as a member of the Group Self Insured Trust, the Employer is jointly and severally liable for all obligations under the Workers' Compensation Law, of all Trust members, during the Employer's period of membership.
4. The Employer, by executing this document, attests that he/she has read the Trust Agreement, Joinder and Indemnification Agreement, and By-Laws of the Group Self Insured Trust, and fully understands the duties and obligations for membership, including, but not limited to the following:
 - a. Methodology to Determine Member Contributions:
Contributions are calculated on an annual basis using a Member's static manual rates, payroll, and experience modification factor. A member's contributions may then be adjusted by an underwriting credit or debit.
 - b. Annual Adjustments to Contributions:
A member's contributions may be adjusted to cover an inadequacy in funding for a program year. It is the intent of the Trust to make this adjustment for members of that program year at renewal.

c. Participating Members Term and Termination Requirements:

A Participating Employer's membership in the Trust Fund is deemed continuous unless resignation or termination is affected pursuant to the terms herein. A Participating Employer may not resign during the first year of membership. Should a member terminate participation within the first year, the following penalty will apply:

During 1st year:
35% of annual contributions

A member may terminate by providing 60 days notice to the trust by notifying the Administrator in writing. After the first year a participating member's term will be renewed on an annual basis and cancellation during the term will also be subject to 60 days notice to the Administrator in writing.

d. Effective Date of Participation:

Membership shall not become effective until member has made an initial contribution to the Trust Fund in the amount specified by the Administrator. Membership shall only remain effective if the member continues to make contributions to the Trust Fund in amounts specified by the Administrator.

e. Disclosure of Information:

Member agrees to provide the Administrator with all requested information of a financial or other nature reasonably necessary to establish and maintain the employer's membership in the Trust and to satisfy its financial obligations under the Trust Agreement or otherwise required by the Chairman of the Workers' Compensation Board of the State of New York.

5. This Agreement is a complete statement of the membership agreement and supercedes any prior terms, representations or agreements made either orally or in writing. Any subsequent agreements are invalid until submitted to and approved by the Self Insurance Office, Workers' Compensation Board.

Now, therefore, the parties have signed this joinder and indemnification agreement on the date set forth above:

On Behalf of the

Elite Contractors Trust of New York
Trust Name

Signature

Authorized representative
Compensation Risk Managers, LLC

Signature

Printed name and title
Corp Name: