

**ARKANSAS HOME BUILDERS ASSOCIATION
WORKERS COMPENSATION SELF INSURED FUND**

To properly underwrite this program in accordance with the guidelines set forth by the Arkansas Workers Compensation Commission and our excess insurer, we need you to complete and submit the following information to First Arkansas Insurance, PO Box 8367, Pine Bluff, AR 71611.

1. Arkansas Workers' Compensation Group Application.
2. Supplemental Application
3. Home Builders Association Membership confirmation form
4. Your current NCCI Data Worksheet. Sign the enclosed release and I will obtain a copy for you.
5. Copy of your Workers' Compensation policies and loss runs for the past Two to five years. Preferably five years.
6. The Fund does not cover work outside the state of Arkansas. Therefore, if you are working outside the state, please provide proof of other states coverage.

If your premium did not average \$3,500 or more for the past three years, you will not have a NCCI worksheet. If this is the case, please send the items listed above.

If you do not have this information in your office, sign the enclosed documents and we will assist you in getting the information.

7. Copy of any safety program currently in use.
8. Financial Statement. The Arkansas Workers' Compensation Commission requires the following.
 - a. Statement must include both a balance sheet and income statement. If you submit Contractors license Renewal Application and Financial Statement, be sure and include an income statement listing income and expenses.
 - b. Statement must be for one full year, and less than 90 days old.
 - c. Do not send tax forms, they will not be accepted.
 - d. An affidavit must accompany the financial statements. Financial information that has been audited by a Certified Public Accountant (CPA) is not required to be accompanied by an affidavit. Statements prepared by a CPA, should include the "Independent Auditor's Report". See enclosed sample of affidavit.
9. **Roofers: The AHBA-WC-SIF does not provide coverage for this type of risk. We ask that you send proof of coverage for your roofer with your application.**

Two Major requirements of the AWCC:

1. **THE ARKANSAS WORKERS' COMPENSATION COMMISSION, (AWCC), REQUIRES ALL APPLICANTS TO HAVE CURRENT WORKERS' COMPENSATION COVERAGE WHEN AN APPLICATION IS SUBMITTED FOR MEMBERSHIP IN THE AHBA-WC-SIF.**
2. **ALL APPLICATIONS MUST BE SUBMITTED TO THE AWCC AT LEAST 30 DAYS PRIOR TO THEIR EFFECTIVE DATE.**

If you have any questions, please call Mike Carter or Andrea Johnson at 800-467-0415.

**Arkansas Home Builders Association
Workers Compensation Self Insured Fund
PO Box 8367 - Pine Bluff, AR 71611**

APPLICATION FOR GROUP MEMBERSHIP

Name Insured: _____

Address: _____
City, State and Zip Code: _____
Telephone Number: (area code) _____ Years in Business: _____
() Individual () Partnership () Corporation () LLC () Other Federal ID # _____
Nature of Business: _____

Physical Locations: List number of locations, city, state and zip code (if more list and attach)					
Officers, Owners or Partners and Addresses:					
(First)	(Middle)	(Last)	(Title)	(Address)	included for coverage
1. _____					() Yes () No
2. _____					() Yes () No
3. _____					() Yes () No

1. Number of Employees working for applicant in Arkansas at this time _____
2. Amount of annual payroll during past year for applicant's employees working in Arkansas _____
3. Current payroll or projected payroll for applicant's employees working in Arkansas _____

**SUPPLEMENTAL APPLICATION
FOR
AHBA-WC-SIF**

Company Legal Name: _____

Db a or Subsidiary of Company: _____

Address: _____

Second Location: _____

Phone: _____ Fax: _____ Pager/Cell: _____

Contact Person: _____ Fed ID# _____

() Individual, () Corporation, () Partnership, () LLC, () other Yrs. in business: _____

Percent of Work: Type of Work Subcontracted out

Residential	_____	1. _____	7. _____
Commercial	_____	2. _____	8. _____
New Construction	_____	3. _____	9. _____
Remodeling	_____	4. _____	
Repair/Maintenance	_____	5. _____	
Subcontracted Out	_____	6. _____	
Insured Sub's	_____		

General Information: fill in each blank

1. Any aircraft or watercraft exposure _____
2. Store/work with hazardous material _____
3. Any work underground or above 15 feet _____
4. Work performed on barges, vessels, docks, bridges over water _____
5. Engaged in any other business _____
6. Subcontractors used _____
7. Insured Subcontractors _____
8. Formal Safety in place _____
9. Provide Group transportation _____
10. Employees 16 or under _____
11. Employees 60 or older _____
12. Any volunteer or donated labor _____
13. Employees with physical handicaps _____
14. Do employees travel out of state _____
15. Sponsor any athletic teams _____
16. Are physicals required after offers of employment made _____
17. Any other insurance with insurer _____
18. Prior coverage declined, cancelled or non renewed _____
19. Provide employee health plan _____
20. Interchange labor with other business _____
21. Lease employees _____
22. Any employees predominantly work at home _____

Do you do any of the following:

- 1. Asbestos related work _____
- 2. Work requiring shoring, trench shields, or sloping _____
- 3. Work related to railroads _____
- 4. Redi Mix operations _____
- 5. Pest Control _____
- 6. Roofing _____
- 7. Roofer provides certificate of insurance _____
- 8. Road Construction _____

Remarks:

Describe average job:

ARKANSAS HOME BUILDERS ASSOCIATION
Membership Confirmation

This form is required for membership in the Arkansas Home Builders Association Workers Compensation Self Insured Fund and/or the Home Builders Insurance Program, as these programs are considered a benefit of membership.

The following company, _____

is a member in good standing with the , _____

Home Builders Association.

HBA EXECUTIVE OFFICER

DATE

Date

NCCI
Boca Raton, FL

Re: Experience Data Worksheet
Federal ID# _____

Dear Sir/Madam:

Please release my experience rating information to First Arkansas Insurance, PO Box 8367, Pine Bluff, AR 71611.

Thank You,

your name and title

Sample Only

The Arkansas workers' Compensation Commission requires:

1. Retype this on your letterhead.
2. If your company is incorporated, you must have two officers sign the form'
3. The company name and date of this form must match the name and year-end date on the financial statement it is attached to.

Affidavit

I/We hereby certify the following:

1. The attached financial statements are true and correct to the best of my/our knowledge, and accurately reflects the financial condition of, _____ as of,

2. I/We declare there has been no material lessening in the net worth nor significant alteration of the current ratio of _____ as of,

President or Sole Owner

Date

Secretary or Treasure

Date

SAMPLE LETTER
(Use your letterhead)

Name of Insurance Company
Address

RE: Policy No:
Effective Date of Coverage

Gentlemen:

Please release premium and loss information directly to First Arkansas Insurance, P.O. Box 8367, Pine Bluff, AR, 71611, attention Andrea Johnson in regard to the above referenced policies.

Sincerely,

* Note: Please list all policies numbers and dates for each company that wrote your coverage and submit letters to each individual carrier.

NAMED INSURED: _____

Policy Term _____

**Workers' Compensation
Election or Rejection of coverage
Arkansas**

Note: Executive officers of a Corporation are covered; unless coverage is rejected.

Each executive officer must sign the following and affix their title.

		<u>Reject</u>	<u>Elect</u>
_____ Name	_____ Title	()	()
_____ Signature	_____ Date		
_____ Name	_____ Title	()	()
_____ Signature	_____ Date		
_____ Name	_____ Title	()	()
_____ Signature	_____ Date		
_____ Name	_____ Title	()	()
_____ Signature	_____ Date		
_____ Name	_____ Title	()	()
_____ Signature	_____ Date		

IF THE WORKERS' COMPENSATION COMMISSION ISSUED YOU A CERTIFICATE OF NON-COVERAGE . DO NOT SIGN THIS FORM, ATTACH A COPY OF THE CERTIFICATE AND RETURN.