APPLICATION

FOR

WORKERS' DISABILITY COMPENSATION

COVERAGE

2900 PACKARD ROAD, SUITE 2
YPSILANTI, MICHIGAN 48197-1968
(866) 919-9578
Fax (734) 572-9297

MADSIF APPLICATION
PAGE 1

1. INFORMATION

CORPORATE NAME: _____

DBA(If applicable): _____

Dealer's Name (if different than owner): _____

LIST ALL NAMES OF PARTNERS, CORPORATE OFFICERS OR DIRECTORS (use a blank piece of page for additional names):

Name: _____ Title: _____ % of Ownership _____

Name: _____ Title: _____ % of Ownership _____

Name: _____ Title: _____ % of Ownership _____

You must notify MADSIF and the Workers' Compensation Agency of any changes in ownership within 10 day.

Is this application for an employee leasing company? (circle one) **Yes** **No**

If yes, list all entities where employees are placed, the names of the entities owners and their % of ownership.
These entities must also be members of MADSIF. If they are not current MADSIF members, a separate application must also be filled out.

Entity: _____

Name of Owner: _____ % of Ownership _____

Entity: _____

Name of Owner: _____ % of Ownership _____

Entity: _____

Name of Owner: _____ % of Ownership _____

You must notify MADSIF and the Workers' Compensation Agency of any changes in ownership within 10 day.

Physical Address: _____

City: _____ State: _____ Zip+4: _____

Mailing Address (if different): _____

City: _____ State: _____ Zip+4: _____

Telephone #: _____ Fax #: _____

Date of Incorporation: _____ **Federal ID #:** _____

Make of vehicles sold: _____

Years under present ownership: _____

MADSIF APPLICATION
PAGE 2

Michigan Employment Security Commission (MESC) number:_____

Total Payroll for all Michigan employees during the previous calendar year:_____

Please circle yes or no

Is the entity named above a division or subsidiary of a parent corporation? Yes No

If yes, please indicate the name of the parent company:_____

Does any of the company's employee's travel outside the state of Michigan on business? Yes No

If yes, please explain:_____

Does your Company own or operate any aircraft or watercraft? Yes No

If yes, please explain:_____

No. of locations for the above ID # in Michigan:_____ No. of employees for the above ID # in Michigan:_____

Street Addresses of other locations in Michigan:_____

_____

2. PERSONS TO BE CONTACTED

Premium Questions:_____ Title:_____

E-Mail address: _____

Claims:_____ Title:_____

E-Mail address: _____

Safety:_____ Title:_____

E-Mail address: _____

3. PROPOSED EFFECTIVE DATE OF COVERAGE WITH MADSIF:_____

Effective date of present coverage:_____

Current workers' compensation carrier:_____

MADSIF APPLICATION
PAGE 3

4. UNDERWRITING REQUIREMENTS

So that we may process your application quickly, it is necessary that we obtain information regarding your previous claims experience. The simplest way to provide this information is for you to request your agent or insurance carriers to provide you with an **up-to-date loss run covering the last four premium years (including current term) as well as your last three years of Audited Payrolls. WE NEED THIS INFORMATION AS FAR IN ADVANCE OF YOUR PROJECTED ENTRY DATE AS POSSIBLE.**

In addition to the request of your agent or insurance carriers please **Retype the following paragraph on your letterhead and have it signed by a Full Officer and send the letter directly to**:

The Compensation Advisory Organization of Michigan
P.O. Box 3337, Livonia, MI 48151-3337

To whom it may concern:

Please send copies of our current and renewal rating data to:

MADSIF
2900 PACKARD RD, SUITE 2
YPSILANTI MI 48197-1968

Sincerely,(signed by full officer)

5. Losses of $25,000 and over for the past four years (if known):

DATE OF INJURY	NATURE OF INJURY	PAID AMOUNT	CASE RESERVE	OPEN OR CLOSED

MADSIF APPLICATION
PAGE 4

6. **PROJECTED ANNUAL PAYROLL BY CLASS: (refer to MADSIF guidelines)**
(insert any other classes not already shown below)

The payroll shown below will be used to determine the estimated premium for the first year of participation in MADSIF. Payrolls are audited after completion of the calendar year. Additional premium will be invoiced if payrolls are underestimated. A refund will be made if the payrolls are overestimated.

CODE #	JOB CLASSIFICATION	ESTIMATED ANNUAL PAYROLL (round to nearest $100.00)
7380	Drivers (parts, dealer trades)	$
7720	Security Guards	$
8010	Parts Dept. employees	$
8393	Body Shop employees	$
8395	Mechanics, porters, etc. (service dept. only)	$
8401	Service Write-up staff Service & Body Shop managers (** see note below)	$
8748	Sales staff	$
8810	Clerical (***see note below)	$
9015	Janitorial Maintenance	$
_____ Code #	_____ job description	$
_____ Code #	_____ job description	$
TOTAL PAYROLL		$

** Service Managers and Body Shop Managers can be included in this class only if they are not directly involved with repair work.

*** Corporate Officers are clerical unless their position involves them with any of the other classes.

LIMIT ANNUAL COMPENSATION FOR ALL CORPORATE OFFICERS TO $26,000.

MADSIF APPLICATION

7. FINANCIAL STATEMENT REQUIREMENTS:

THIS APPLICATION REQUIRES THE SUBMISSION OF A COPY OF THE BALANCE SHEET FROM YOUR LATEST YEAR-TO-DATE FINANCIAL STATEMENT, **OR** COMPLETE THE FOLLOWING AND HAVE SIGNED BY A CORPORATE OFFICER.

A copy of the application and financial information is submitted to the Michigan Department of Consumer & Industry Services as required by law. This information is confidential and not subject to the Freedom of Information Act. The Fund Trustees do not see this information. Your financial information is reviewed by the Fund Administrator to determine current, quick asset, and net worth to manual premium ratios.

STATEMENT DATE: _____

STATEMENT OF ASSETS & LIABILITIES

ASSETS

Current Assets

Cash on Hand and in Banks:	$_____	
Stocks & Bonds	$_____	
Notes and Accounts Receivable	$_____	
New Car Inventories	$_____	
Used Car Inventories	$_____	
Parts & Accessories	$_____	
Other Current Assets	$_____	
Total Current Assets		$_____

Other Assets

Properties, Buildings & Equipment	$_____	
Other Receivables	$_____	
Other Assets	$_____	
Total Other Assets		$_____
TOTAL ASSETS		$_____

LIABILITIES:

Current Liabilities

Notes Payable - New Vehicles/ Demos	$_____	
Notes Payable - Used Vehicles	$_____	
Notes Payable - short term	$_____	
Accounts Payable	$_____	
Accrued Taxes & Payroll	$_____	
Other	$_____	
Total Current Liabilities		$_____

Other Liabilities

Notes Payable - long term	$_____	
Mortgages Payable	$_____	
Other	$_____	
Total Other Liabilities		$_____
TOTAL LIABILITIES		$_____

Capital & Surplus

Capital Stock	$_____	
Additional Paid in Capital/Surplus	$_____	
Retained Earnings	$_____	
Net Investment		$_____
Year to Date Net Profit (loss)		$_____
Net Worth		$_____
TOTAL LIABILITIES & NET WORTH		$_____

_____

Signature of Corporate Officer Date

MADSIF APPLICATION
PAGE 6

Corporate Name:_____

Corporation / / Co-Partnership / / L.L.C./ / ELC / /

DBA (if applicable):_____

Address:_____
Street address

_____
City State Zip+4

The Applicant hereby certifies, warrants and represents, that the financial statement included herewith and signed by the Applicant, and the payroll information provided herein are accurate and true as of the date of this application. Also the Applicant will provide MADSIF with such other information required to qualify the Applicant with the applicable state authorities or other such persons designated by MADSIF. The Applicant warrants and represents that the Applicant will report all payroll of any kind, whether paid in cash, by check, or any other method, to MADSIF periodically, when requested, and agrees to make available all pertinent records at such reasonable times as requested.

We hereby formally apply for continuing membership for workers' disability compensation self-insurer coverage in MADSIF, to be effective 12:01 a.m. on the effective date given by the Michigan Bureau of Workers' Disability Compensation on the application and Form 650, following acceptance by the board of trustees or their designated representative. With the acceptance and approval of the application, the Applicant hereby constitutes and appoints MAXCIS INCORPORATED to act as our agent and/or attorney-in-fact in all matters relating to the Workers' Disability Compensation Act. We further agree as follows:

(a) To accept and be bound by the provisions of the Michigan Workers' Compensation Act of 1969, as amended.

(b) That, by this reference, the terms and provisions of the Memorandum of Coverage and Indemnity Agreement and/or Amendments thereto filed or which may hereafter be filed with the Michigan Bureau of Workers' Disability Compensation 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 member of the Fund; and in the event we fail to pay any premium or lawful assessment within thirty (30) days of the date the same shall become due, we will pay all costs of the collection thereof, including reasonable attorney's fee;

(c) To abide by the rules and regulations of the 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 we remain a member of the Fund;

(d) That, in the event of any changes in corporate structure, or in legal entity, or if any locations are to be added to or deleted from this coverage, we agree to immediately notify THE FUND ADMINISTRATOR OF MADSIF, 2900 Packard Road, Ste. 2, Ypsilanti, MI 48197-1968.

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

(f) That coverage under this membership shall be for Michigan operations only;

(g) That in the event of any payment under this agreement, the Fund shall be subrogated to all the Participant's rights of recovery therefore against any person or organization, and the Participant shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The Participant shall do nothing after loss to prejudice such rights.

_____
Type name of applicant (Owner, Partner, Director, Corporate Officer)

_____
Signature of applicant

_____
Title

CORPORATE SEAL (if available)

_____
Corporate Secretary

WITNESSES:
Signature 1:_____

Type Name:_____

Address:_____

Signature 2:_____

Type Name:_____

Address:_____

Date:_____

FOR MADSIF USE ONLY

The above applicant is hereby approved for membership in this Fund, and coverage is effective the _____ day of _____, 20_____.

Signed this _____ day of_____ 20_____

By:_____
MADSIF Fund Administrator or Trustee

GROUP SELF-INSURER
JOINT AND SEVERAL
INDEMNITY AGREEMENT

THAT we, the individual members of *MADSIF*, have executed this joint and several indemnity agreement pursuant to the Workers' Disability Compensation Act of 1969, as amended, MCL 418.611(2).

WHEREAS, execution of this indemnification agreement by each initial member and subsequent members accepted into the group will be by reference in the application for membership and by signature on this document as an attachment to the application. Each application and indemnity agreement will be signed by an authorized representative of each employer with legal authority to execute the application and indemnity agreement.

WHEREAS, each group member, as a self-insurer, by this signature on the application for membership and this indemnification agreement, hereby acknowledges and accepts joint and several liability with all other group members for all liability incurred by each member, arising under the aforesaid act, and all liability incurred by the group members in the operation of this self-insured group.

WHEREAS, each member, pursuant to Michigan Administrative Code, 408.43e(I) 1984, MR 7, effective July 19, 1984, agrees to comply with all provisions of the workers' Disability Compensation Act of 1969, as amended, and further each member understands assessment of the members may be ordered pursuant to Michigan Administrative Code 408.43j(3)c 1984, MR 7, effective July 19.1984.

NOW, THEREFORE, this agreement is in full force and effect this _____ day of _____, 20_____ and is irrevocable. Initial members and subsequent approved members are bound by this agreement. This agreement shall become effective for each member on the date of admission into the group.

Member Name:_____
CORPORATE NAME (please print)

BY:_____
Type Name of Person Signing
(Owner, Partner, Director, Corporate Officer)

TITLE:_____
Title of Person Signing

SIGNATURE:_____

NOTARY SIGNATURE:_____

COUNTY OF:_____

MY COMMISSION EXPIRES:_____

DATE:_____

AFFIX STAMP: