



STATE WORKERS' INSURANCE FUND
 100 LACKAWANNA AVENUE, P.O. BOX 5100
 SCRANTON, PA 18505-5100



SWIF

DEPARTMENT OF
LABOR & INDUSTRY
 COMMONWEALTH OF PENNSYLVANIA

570-963-4630

www.state.pa.us, PA Keyword: swif

APPLICATION FOR WORKERS' COMPENSATION COVERAGE

INSTRUCTIONS:

You must answer **all** questions completely and correctly. Please type or print.

Sign the application as indicated in Item 18.

If represented by a **Broker/Agent**, you must complete Item 19.

(Mark N/A when not applicable.)

Return the completed application to the State Workers' Insurance Fund at the address set forth above.

Coverage will become effective as of the date set forth on the Certificate of Insurance.

1. Business Name _____

Mailing Address _____

(IF R.D. OR P.O. BOX, ALSO LIST ACTUAL GEOGRAPHICAL LOCATION)

PA Primary Operating Location _____

(ATTACH LIST WITH ADDRESSES OF ALL PA OPERATING LOCATIONS)

County _____

Telephone No. you can be reached at during the day _____ - _____
AREA CODE

2. Federal ID No. _____

a. If new, date applied for _____

b. List the names and Federal identification numbers of additional businesses owned and operated to be **included** in this policy.

NAME _____ FED. ID NO. _____

NAME _____ FED. ID NO. _____

c. If multiple insureds are to appear on one policy, please submit an ERM-14 to identify ownership of each business.

3. a. Are you a: Leasing Company Temporary Agency Both N/A/

b. Type of Business: Individual If Individual, S.S. No. _____

Corporation Partnership Non-profit Other _____

4. Corporate Entity Only: a. Date articles filed _____ b. State _____

5. Are you currently in the process of liquidation or termination of this business? Yes No

If yes, explain

6. Has the firm ever filed for bankruptcy? Yes No If yes, date filed _____

Is the business currently in bankruptcy? Yes No If yes, **YOU MUST** enclose a copy of the petition as filed in bankruptcy court, including all attachments.

