EMPLOYEE LEASING COMPANY REGISTRATION FORM

INSTRUCTIONS

The original EL1 must be approved and filed with the Division of Security and Compliance, Attention: Tonya Keith, Department of Workers’ Claims, Prevention Park, 657 Chamberlin Avenue, Frankfort, KY 40601, prior to coverage being placed with the employer. If there is no original on file, the employee leasing entity will not be listed as registered with the Department of Workers’ Claims. A duplicate copy will be returned as evidence of registration.

NOTICE: Falsification of this application constitutes a criminal offense (KRS 523.1001. Violation of the employee leasing provisions of Kentucky law can result in civil and criminal penalties (KRS 342.990).

(A) Lessor Information - (Employee Leasing Company)

1. Company: __________________________________________________________________________
   Name
   Contact Name _______________________________ Phone Number _______________________________
   Email Address _______________________________ Fax Number _______________________________

2. Address: __________________________________________________________________________
   Principal Place of Business
   _______________________________ Telephone No. _______________________________

3. KY. Address: ________________________________________________________________________
   Contact Name _______________________________ Telephone No. _______________________________
   Email Address _______________________________ Fax No. _______________________________

4. Type of Entity: _______________________________________________________________________
   Proprietorship, Partnership, Corporation

5. FEIN or SSN: _______________________________________________________________________

6. Parent or Holding Company: _______________________________________________________________________
   Name _______________________________________________________________________________________
   Address _______________________________________________________________________________________

7. List, by jurisdiction, of each and every name Lessor has operated under in preceding five (5) years including any alternative names and names of predecessors or successors (use additional sheets, if necessary):

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

8. List of each and every person or entity currently owning a five percent (5\%) or greater interest in the employee leasing company: ___________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

9. List of each and every person or entity formerly owning a five percent (5\%) or greater interest in the employee leasing company or its predecessors, successors or alter egos in the preceding five (5) years: _____________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

(B) **Current Workers' Compensation Insurance Information**

1. Carrier Name:_____________________________________________________________________
2. Policy Number:____________________________________________________________________
3. Policy Period:____________________________________________________________
4. Name of insured as it appears on policy:__________________________________________
__________________________________________________________________________________

(C) **Past Workers' Compensation Insurance Information**

1. The following workers' compensation policies issued to the employee leasing company or its predecessor(s) have been cancelled or non-renewed within the last five (5) years (use additional sheets, if necessary):

   Carrier:_____________________________________________________________________________
   Policy or Certificate Number_________________________________________________________
   Date of cancellation_________________________________________________________________
   Reason for cancellation:_____________________________________________________________
__________________________________________________________________________________

2. The following Affidavit must be executed by the Chief Executive Officer of the employee leasing company if no such cancellation or non-renewal has occurred.
AFFIDAVIT

Comes now the affiant,_______________________________, and after having being duly sworn states as follows:

1. My name is_______________________________ and I am the Chief Executive Officer of_______________________________, an employee leasing company.

2. During the five (5) years preceding the date of this application neither the applicant nor any of its predecessors, successors or alter egos has had a workers' compensation policy cancelled or non-renewed.

3. Further affiant saith naught.

_______________________________________________
CHIEF EXECUTIVE OFFICER OF APPLICANT
Phone No._____________________________________
Email Address_________________________________

STATE OF______________
COUNTY OF______________
Acknowledged, subscribed and sworn to before me by_________________________________,
This___day of______________, 20___.

_________________________________________
NOTARY PUBLIC

MY COMMISSION EXPIRES:__________________________, 20____.

(D) CERTIFICATION

I do hereby certify that I am the duly authorized agent of a_______________________________, an employee leasing company; that the information contained in this application is true; and that the applicant will comply with the mandate of 803KAR 25:230 to immediately notify the Commissioner of the Department of Workers' Claims of any changes in the information provided in this application, and to provide information regarding workers' compensation coverage of leased employees within ninety (90) days of approval on Form EL-2.

DATE __________________________ NAME(typed) _______________________________
Address__________________________ SIGNATURE_____________________________
Telephone No.____________________
Fax No.__________________________
Email Address__________________________________________________________