



Application for Coverage under Coal-Workers' Pneumoconiosis Fund

Return complete form to:
BrickStreet Mutual Insurance
P.O. Box 3064
Charleston, WV 25332-3064
Telephone: (304) 926-3400 Fax: (304) 926-1996

BrickStreet use only	
C.W.#	
Status	
Class	
County	
Effective Date	
Wages	
Rate	
Remitted	

The undersigned hereby applies for coverage by the Coal-Workers' Pneumoconiosis Fund of the State of West Virginia of liability created by Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, and as provided in Article 4B, Chapter 23 of the West Virginia Code, as amended, and further agrees by making this application to be bound by the rules and regulations of the Coal-Workers' Pneumoconiosis Fund. Failure of the subscriber to timely file quarterly payroll and premium reports and to pay any premium due shall result in action taken by the Fund to cancel the subscriber's insurance coverage.

A. IDENTIFICATION OF APPLICANT.

1. Name		2. Telephone number (include area code)	
3. Address			
Street or P.O. Box		City	County
		State	Zip Code
4. Type of Business entity: (check one)		5. Other:	
<input type="checkbox"/> Sole proprietorship		<input type="checkbox"/> Corporation	
<input type="checkbox"/> Partnership		<input type="checkbox"/> Other:	
6. If a corporation: (attach verification) Date of incorporation		7. BrickStreet Policy Number	
/ /		State of incorporation: / /	
8. If a corporation, partnership, or sole proprietor, list names and social security numbers of officers or owners			
9. Is the applicant a lessee? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide the name and address of the lessor and attach copies of the lease agreements.		10. Is the applicant a subsidiary of any other business entity? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide the name and address of the parent organization.	
11A. Is the applicant a transferee or successor of another business entity? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide the name and address of the transferor or predecessor entity (attach copies of all documents and agreements of transfer or succession.)		12. Address at which a field auditor may conduct an audit of your payroll	
11B. Has the applicant ever had coverage before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what was the policy number?		Contact person: Telephone number:	

USE BLACK INK.

B. EMPLOYEE & PAYROLL INFORMATION PREVIOUS TO APPLICATION.

1. Date you began coal mine operations	2. Estimated average number of employees:	3. Estimated gross payroll:
/ /	For the next three months:	For the next three months: \$
	For the next year:	For the next year: \$
4. Total estimated gross payroll for all operations for the next three months: Underground \$		Surface \$

C. OPERATIONS INFORMATION MUST BE GIVEN FOR ALL WEST VIRGINIA OPERATIONS. ATTACH ADDITIONAL SHEETS IF MORE SPACE IS NEEDED.

1. Name of operation	2. Location (include county)	3. Federal Mine Identification Number
4. Type of operation	5. Federal Employer's Identification Number (FEIN)	6. Date operation began or will begin
<input type="checkbox"/> Underground <input type="checkbox"/> Surface <input type="checkbox"/> Trucking		/ /
<input type="checkbox"/> Other (explain)		

CERTIFICATION

I certify, swear, or affirm that all of the statements made and information provided within or accompanying this application are true, complete, and correct to the best of my knowledge and belief and are made in good faith.

Signature of owner or principal officer (sign in ink) Title Date