



**State Fund Agricultural Workers'  
Compensation  
Group Program**



**Enrollment Application**

The Montana State Fund and the Agricultural Group Associations have entered into an agreement to provide a group plan to qualifying Agricultural Group Association members. To participate in the group plan, a group association member must complete and sign this enrollment application.

**General Provisions**

Acceptance into the State Fund Agricultural Group program is subject to approval based on the eligibility criteria for the program. The criteria define the classes of business that qualify and eligible loss ratio and/or experience modification factors. The effective date of the policy must be within the contract year. This enrollment application must be received within 90 days of the effective date of the policy to be considered for participation in the group program.

**Participating members shall:**

1. Maintain an individual workers' compensation policy with Montana State Fund and shall be subject to the terms of the policy.
2. Report all accidents immediately to the Montana State Fund (1-800-332-6102).
3. Adhere to and comply with the minimum safety requirements of the Montana Safety Culture Act and must participate in the loss control program conducted by Montana State Fund. Participation in the loss control program may include but is not limited to attendance of a safety-related seminar, on-site safety audit or response to a correspondence type program including but not limited to program-specific materials or publications.
4. Maintain an Agricultural Group Association membership in good standing.

**The Agricultural Group Associations shall:**

1. Assist Montana State Fund in implementation of the plan.

**Montana State Fund shall:**

1. Retain exclusive responsibility for soliciting, underwriting, individual policy issuance and cancellation, claims management and administer and develop, implement and conduct the loss control program.

**Release**

By signing this form, I authorize Montana State Fund to release to the Agricultural Group Associations (for internal use only) premium, loss and other data on my workers' compensation policy, information which reflects the timeliness of reporting any work-related injuries and the status of my adherence to the terms of the group contract.

**Termination**

1. Montana State Fund may terminate a member's participation in this program if the insured does not maintain an Agricultural Group Association membership in good standing, is in default of an obligation to Montana State Fund or fails to meet minimum eligibility requirements in future years (if applicable).
2. Montana State Fund may terminate a member's participation by serving notice in writing to all affected parties. Termination is effective the date specified in the notice. If no date is specified in the notice, the date of the written notice is the termination date.
3. Members may terminate their participation by serving notice in writing to the Montana State Fund. Termination is effective the date of the written notice.

**Effective Date**

If the enrollment application is received by Montana State Fund within 90 days of the effective date of the policy within the contract year and the policy qualifies, participation shall commence on the effective date of the policy.

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I am a member of this Agricultural Group Association: \_\_\_\_\_

My membership is under the name of: \_\_\_\_\_

Montana State Fund Insured Name: \_\_\_\_\_

Montana State Fund Policy #: \_\_\_\_\_ Policy Effective Date: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City State Zip: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Return completed form to: **Montana State Fund** PO Box 4759 Helena, MT 59604-4759