M E M O R A N D U M

TO: The Members of the HSAWCF
FROM: Mary Penz, HSAWCF Administrator
DATE: August 25, 2020

SUBJECT: NEWS AND UPDATES FROM HSAWCF

SAVE THE DATE - THE HSAWCF ANNUAL MEETING SEPTEMBER 23, 2020 LOCATION – ZOOM MEETING

On Wednesday September 23rd, 2020, The Human Service Association Workers Compensation Fund will hold their 34th Annual Meeting. This year the meeting will be held via Zoom. An invitation to the Zoom call that will be scheduled from 11:00 am to Noon will be sent separately.

.

Meeting materials for the Annual Meeting will be mailed under separate cover.

MEMBERSHIP RENEWAL INFORMATION – DUE OCTOBER 1ST

It is that time of year when we request that the membership provide the HSAWCF with payroll renewal information for the upcoming year. The estimated payroll data is required by the Excess Carrier in order to assist in establishing the HSAWCF workers compensation premium rates for the 2021 year. In our continued efforts in transitioning in handling the paperwork electronically**,** we are attaching the payroll renewal form packets to this email, once completed they can be returned to the HSAWCF via email or fax. The instructions on how to complete these forms are included in the packet information. We have attached your agency audit data for the 2019 year to use as a guide along with a packet of additional forms that need to be completed. We understand that your agency may have had significant changes in payrolls so please take a look at this information closely and provide your best estimates for the 2021 year.
Please note that the payroll verification forms and other information will need to be submitted to the HSAWCF **NO LATER THAN OCTOBER 1ST**The timing of this is very important. **If we do not receive the estimated figures by October 1st.we will automatically use the 2019 FINAL AUDIT** figures to estimate payroll for the 2021 year. Please make every effort to file these forms in a timely manner. As always please let me know if you have any questions or concerns.
I can be reached at marypenz@hsawcf.com

WORKERS COMPENSATION FOURTH QUARTER BILLINGS 2020

Attached you will find your 2020 4th quarter workers compensation billing for your agency. The payments for your 4th quarter coverage is due no later than **October 1, 2020**. Please let me know if you have any questions. I can be reached at 586 416-8950 or marypenz@hsawcf.com

TO: Members of the Human Service Association
Workers Compensation Fund

DATE: August 28, 2020

FROM: Mary Penz, Administrator

RE: **HSAWCF Membership Renewals**

It is that time of year again when the HSAWCF begins gathering information necessary in order to calculate the **2021** renewal estimates for your workers compensation policy premiums To start this process we request that each agency provide the HSAWCF estimated payroll information for the upcoming 2021 year. We have attached payroll renewal forms that include the final 2019 audited payroll figures that we have for your agency. These figures are there to help guide you with the classifications associated with your agency employees as most recently reviewed by the auditors and the HSAWCF. Please refer to your final 2019 audit paperwork for the job classifications associated with your employees. It is very important that we have this information submitted to us, in order to provide the most accurate estimates of your annual premium.

Please note that if these forms are not received by our office by October 1st, we will automatically utilize the 2019 final audit figures for your estimates. No changes will be made after that date.

Included in this packet are the following documents:

1. **Payroll Verification Form (to be completed by all members) Due by October 1st.**
2. **Volunteer Coverage Statement (to be completed by all members) Due by October 1st**
3. **Bureau Letter (to be completed if you have been with the HSAWCF program less than 5 years) Due by October 1st**
4. **HSAWCF Independent Contractor Statement (to be completed by all independent contractors hired by your agency) To Be Retained for the Payroll Auditors at Year End**
5. **Waiver of Subrogation Request Form (only complete if needed) Due by December 1st**
6. **Additional Certificate Holder Requests (only complete if needed) Due by December 1st**

Please take the time to review these documents and complete the ones that are applicable for your agency.
The forms that are to be remitted to ShayAnn Copley via fax at (248) 916-9783 or email at scopley@crsmi.com

All members must complete the Payroll Verification Form and Volunteer Coverage Statement and submit by October 1ST2020.

The **Bureau Letter** is to be completed by those members who have been with the HSAWCF less than 5 years and submit by **October 1st, 2020**.

The **Independent Contractor Statement** is required for the year end payroll audit. **Please retain in your files. These forms must be presented at the time of your payroll audit for independent contractors hired in 2021.**

The **Subrogation Waiver Form and Certificate Holder Requests** are only required if you need these listed on your Certificate of Insurance Statement please submit by **December 1st, 2020.**

Thank you in advance for your assistance in completing these forms. The HSAWCF believes that gathering this information ahead of time will result in enhanced service and efficiencies to the membership. If you have any questions or concerns please do not hesitate to reach me at marypenz@hsawcf.com

We also want to Thank You for your continued membership in the Human Service Association Workers Compensation Fund (HSAWCF).

VOLUNTEER COVERAGE - OPTIONAL
(MEDICAL ONLY)

HSAWCF provides optional medical coverage for injuries sustained by volunteers of member insureds, providing that the injury sustained would have otherwise been covered under the Michigan Workers' Disability Compensation Act. The Volunteer Coverage provided by the HSAWCF is to be secondary to the individual's medical coverage. Coordination in accordance with federal and contractual laws will be followed. The medical coverage will be paid pursuant to the workers compensation statue which allows for cost containment.

Volunteer coverage does not extinguish other remedies the volunteer may have under state or federal law against the member insured.

This coverage does not apply to employees of member insureds.

A volunteer is defined as a person who gives his or her services to an insured member without the expressed or implied promise of remuneration. All claims under this coverage are to be submitted to Comprehensive Risk Services by the member insured, along with the designation that volunteer medical coverage is requested.

Please complete either item 1, 2 or 3 from below:

MEMBER AGENCY: _____

CONTACT INFORMATION: _____

1. Estimated Number _____of Volunteers for _____to be covered for the 2021 year.
Name of Member Agency

_____
Signed Dated

2. Not Applicable - _____ organization does not have volunteers.
Name of Member Agency

_____
Signed Dated

3. The _____elects to not have volunteers covered under the HSAWCF policy.
Name of Member Agency

_____
Signed Dated

SAMPLE RELEASE LETTER

(THIS LETTER MUST BE TYPED ON YOUR COMPANY'S LETTERHEAD)

(Today's Date)

Compensatory Advisory Organization of Michigan
P.O. Box 3337
Livonia, Michigan 48151-3337

To Whom It May Concern:

Please release our current and renewal rating data for the past 5 years to:

ShayAnn M. Copley, Client Administrator
Comprehensive Risk Services
P.O. Box 505
Novi, MI 48376

scopley@crsmi.com

_____

Signature of Officer and Title

NOTE: Please do not send this letter directly to the Compensatory Advisory Organization. Return the original letter, along with your payroll estimate to the attention of ShayAnn Copley at Comprehensive Risk Services.

Human Service Association Workers Compensation Fund
2021

Independent Contractor Statement

Member Agency

Member Number

The following information must be provided in order for insurance company to make a determination as to whether an independent contractor situation exists.

Name of Subcontractor: _____

Type of Work Performed _____

Time Period of Work _____

1 I do / do not have workers compensation coverage **(please circle)** If you have coverage please provide a copy of your Certificate of Insurance.

2 I, _____, DBA:_____ am a ____ sole proprietorship, _____LLC, ____ partnership, ____ corporation.

3 I have / have not hired any employees, casual laborers, or subcontractors. (**please circle**)

4 My Federal I.D. Number is: _____

5 I did / did not provide all materials/equipment needed while working for the above insured. (**please circle**)

6 For the above mentioned policy period, my gross income was $_____, of which $_____ was paid by the above named insured.

7 I do / do not have an Assumed Name Certificate on file with _____ County. (**please circle) (If one is on file, please provide a copy.)**

8 I do / do not have general liability coverage. (**please circle**) **If a certificate of general liability is available, please provide a copy.**

9 To further validate my standing as an independent contractor, I have not worked exclusively for the above named insured and have worked for the following general contractors or clients during the period in question.

_____ _____

_____ _____

_____ _____

_____ _____

Signed Dated

INDEPENDENT CONTRACTORS

HSAWCF does not provide worker disability compensation coverage to any independent contractors retained by member insureds.

All member insureds retaining independent contractors should require that the independent contractor provide a valid certificate of workers' compensation coverage before any work is performed by the independent contractor.

Please have all independent contractors complete the attached form for your records. These forms must be presented to the third party payroll auditors at year end.

Strict adherence to this policy will prevent independent contractors and/or their subcontractors from claiming and receiving workers' disability compensation benefits from HSAWCF.

SUBROGATION WAIVER FOR MEMBERS OF THE HUMAN SERVICE ASSOCIATION WORKERS COMPENSATION FUND

The State of Michigan Department of Human Services is now requiring a subrogation waiver to be included with the standard certificate of insurance for the workers compensation coverage. The information listed below is needed to complete a subrogation waiver for your agency. Each member of the HSAWCF requiring a subrogation waiver for the **2021** year, will need to answer all the questions listed below and we will do our best to have this to you as soon as possible. It needs to work its way through a couple of departments before approval. **Please Note: Certificates of Insurance will only be issued to the member agency once the first quarter workers compensation premium payment is received.**

Please complete this form and return via email or fax to:

scopley@crsmi.com Fax: 248 916-9783

1. What is the full name of the Human Services' member (your company name) requesting the waiver of subrogation? Member_____

2. What is that member's (your address) address and primary contact information?

3. What is the full entity name, address and primary contact info for the 3rd party requiring the Human Services' member to obtain the WOS?

4. Describe the work to be performed by the fund member for third party name, if possible (by class code with estimated payroll) for this project.

5. What is the duration of the project (estimated starting and ending dates):

6. Need estimated payroll breakdown for this project:

7. Effective Date:

8. Is there work to be performed by FUND MEMBER employees outside of the state of Michigan? If so, will those employees be residents of Michigan or another state(s)?

Signed_____Dated_____

CERTIFICATE HOLDERS FOR HSAWCF
WORKERS COMPENSATION POLICY
2021

Many of our insured require additional certificate holders be listed on their workers compensation certificates of insurance. If your agency is in need of this information please submit the certificate holder information on the lines below and submit to the HSAWCF by December 10,2020. This will help expedite the process of issuing the HSAWCF Certificates of Insurance.

Name of Member Agency _____

Contract Period _____
Certificate Holder _____
Address _____
City,State,Zip _____

Contract Period _____
Certificate Holder _____
Address _____
City,State,Zip _____

Contract Period _____
Certificate Holder _____
Address _____
City,State,Zip _____

Contract Period _____
Certificate Holder _____
Address _____
City,State,Zip _____

Contract Period _____
Certificate Holder _____
Address _____
City,State,Zip _____

Contract Period _____
Certificate Holder _____
Address _____
City,State,Zip _____