

Please complete this form in its entirety, and return it to Kate Shanahan at the address below for access to the On-line Reporting System. Once your account has been created, you will receive an e-mail with login information. Be sure to sign, date and check the box for the fund your company participates.

Does your company wish to participate? Yes No

If yes, complete form in its entirety. If no, complete Section B.

<input type="checkbox"/> Trifac Workers' Compensation Fund	<input type="checkbox"/> Care Providers Workers' Compensation Fund
<input type="checkbox"/> Builders & Contractors Workers' Compensation Fund	<input type="checkbox"/> Health Care Select Group Self-Insurance Fund
<input type="checkbox"/> Collectively Bargained Contractors Workers' Compensation Fund	<input type="checkbox"/> Forest Products Commercial Self-Insurance Group
<input type="checkbox"/> Greater Minnesota Self-Insurance Fund	

Section A - Authorized Representative Information

Authorized Representative:	_____
Job Position and Title:	_____
E-mail Address:	_____
Primary Daytime Phone Number:	_____
Fax Number:	_____
Full Legal Name of Member:	_____
Type of Entity (LLC, Corporation, Partnership, etc.):	_____
Address (no PO Box):	_____

City, State, Zip:	_____

Section B

Member Name:	_____
Do you grant your agent of record access to your On-line account data? Yes <input type="checkbox"/> No <input type="checkbox"/>	
This question must be completed before you will be granted on-line access.	
Agency Name:	_____
Agent of Record:	_____
Authorized Representative:	_____
	Signature
	Date

Return form to Kate Shanahan at:

Meadowbrook Insurance Group
 7900 Xerxes Ave. So., #300
 Bloomington, MN 55431-1118
 Fax: 952-516-5256
 E-mail: kate.shanahan@meadowbrook.com

Section C - Registrant Information

Full Name of Person Needing Access: _____

Job Position and Title: _____

E-mail Address: _____

Primary Daytime Phone Number: _____

Fax Number: _____

Full Name of Person Needing Access: _____

Job Position and Title: _____

E-mail Address: _____

Primary Daytime Phone Number: _____

Fax Number: _____

Full Name of Person Needing Access: _____

Job Position and Title: _____

E-mail Address: _____

Primary Daytime Phone Number: _____

Fax Number: _____

Full Name of Person Needing Access: _____

Job Position and Title: _____

E-mail Address: _____

Primary Daytime Phone Number: _____

Fax Number: _____

Full Name of Person Needing Access: _____

Job Position and Title: _____

E-mail Address: _____

Primary Daytime Phone Number: _____

Fax Number: _____