PARTICIPANT APPLICATION FOR THE SHEFFIELD FUND

1. Name of Employer (dba):____

2. Legal Name, if different from above (As shown on Tax Records):____

3. Mailing Address:____

City:____ State: ____________________ Zip_____________________

4. Physical Location (If different from Above):____

City:____ State:_____________________ Zip_____________________

5. Operating as: ____ Corporation; ____Partnership; ____ Sole Proprietorship; _____ Other (explain); ____________________

6. Unemployment compensation #:______________________________ Federal Tax I.D.___________________________

7. Business Phone #: ____ Residence Phone #:________________________

8. Social Security # of owner, if sole proprietor:____

9. Present Workers' Compensation Insurer:____

Current Annual Premium: $_________________

10. Describe Nature of your Business:____

11. List owners(s), partners or corporate officers below. If corporation, indicate percentage of ownership:

Name:__________________________ Title:______________________________ Percentage of Ownership_________

Name:__________________________ Title:______________________________ Percentage of Ownership_________

12. List below Workers' Compensation Premium paid for the latest three (3) complete insurance years:

Year_______ Premium $________ Year _________ Premium $________ Year________ Premium $________

13. Attach the following: ______ Incurred Loss History ______ Complete Financial Statement for the most recent tax year.

I/WE hereby make application to participate in The Sheffield Fund and certify that the information above is true and accurate.

Signed this __________ day of _____________________,20___.

By:_______________________________________ Title____________________________________

By:_______________________________________ Title____________________________________

(Must be signed by owner, if sole proprietor, all partners, if partnership; or authorized officer
of the corporation and witnessed by two persons or notary.

Witness:_______________________________________ Date:____________________

Witness:_______________________________________ Date:____________________

Sworn to and subscribed before me this the ________ day of ____________________, 20___.

___________________________________ My Commission Expires:____________________

Date Participation is to begin:______________________

Participation approved by: __________________,

Participation approved by: __________________, Fund Designee on ___________________________ (Date)