Workers Compensation Fund
ABC Participation Agreement

Associated Builders and Contractors, Inc.

Provided by Workers Compensation Fund for the members of the Associated Builders and Contractors

1 BUSINESS NAME

Give Exact or Full Name	Policy Number

2 MAILING ADDRESS

Street or P.O. Box			Business Telephone Number
City	**State**	**Zip Code**	**Fax Number**

In order to be eligible for, and continue in the program, I/we agree to adhere to the following:

1. Implement written recommendations made by WCF's safety and health staff pertaining to hazards that would qualify as OSHA serious violations.

2. Attendance by an owner, member of management or supervisor at a minimum of two WCF safety seminars each policy year. These seminars must be conducted by WCF's safety and health staff. Association sponsored seminars may be used to satisfy this requirement only if the course has been pre-approved by WCF's safety and health management and the content is directly related to injury prevention. This requirement may also be satisfied by completion, within the policy year, of an OSHA 10-hour or 30-hour course. A copy of the student's graduation certificate with the signature of an OSHA approved instructor must be provided. Training requirements will be waived if an owner, member of management, or supervisor of the member/policyholder organization holds and maintains a WCF Safety & Health Associate or Master certificate from the WCF Safety Academy program.

Association members must meet program eligibility criteria established by WCF and the Associated Builders and Contractors in order to participate in the program.

Termination of membership in the Associated Builders and Contractors, failure to comply with participation guidelines, or the expiration or cancellation of workers compensation coverage through WCF will void this agreement. Should you, for any other reason, elect to terminate this agreement, written notification must be submitted to the Associated Builders and Contractors and Workers Compensation Fund.

Print or Type Name and Title of Contact Person	Signature of Contact Person	Date

Please retain a copy for your records and give the original to your agent or marketing representative, or send to:

Workers Compensation Fund
100 West Towne Ridge Parkway
Sandy, Utah 84070

800.446.2667 | Fax: 385.351.8984

www.wcf.com