



**Workers Compensation Fund**  
URCA Participation Agreement

Provided by Workers Compensation Fund for the members of the Utah Roofing Contractors Association

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 Utah Roofing Contractors Association in order to participate in the program.

Termination of membership in the Utah Roofing Contractors Association, 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 Utah Roofing Contractors Association 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

For your protection, Utah law requires the following to appear on this form:

Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in the state prison.