



MEMBERSHIP APPLICATION

Company/Individual Name: _____

Contact Person if not an individual member: _____

Address, City, State and Zip: _____

County: _____ Phone: _____ Mobile phone: _____

Fax: _____

Email: _____ Website, if applicable: _____

By the authorized signature below, member applicant:

1. states that they are actively at work in production agriculture whereby at least 66 percent of gross income is derived from farming. Actively at work is defined as: (a) an adult individual working a minimum of 30 hours per week on a regular basis and not on a temporary (less than six months) or substitute basis within the State of Wisconsin or while a Wisconsin resident or (b) a business enterprise providing direct services to production agriculture in Wisconsin, and
2. agrees to have \$12 per applicant per month or \$12 per covered employee per month added to the monthly insurance premium for monthly cooperative membership dues (dues are non-refundable and subject to adjustment by the FHCW Board of Directors), and
3. agrees to provide accurate and complete information on the required application for insurance/health questionnaire. Intentional misrepresentation of health history will be considered fraud and may result in a termination of coverage effective to the date of enrollment.
4. agrees to maintain worker's compensation coverage if required under Wisconsin law while insured by FHCW. Farmers with six or more workers on the same day for any 20 days during the calendar year are required by FHCW to carry workers' compensation; non-farmer employers with one or more full- or part-time employees that are paid combined gross wages of \$500 or more in any calendar quarter are also required by FHCW to carry workers' compensation. Coverage for work-related injuries will not be provided in the event that worker's compensation is required.
5. agrees to a capitalization fee equal to the first month's premium plus 10%. Such capitalization fee may be paid by promissory note or in installments upon such terms as may be made available by the cooperative from time to time. Failure to make a capitalization installment payment by the due date could result in termination of membership in the cooperative. If member terminates coverage prior to the three (3) year period and has an outstanding capitalization payment balance, the cooperative may pursue recovery of the balance through an outside collection agency. Once member applicant has remained in the Farmers' Health Cooperative for a period of three (3) years, the capitalization fee paid to date will be refunded and any outstanding promissory note cancelled. If the member applicant dies, ceases business operations or otherwise ceases to exist, capitalization fee not previously refunded will be returned at that time, and
6. agrees to such other terms and conditions to membership as may be implemented from time to time by the Board of Directors and management of the cooperative, including reasonable participation in consumer-driven wellness and disease management or prevention initiatives.

Membership in the cooperative is contingent upon approval. Upon approval, you will be sent a membership packet. You will no longer be eligible for cooperative membership if you do not meet the above membership qualifications.

I have read, understand and agree to the above membership requirements for the Farmers' Health Cooperative of Wisconsin.

Signature: _____ Title: _____

Print name: _____ Date: _____