Instructions Print Reset **OCR 400**

INSURER'S NOTICE OF ISSUANCE OF POLICY

Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
P O Box 30016, Lansing, MI 48909

INSTRUCTIONS: SEE REVERSE SIDE

A separate Form 400 is required for each legal entity insured under a policy

1. Employer Federal I.D. Number	2. Name of Business		
3. Parent Co. Federal I.D. Number	4. Owner of Business (If applicable)		
5. Mailing Address (Street No. and Name)	City	State	ZIP Code

6. Type of Organization

☐ a. Corporation ☐ c. Individual ☐ e. Joint Venture ☐ g. Limited Liability Company

☐ b. Partnership ☐ d. Public Employer ☐ f. Other/Trust

7. NAIC Carrier I.D. Number (9 digits)	8. ZIP Code of Issuing Office	9. Name of Insurance Company
10. Policy Number		11. Effective Date of Coverage
12. Annual Payroll in Dollars	13. Michigan Class Code	14. Number of Employees

Pursuant to the Workers' Disability Compensation Act, this is to certify that the above referenced employer has been issued a policy of insurance by the above carrier. This policy covers all the liability imposed upon the employer by the provisions of the Michigan Workers' Disability Compensation Act for all employees in any and all of the employer's businesses.

15. Authorized Signature	Date

16. Please list below additional names and/or addresses for the Federal I.D. Number listed in Item #1. (A separate Form 400 is required for each legal entity insured under a policy.)

Name of Business			Name of Business		
Address (Street No. and Name)			Address (Street No. and Name)		
City	State	ZIP Code	City	State	ZIP Code
Name of Business			Name of Business		
Address (Street No. and Name)			Address (Street No. and Name)		
City	State	ZIP Code	City	State	ZIP Code

LARA is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.

Authority: Workers' Disability Compensation Act 418.625(1); R408.41
Completion: Mandatory

Purpose of Form WC-400:
To notify the Michigan Workers' Compensation Agency that a policy of workers' compensation insurance has been issued to an employer.

When Required:
Must be filed with the Agency within 30 days after the effective date of coverage.

General Guidelines for Completing Form WC-400:

a. A Form WC-400 is a continuous filing. A Form WC-401, Notice of Termination of Liability, only needs to be filed when terminating all coverage for an employer.
b. If a new division (assumed name or DBA) is to be added to an existing policy, a Form WC-403, Insurer's Notice of Name or Address Change, must be filed which shows the additional business name operating under the same Federal I.D. Number. Do not file a Form WC-401 in this situation.
c. If there are certain locations of the employer that change address, Form WC-403 must be completed. Forms WC-400 and WC-401 **should not** be filed for address changes. If the main address of the employer changes, that change must be submitted on a Form WC-403.
d. A separate Form WC-400 must be filed for each business which has a different Federal I.D. Number.

INSTRUCTIONS FOR COMPLETION

Item #1 – Employer Federal I.D. Number (9 digits)
Enter employer's Federal Identification Number. This is a nine digit number. If an individual (sole proprietor) does not have a Federal I.D. Number, the Social Security Number of the individual will be accepted. A Federal I.D. Number or a Social Security Number is **required** on all Form WC-400 filings.

Item #2 – Name of Business
Enter complete names of all of the businesses including all assumed names (even if the names are not registered) and division names that operate under the **same** Federal I.D. Number listed in Item #1. Additional assumed names or division names operating under the same Federal I.D. Number should be listed in Item #16 on the lower portion of the form. If there are more than four additional names, another Form WC-400 must be completed. Do not place additional business or division names on the back of the Form WC-400.

Item #3 – Parent Co. Federal I.D. Number
Enter Federal I.D. Number of parent company when applicable.

Item #4 – Owner of Business (If applicable)
List the complete name of the corporation, partnership, individual, public employer, joint venture, or limited liability company which owns the business. If Item #2 is identical to Item #4, leave Item #4 blank.

Item #5 – Mailing Address
The mailing address of the business, including city, state, and ZIP Code (5+4) must be identified. Street address of the business should be shown in Item #16. Additional Michigan addresses should be placed in Item #16. If there are more than four additional addresses, another Form WC-400 must be completed.

Item #6 – Type of Organization
State whether the employer is a corporation, partnership, individual, public employer, joint venture, other/trust or limited liability company.

Item #7 – NAIC Carrier I.D. Number (9 digits)
National Association of Insurance Commissioner's (NAIC) I.D. Number (5 digits) followed by the group number (4 digits) of the insurance company.

Item #8 – ZIP Code of Issuing Office
Show the complete ZIP Code for the insurance carrier office issuing this form. A complete list of the ZIP Codes for all carrier issuing offices must be on file with the Agency. This ZIP Code will be used on all correspondence sent by the Agency to the designated contact person for each carrier.

Item #9 – Name of Insurance Company
The full name of the insurance company.

Item #10 – Policy Number
Enter complete policy number. Maximum 20 digits.

Item #11 – Effective Date of Coverage
Enter the date the policy is effective. Numeric (month/day/year).

Item #12 – Annual Payroll in Dollars
Anticipated or actual annual payroll in dollars for the employer.

Item #13 – Michigan Class Code
Use class code found in the Michigan Workers' Compensation Statistical Plan which shows the highest amount of payroll (other than standard exceptions).

Item #14 – Number of Employees
Enter the number of employees for employer who are employed in Michigan.

Item #15 – Authorized Signature
Must have an original signature in black or blue ink. Typed signatures are not acceptable. Include the date the form was signed.

Item #16 – Additional Names and/or Addresses of the Business
See Item #2 and Item #5 for instructions.

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