FORM 375 PROCEDURES
SPLIT COVERAGE
WRAP-UP (SPECIAL) PROJECTS

The entity applying for the approval of split coverage shall supply the following information:

1. A cover letter indicating why split coverage is necessary. A contact name with phone number, fax number, and e-mail address must be included.
2. A list, if for wrap-up (special) project, of the subcontractors that will be on the work site.
3. A completed application for split coverage by the requesting entity.
4. Original Application must be submitted for processing.

After approval of the split coverage by the Department of Workers' Claims, the carrier for the requesting entity must file the following:

1. Proof of coverage through the Electronic Data Interchange for the requesting entity.
2. Proof of coverage for subcontractors listed for the wrap-up (special) project. (Will only be accepted if coverage is on file for the requesting entity)

Upon approval of wrap-up (special) project, monthly submission to Department of Workers' Claims listing subcontractor information is required until the completion of project. Submission shall include Project Name, Project FEIN, Project Start Date, Project Policy Number, Subcontractor Name, Subcontractor FEIN, Subcontractor Start Date, Subcontractor Policy Number, and Subcontractor End Date on a monthly basis.

Submit Application to:
Department of Workers' Claims
Compliance Branch
657 Chamberlin Ave
Frankfort, KY 40601

Monthly Subcontractor submission for approved wrap-up (special) projects may be emailed to:
LaborKYWCCompliance@ky.gov

APPLICATION FOR APPROVAL OF SPLIT COVERAGE WRAP UP (SPECIAL) PROJECTS

Pursuant to KRS 342.375, _____
(Employer)

_____, _____
(Address) (FEIN)
does hereby request authorization from the Commissioner of the Department of Workers' Claims to secure the employer's liability under KRS Chapter 342 through separate insurance policies for specific plants or work locations.

The applicant proposes that the principal work force of the employer, which is engaged in _____ at _____
(Type of Business) (Location)
shall be covered by _____ issued by _____.
(Policy Number) (Insurance Carrier)

A separate work force engaged in _____ located at
(Type of Business)
_____ shall be covered by _____
(Location) (Policy Number)
issued by _____. Employees in the separate work forces
(Insurance Carrier)
have distinct duties and are not commingled.

This _____day of _____, 20_____.

_____
REPRESENTATIVE OF EMPLOYER

STATE OF _____

COUNTY OF _____

Acknowledged, subscribed and sworn to before me by _____,

This _____ day of _____, 20___.

_____
NOTARY PUBLIC

PRINTED NAME: _____

ADDRESS: _____

MY COMMISSION EXPIRES: _____