Town of Ludlow, Massachusetts

Office of the Select Board

APPLICATION FOR/AND RENEWAL FORM
CLASS I, II OR III LICENSE

Date: _____

Please complete the following and return it to the Office of the Select Board, 488 Chapin Street, Ludlow, MA 01056 with the $200 check made payable to the Town of Ludlow, the Worker's Compensation Insurance Affidavit form, the declaration page of the worker's comp policy and if Class II license proof of $25,000 bond.

Corporate Name: _____

DBA: _____

On-Site Manager Name & Phone Number: _____
(Please list ALL names required for your license)
Business Address: _____

Email Address: _____
Type of License: _____

Additional Information: _____
_____
_____

_____ _____
Signature of Owner/License Holder Federal ID # or Social Security #

Submit to the Select Board's Office the following:

- Application
- Check for $200 (payable to the Town of Ludlow)
- Workers Compensation Insurance Affidavit (including copy of declaration page of policy)
- Class II Only: Proof of $25,000 Bond

◇ 488 Chapin Street Ludlow, MA 01056 ◇ (413) 583-5600 ◇ FAX: (413) 583-5603 ◇
◇ TTY (413) 583-5668 ◇ Email: selectboard@ludlow.ma.us ◇

The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
Lafayette City Center
2 Avenue de Lafayette, Boston, MA 02111-1750
www.mass.gov/dia

Workers' Compensation Insurance Affidavit: General Businesses

Applicant Information **Please Print Legibly**

Business/Organization Name: _____

Address: _____

City/State/Zip: _____ Phone #: _____

Are you an employer? Check the appropriate box:

1. ☐ I am a employer with _____ employees (full and/ or part-time).*
2. ☐ I am a sole proprietor or partnership and have no employees working for me in any capacity. [No workers' comp. insurance required]
3. ☐ We are a corporation and its officers have exercised their right of exemption per c. 152, §1(4), and we have no employees. [No workers' comp. insurance required]**
4. ☐ We are a non-profit organization, staffed by volunteers, with no employees. [No workers' comp. insurance req.]

Business Type (required):

5. ☐ Retail
6. ☐ Restaurant/Bar/Eating Establishment
7. ☐ Office and/or Sales (incl. real estate, auto, etc.)
8. ☐ Non-profit
9. ☐ Entertainment
10. ☐ Manufacturing
11. ☐ Health Care
12. ☐ Other _____

*Any applicant that checks box #1 must also fill out the section below showing their workers' compensation policy information.
**If the corporate officers have exempted themselves, but the corporation has other employees, a workers' compensation policy is required and such an organization should check box #1.

I am an employer that is providing workers' compensation insurance for my employees. Below is the policy information.

Insurance Company Name: _____

Insurer's Address: _____

City/State/Zip: _____

Policy # or Self-ins. Lic. #_____ Expiration Date: _____

Attach a copy of the workers' compensation policy declaration page (showing the policy number and expiration date).

Failure to secure coverage as required under § 25A of MGL c. 152 can lead to the imposition of criminal penalties of a fine up to $1,500.00 and/or one-year imprisonment, as well as civil penalties in the form of a STOP WORK ORDER and a fine of up to $250.00 a day against the violator. Be advised that a copy of this statement may be forwarded to the Office of Investigations of the DIA for insurance coverage verification.

I do hereby certify, under the pains and penalties of perjury that the information provided above is true and correct.

Signature: _____ Date: _____

Phone #: _____

Official use only. Do not write in this area, to be completed by city or town official.

City or Town: _____ **Permit/License #**_____

Issuing Authority (check one):

1.☐Board of Health 2.☐ Building Department 3.☐ City/Town Clerk 4.☐Licensing Board
5.☐ Selectmen's Office 6.☐Other _____

Contact Person: _____ **Phone #:** _____