**Matthew H. Mead**
Governor

# State of Wyoming
# Department of Workforce Services

**Workers' Compensation Division**
**Employer Services**
**1510 E. Pershing Blvd 2nd Floor**
**Cheyenne, Wyoming 82002**
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**www.wyomingworkforce.org**

**John Cox**
Director
**John Ysebaert**
Deputy Director

## WORKERS' COMPENSATION
## DEDUCTIBLE PROGRAM APPLICATION

I want to enroll the following company in the Workers' Compensation Deductible Program:

Employer Name: _____

WC Employer Number: _____

Elected Deductible Level*: _____
*Deductible Level is limited to levels listed in your company's Deductible Program Analysis

Contact Information

Contact Name: _____ Title: _____

Email Address: _____

Street Address: _____

Mailing Address: _____

City/State/Zip:_____

Phone: _____ Fax: _____

I certify that I am an authorized representative of the business listed above. I understand that this company is not enrolled in the Deductible Program until the required following has completed Irrevocable Letter of Credit (or Cash Deposit), required financial information is delivered to the Division and a Deductible Program Contract has been signed by all parties. (Note: A draft contract will be mailed following receipt of this application.)

_____ _____
Printed Name Title

_____ _____
Signature Date