Montana Department of Labor & Industry
Employment Relations Division
Workers' Compensation Regulation Bureau
P.O. Box 8011
Helena, MT 59604-8011

CORPORATE RESOLUTION
Plan 2 INSURANCE

The Board of Directors of _____
(hereinafter called the Insurer), a corporation organized and existing under the laws of the State of _____, who does or wishes to do business in Montana as an approved insurer operating under compensation plan No. 2, administered by the Montana Department of Labor & Industry, Employment Relations Division (hereinafter called the Department), held a meeting on _____.
A quorum was present and after discussion, the following Resolution was adopted:

A. Whereas, a private insurer desiring to operate in Montana as a insurer under compensation plan No. 2 must furnish security to the Department pursuant to § 39-71-2215, MCA;

B. Whereas, this deposit of security by the Insurer is for the protection of and to guarantee the payment of all workers' compensation liabilities which the Insured employer may owe to its employees, or the beneficiaries of its employees;

C. Whereas, a private insurer desiring to operate in Montana as an insurer under compensation plan No. 2 must become a member of the Montana Insurance Guaranty Fund; and

D. Whereas, the Insurer desires to conduct business in Montana as an insurer under compensation plan No. 2 of the Montana Workers’ Compensation Acts.

THEREFORE, BE IT RESOLVED

1. That the Insurer shall deposit security with the Department as required by law;

2. That the Insurer become or continue to be a member of the Montana Insurers Guaranty Fund; and

3. That the President, Vice President, or Treasurer, and the Secretary, as officers of this corporation are authorized to execute such documents and terms as are necessary for the Insurer to furnish security to the Department in the amount and manner as required or permitted by law, so that the insurer may be permitted to operate as a insurer compensation plan No. 2 insurer under the Montana Workers' Compensation and Occupational Disease Acts.

Dated this _____ day of _____, _____.

_____
Typed Insurer Corporation Name

By:_____
Signature

_____
Typed Name and Title

I, _____, the undersigned secretary of the above named corporation, do hereby certify that I am the secretary of the above named corporation, that the foregoing is a full, true, and correct copy of a Resolution duly passed by the Board of Directors thereof at a meeting held on _____ day of _____, _____, and that the resolution has never been revoked, rescinded, or set aside, and is now in full force and effect.

CORPORATE SEAL

By:_____
Signature of Secretary

_____
Typed Name of Secretary