The application fee is:

___ $750.00 Unrestricted license
___ $500.00 Restricted license

Fees Payable To: Department of Labor and Industry
Employment Relations Division

Mailing Address: PO Box 8011, Helena MT 59624-8011

Street Address: 1315 Lockey Ave, Helena MT 59601

Contact Person: Amber Weekes, Program Manager
Phone: (406) 444-7748
Email: DLIERDPEO@mt.gov
Web Address: http://erd.dli.mt.gov/work-comp-regulations/professional-employer-organizations

Revision 11/1/2021
Important Information
(Must be completed)

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<th>Field</th>
<th>Information</th>
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<td>Applicant Name(s):</td>
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<tr>
<td>FEIN(s):</td>
<td></td>
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<tr>
<td>Street and Mailing Address:</td>
<td></td>
</tr>
<tr>
<td>Montana Branch Offices:</td>
<td>Yes  No (If yes, attach list of all MT branch locations, street address and phone number)</td>
</tr>
<tr>
<td>Contact Person(s):</td>
<td></td>
</tr>
<tr>
<td>Business Phone #:</td>
<td>Email(s):</td>
</tr>
</tbody>
</table>

State Unemployment Tax Account(s) (SUTA):__________________________
Workers' Compensation Policy Number(s):__________________________

BENEFITS PROGRAMS: A professional employer organization or group shall disclose to the department, to each client, and to its employees information on any health or life fringe benefit program provided for its employees.
Are benefits provided ____ Yes ____ No

If yes, please complete the following information or submit as an attachment:

Type of benefits:_________________________________________________
Identity of each Insurer providing coverage:_______________________
Amount of benefits for each type of coverage:_____________________
Policy limits on each insurance policy:____________________________
Whether coverage is fully insured, partially insured or fully self-funded:________________
CHECKLIST A:
The following supporting documents must be submitted with your application for compliance with Title 39, Chapter 8 Montana Code Annotated (MCA). Please read the instructions carefully to ensure proper completion of the application. The non-refundable application fee is $750 for a resident or nonresident unrestricted license, or $500 for a restricted license.

___ Financial Statements–Pursuant to 39-8-202 (6)(a) (MCA), Except for an applicant who is granted a restricted license under subsection (9), an applicant shall maintain a tangible accounting net worth of not less than $50,000, evidenced by: (i) providing financial statements that have been independently audited by a certified public accountant in accordance with generally accepted accounting principles; or (ii) providing independently compiled financial statements and a $100,000 security deposit in a form that is acceptable to the department. 39-8-202 (7) MCA, The applicant shall maintain a positive working capital, as evidenced by financial statements (reference

___ Attestation of Financial Statement (reference 39-8-202 (6)(c)(ii) MCA)

___ Proof of workers’ compensation for each client company. If no clients, provide MT endorsed master policy. (reference 39-8-207 (4)(c) MCA) Note: If your insurer provides policies to this office or you previously submitted policies, please don’t duplicate!

___ List of Montana Client Companies – (reference 39-8-207 (2)(e) (MCA) currently under contract with the applicant, including the name of the business, their Federal Employer ID number, business address, primary business operation and the beginning date of the contract.

___ Applicant/Controlling Person Questionnaire (reference 39-8-202 (5)(a)(iii) MCA)
___ Declaration of Accuracy form (reference 39-8-202 (5)(a)(iii) MCA)
___ Professional Employer Organization Group Guarantee form – if applicable (reference 39-8-202 (4)(e)(iii)

CHECKLIST B:

THE FOLLOWING NEED TO BE SUBMITTED IF CHANGES HAVE OCCURRED OR OCCUR DURING THE LICENSE YEAR.

Pursuant to 39-8-207(2)(d) MCA Requirements of Licensee The professional employer organization or group shall: notify the department in writing within 20 days of a change of business address or a change in partners, directors, officers, members, or controlling persons designated in the license. The following forms should be used for these changes:

___ APPLICANT AUTHORIZATION FOR RELEASE OF INFORMATION
___ PEO OWNERSHIP INFORMATION/Business Operational History
___ APPLICANT/CONTROLLING PERSON INFORMATION SHEET
___ CONTROLLING PERSON AUTHORIZATION FOR RELEASE OF INFORMATION
___ CHARACTER REFERENCE AFFADAVIT (needs to be notarized)

Pursuant to 39-8-207(2)(e) MCA Requirements of Licensee The professional employer organization or group shall: notify the department in writing within 20 days after a client either commences or terminates a professional employer arrangement or an employee leasing arrangement with that professional employer organization or group. The following form should be used and can be emailed, once completed:
___ Professional Employer Arrangement Client Initiation or Termination Form

Pursuant to 39-8-207(1) (2) MCA Requirements of Licensee A professional employer organization or group shall, by written contract with the client, establish the responsibilities and duties of each party.

Client contract agreements and or Employee Disclosure

Revision 11/1/2021
STATE OF MONTANA
PROFESSIONAL EMPLOYER ORGANIZATION
CLIENT INITIATION OR TERMINATION FORM

39-8-207 (2)(e) Montana Code Annotated, states the professional employer organization or group shall:
notify the department in writing within 20 days after a client either commences or terminates a professional
employer arrangement or an employee leasing arrangement with that professional employer organization or
group.

Please furnish a copy of this completed form:
Email: DLIERDPEO@mt.gov
Mail: State of Montana
Department of Labor & Industry
Employment Relations Division
Attn: Amber Weekes
PO Box 8011, Helena MT 59604-8011
1805 Prospect Ave, Helena MT 59601
Phone: 406-444-7748

Professional Employer Organization Information:
Name of Company: ____________________________________________________________
Address of Company: ____________________________________________________________
City, State & Zip: ______________________________________________________________
Contact Person: ____________________________________Telephone#_________________
Federal Tax ID # ____________________________________

Client Company Information:
Name of Client Company: _______________________________________________________
Address of Client Company: _____________________________________________________
City, State & Zip: ______________________________________________________________
Contact Person: _____________________________________Telephone #_______________
Federal Tax ID #: ____________________________
Month, Day and Year leasing arrangement initiated in Montana: _______________________
Month, Day and Year leasing arrangement terminated with PEO: _______________________
If different than term date, please provide the last date of payroll in Montana: ____________
If Montana business address is not a home residence, please provide the MT address (upon termination):
___________________________________________________________________________________

Reason for termination (be specific):
☐ Client has terminated with PEO
☐ Client is still active with PEO but no MT employee exposure
WC class codes used for this client: ________________________________________________
WC policy number: ____________________________Policy effective date: ______________________

Completed by: _______________________________
Date form completed: ______________

Excel: ________________________
Policy: ________________________
NCCI: ________________________
UI: ________________________
UEF Letter: ________________________
Notes: ________________________
_____________________________

DLI/ERD use only
ATTESTATION OF FINANCIAL STATEMENT

We, the undersigned, in conformance with section 39-8-202, MCA, do hereby attest to the accuracy and completeness of the financial statements **submitted herein** and **attached hereto** by ________________________________ (applicant) as part of the application process for licensure as a Professional Employer Organization.

<table>
<thead>
<tr>
<th>attest: ________________________________</th>
<th>Date</th>
<th>Signature and printed name of applicant <strong>president</strong></th>
</tr>
</thead>
<tbody>
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</table>

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<tr>
<th>attest: ________________________________</th>
<th>Date</th>
<th>Signature and printed name of <strong>chief financial officer</strong></th>
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<table>
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<tr>
<th>attest: ________________________________</th>
<th>Date</th>
<th>Signature and printed name of a <strong>controlling person</strong></th>
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DECLARATION OF ACCURACY

I, ________________________________, declare that to the best of my knowledge the applicant is qualified in all respects for the license for which applied in this application; that all of the questions in this application have been answered truthfully; that all supporting documents, submitted with this application are true, correct, complete and valid; and that there have been no material omissions of fact which would have bearing upon the State of Montana’s decision to grant the requested license.

I understand and agree that furnishing false information or failing to disclose material information regarding the applicant’s background and qualifications is grounds for refusing to issue a license and/or the revocation of a license already issued. I also understand that making false statements under penalty of perjury may subject me to criminal liability.

I declare that: (check one)

_____ I am the named applicant for licensure as a Professional Employer Organization

_____ I am the ______________________________ (title) of ______________________________ and I have been duly authorized to execute this Declaration on behalf of the applicant.

I declare under penalty of perjury of the laws of the State of Montana that the above statements and the statements made in this Application for Professional Employer Organization License are true and correct. I declare that this declaration was executed on ________________, 20____ at ______________________________ (city), ______________________________ (state).

Printed name, signature and title of a control person
A separate form must be completed for each applicant or each controlling person, if applicable.

1. NAME OF (APPLICANT/CONTROLLING PERSON)

_________________________________________________________________________________
(Typed or Printed, Full Legal Name – First, Middle, Last)

2. SOCIAL SECURITY NUMBER ______________________________________________________

3. MAILING ADDRESS
(Number & Street or PO Box, City, County, State, Zip)

4. HOME ADDRESS _____________________________________________________________
(Number & Street or PO Box, City, County, State, Zip)

5. TELEPHONE NUMBER _______________________________________________________
(Area Code/Number)

6. DATE OF BIRTH _____________________________________________________________

7. TITLE OF CONTROLLING PERSON    [ ] Owner    [ ] Manager    [ ] Other

8. LIST BELOW employment history for the last four (4) years, identify management and supervisory
positions. (Attach additional sheets if necessary and reference item number.)

<table>
<thead>
<tr>
<th>EMPLOYER &amp; ADDRESS</th>
<th>DATE FROM/TO</th>
<th>TELEPHONE NUMBER</th>
<th>BRIEF DESCRIPTION OF RESPONSIBILITY</th>
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<td>A.</td>
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<td>C.</td>
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<td>D.</td>
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</table>
APPLICANT/CONTROLLING PERSON QUESTIONNAIRE

Note: This questionnaire shall be completed each year by the applicant/controlling person. All attachments shall also be provided each year and controlling person shall sign and date.

If the answer to any of the following questions is “YES” attach a full explanation detailing the circumstances or condition which cause the “YES” answer. Any bankruptcy within the last 10 years must attach Schedules A & B and the court order discharging the bankruptcy.

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Does the applicant, controlling person, officer, director, shareholder, or partner now hold or have they ever held an employee leasing company, or authority to practice as an employee leasing company in the State of Montana or any other state?</td>
<td>☐</td>
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</table>

2. Has the applicant or any officer, controlling person, director, shareholder, member, partner, owner or managing employee:

   a. been convicted of, pled guilty to, or entered a plea of no contest to any criminal violation? | ☐ | ☐ |

   b. ever filed for, or been subjected to an involuntary petition for, or been adjudged bankrupt, or sought protection under the bankruptcy laws? | ☐ | ☐ |

   c. had a judgment entered against them in any court? | ☐ | ☐ |

   d. applied for and been denied a bond? | ☐ | ☐ |

   e. had a bonding company or surety make a financial settlement in their behalf? | ☐ | ☐ |

   f. had a bonding company or surety revoke a bond or surety agreement executed in their behalf? | ☐ | ☐ |

   g. had a license or authority to practice denied, revoked, suspended, placed on probation or been subject to disciplinary action or restriction? | ☐ | ☐ |
3. Are there now any outstanding unpaid past due bills; claims for salaries, wages, benefits or services; judgments, assessments or liens resulting from acts or omissions of this applicant, controlling person, officer, director, shareholder, member, partner, owner, or managing employee, for which these persons may be responsible?

I, ___________________________________, do hereby certify that all of the questions in this applicant/controlling person questionnaire have been answered truthfully; that all supporting documents, submitted with this questionnaire are true, correct, complete and valid; and that there have been no material omissions of fact which would have bearing upon the State’s decision to grant the requested license to the Professional Employer Organization applicant.

I understand and agree that furnishing false information or failing to disclose material information regarding the applicant’s background and qualifications is grounds for refusing to issue a license and/or the revocation of a license already issued. I also understand that making false statements under penalty of perjury may subject me to criminal liability.

I declare under penalty of perjury of the laws of the State of Montana that the statements made in this Applicant/Controlling Person Questionnaire are true and correct. I declare that this declaration was executed on ____________________, 20____ at ___________________________ (city), _______________________ (state).

____________________________________________
Printed name and Signature

Revision 11/1/2021
CONTROLLING PERSON AUTHORIZATION FOR RELEASE OF INFORMATION

PROFESSIONAL EMPLOYER ORGANIZATION (PEO)

(A separate form must be completed for each controlling person)

I, _____________________________, hereby authorize all persons, institutions, organizations, schools, governmental agencies (including criminal justice agencies and tax authorities), employers, references, or any others not specifically included in the preceding characterization, which are set forth directly or by reference in the Applicant/Controlling Person questionnaire, to release to the State of Montana, Department of Labor and Industry, Employment Relations Division (“the Division”), and its employees, agents and attorneys, any files, records or information of any type reasonably required for the Division to properly evaluate my eminence in regard to the application for licensure as a Professional Employer Organization by the State of Montana.

A copy of this authorization may be used with the same effect as the original.

_________________ ________________________________
Date Printed name and Signature

Date of Birth ______________

Social Security Number: __________________
STATE OF MONTANA, DEPARTMENT OF LABOR AND INDUSTRY
PROFESSIONAL EMPLOYER ORGANIZATION (PEO)

CHARACTER REFERENCE AFFIDAVIT

STATE OF ___________________) : SS
COUNTY OF _________________)

______________________________________, being first duly sworn says:

1. That I have known _________________________________________ (printed name of applicant/controlling person) for at least three years and know that he/she is of good moral character and has a reputation for honesty and fair dealing.
2. That I am not related by blood or marriage to the person named in paragraph 1.
3. That I am not a controlling person in the Professional Employer Organization for which this character reference relates.

By:__________________________________________
   (signature of affiant)

SUBSCRIBED AND SWORN to before me this _____ day of _________________, 20____.

______________________________
(Seal)
Notary Public for the
State of_________________________
Residing at_________________________
My commission expires _______________
PEO OWNERSHIP INFORMATION
(reference 39-8-202 (4)(a-d) MCA)

Provide information for all owners, partners, corporate officers, shareholders with greater than 5% interest, and limited liability company individuals who have a 5% or greater interest in the company.

<table>
<thead>
<tr>
<th>NAME</th>
<th>HOME ADDRESS (PO BOX NOT ACCEPTABLE)</th>
<th>FEIN or SOCIAL SECURITY NUMBER</th>
<th>AGE</th>
<th>TITLE</th>
<th>% OF VOTING INTEREST</th>
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BUSINESS OPERATIONAL HISTORY
(reference 39-8-202 (5)(a) MCA)

List by jurisdiction of each name under which the applicant has operated in the preceding 5 years, including any alternative names, names of predecessors, and names of related business entities with common majority ownership.

________________________________________________________________________
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________________________________________________________________________
APPLICANT AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize all persons, institutions, organizations, schools, governmental agencies (including criminal justice agencies and tax authorities), employers, references, or any others not specifically included in the preceding characterization, which are set forth directly or by reference in this license application, to release to the State of Montana, Department of Labor and Industry, Employment Relations Division (“the Division”), and its employees, agents and attorneys, any files, records or information of any type reasonably required for the Division to properly evaluate the applicant’s qualifications for licensure as a Professional Employer Organization by the State of Montana.

__________   By: ________________________________

____________________________________________
Name of Applicant: ______________________________

Applicant’s FEIN or Social Security Number: ______________________________

Date                  Printed Name, Signature and Title

Revision 11/1/2021
PROFESSIONAL EMPLOYER ORGANIZATION GROUP GUARANTEE FORM

Pursuant to the provisions of the Montana Professional Employer Organizations and Groups Licensing Act, the undersigned, hereby: 1) unconditionally guarantee and promise to pay any and all financial obligations of each entity of the group with respect to wages, payroll-related taxes, insurance premiums, and employee benefits; 2) authorize any entity of the group to act on behalf of the group; and 3) guarantee that each PEO within the group is majority-owned by the same person.

Guaranteeing Entity to include FEIN:
________________________________________________________

Signature of certifying Controlling Person

Printed Name of certifying Controlling Person

State of _______________________________
County of _______________________________
Before me, personally appeared __________________________ (controlling person of____________________), whose identity is known to me by __________________________ (type of identification) and who, under oath, acknowledge their signature appears above. Sworn and subscribed before me this day of __________, 20__.

(Seal)
Notary Public
My Commission Expires:

(1) First entity name and FEIN:__________________________________________________________
(2) Second entity name and FEIN:________________________________________________________
(3) Third entity name and FEIN:__________________________________________________________
(4) Fourth entity name and FEIN:_________________________________________________________
(5) Fifth entity name and FEIN:___________________________________________________________