State of Rhode Island and Providence Plantations
Department of Labor & Training
Workers' Compensation Self-Insurance Unit
P.O. Box 20190
Cranston, RI 02920-0942
Telephone: (401) 462-8100
Fax: (401) 462-8095

INDEMNITY AGREEMENT BY THE PARENT CORPORATION FOR WHOLLY OWNED SUBSIDIARY OR IF APPLICABLE PARTIALLY OWNED OR CONTROLLED AFFILIATE

KNOWN ALL MEN BY THESE PRESENT, that _____
(Parent Corporation)
a corporation, organized and existing under and by virtue of the laws of the State of _____ (or Province of _____ or other _____) for and under the Workers' Compensation Acts of the State of Rhode Island, and in the event that said _____ shall not pay or cause to be paid direct to its' employees monies due such employees under the Workers' Compensation Laws of the State of Rhode Island, then said employees are hereby empowered and authorized to maintain direct action on this agreement against the parent corporation and that the parent corporation does recognize this agreement as a direct financial guarantee to said employees or the dependents of a deceased employee; that the parent corporation shall have a right to cancel and terminate this agreement at any time upon giving the name subsidiary and the State of Rhode Island at least **SIXTY (60) DAYS** written notice of its' intent to cancel. Such cancellation shall not affect its' liability as to any compensation for injuries occurring prior to **TEN (10) DAYS** after the date of cancellation specified in such notice.

PROVIDED HOWEVER, that upon cancellation of this indemnity agreement the self-insurance status heretofore given to the named subsidiary by the State of Rhode Island approval of which was expressly conditioned on the continued existence of this indemnity agreement, shall terminate upon the effective date of any cancellation hereof.

This agreement shall be effective as of _____, _____.

Executed at _____ this _____ day of _____, _____.

FOR PARENT CORPORATION: WITNESS:

_____ _____

_____
PRINTED NAME TITLE

(SEAL)