Form 109 (127E) Date submitted _____

STATE OF UTAH

UTAH LABOR COMMISSION

DIVISION OF INDUSTRIAL ACCIDENTS

APPLICATION FOR SELF INSURANCE

Name: _____ FEIN# _____
Applicant Organization Name

hereby applies for the privilege of being a self-insurer under the Utah Workers' Compensation Act and submits the following report in support of said application.

1. Address of principal office: _____
2. Applicant is Individual, Co-partnership, Ltd. Partnership, Corporation, or Public Authority: _____

3. Applicant's General Officers (if Corporation)

	Name	Address	Phone Number
President:	_____	_____	_____
Vice President:	_____	_____	_____
Secretary:	_____	_____	_____
Treasurer:	_____	_____	_____

4. Applicant's business chartered under laws of state of _____ Date _____
5. Person responsible for self-insurance program: Name _____

Send Correspondence to: Name _____ Phone #: _____

Address: _____ Fax #: _____

Email: _____

6. Service Company Information (TO BE FILLED OUT IF SERVICE COMPANY IS USED. IF NOT, PROCEED TO #7)

(a) Loss Prevention Services:

(l) Name of Service Company: _____

(2) Address: _____

(3) Telephone Number: _____

(4) Contact Person: _____ Email: _____

(5) Give details of services that will be furnished by service company (add an attachment if more space is needed): _____

(b) Claims Handling Services (Third Party Administrator/ Adjusting Company):

(1) Name of Service Company:

(2) Address:

(3) Telephone Number:

(4) Contact Person: Email:

(5) Give details of kinds of services that will be furnished by the service company:

(c) If the TPA and /or claims adjuster is not located in Utah, who is their Designated Agent?
Address: Phone: Email:

Do the preceding (a) and (b) have a working knowledge of the **Utah** Workers' Compensation Act and Rules? Yes No. (Include curriculum vitae)

7. IF AN ADJUSTING COMPANY IS NOT TO BE USED, COMPLETE THE FOLLOWING:

(a) Name, title, address, and telephone number of person responsible for authorizing payments of temporary total disability benefits:

Is the same person responsible for permanent partial disability benefits?
Yes No (If not, provide above information on that person).

(b). Additional Benefits:

1. Do workers receive full pay when off because of an industrial accident? Yes____ No____.

2. Does the company tax all of that pay? Yes____ No____. (Workers' compensation is **not** taxable)

3. Does the employee have the option of receiving enough of either sick leave or vacation benefits to make up the difference between compensation and full pay? Yes____ No____.

4. Does the company provide long term disability insurance or any other supplementary? benefits to injured employees, in addition to workers' compensation insurance? Yes____ No____. If so, does the employee pay any premium on that long term disability? or other compensation insurance? Yes____ No_____

5. When additional benefits are paid, above the workers' compensation benefits, during the period of temporary total disability, does the company consider those to be a credit against any possible permanent partial impairment settlement? Yes____ No____
If so, is the employee made aware of that at the time of his/her injury? Yes____ No____
(If written notice is given, please enclose an example.)

6. Do the group health policies, life insurance, accident insurance, etc. continue in force during the period of disability? Yes____ No____ if so, does the employee make direct payments of premiums? Yes ____ No____
Is the employee given instructions about this at the time of injury? Yes____ No____
(If written instructions given, please enclose a sample.)

(c). Reporting:

1. Are employees told that they must report all accidents within a certain period of time? Yes____ No____ If so, what is time limit? _____. If notices are posted regarding such, indicate where and enclose a sample. _____
If written notice provided at time of employment, please enclose sample.

2. Are the Employer's First Report of Accident forms filled out at the time of reporting by the person to whom the report is made or does a central office handle that?
Is every accident or injury reported to an agent of the company reported to the Commission? Yes____ No____ If not, why?

_____

3. Does your company have a nurse and/or physician on the premises Yes____ No
or do you have a company physician and/or company approved treatment facility?
(Yes____ No____) If so, give name(s), address(es), and phone number(s).

_____

_____

_____

If the above question is answered in the affirmative, does that nurse and/or physician file their reports directly with the Commission with a copy to the company or are their reports filed directly through the company? Direct_____ Through Company _____ If filed through the company, why?

_____

_____

8. Safety Program

(a) Person in charge_____
(Attach additional sheets if necessary for details)

(b) Please furnish a copy of the engineering report which gives a description of the risk's operations from raw material received to finished product and engineer's evaluation of the safety program.

(c) When were premises last inspected?_____

Inspecting Agency:_____

9. Medical and Hospital Care

(a) Do you employ a full _____ or Part-Time _____ doctor: Yes _____ No_____

Name/Address_____

(b) Name and address of physician to whom injured are normally sent:_____

_____

(c) Do you have a hospital in the plant? Yes _____ No_____

First Aid Room? Yes _____ No_____

Professional Nurse on Premises? Yes _____ No_____

10. Loss History (5 years)

Liability Period From	To	Gross Payroll	Total Losses	Paid Losses	Reserves	Natl.Council on Compensation Experience Modification

11. Give the following information regarding the State of Utah: (if more space is needed, use separate page.) **NOTE**: If not available, please indicate why, and if a similar method is used.

W.C. Code No.	Classification	Number of Employees	Estimated Gross Payroll	Current Manual Rates	Manual Premium

Total Number of employees in Utah _____ Total Estimated Manual Premium _____

Excess Insurers' Experience Modification _____ Standard Premium _____

12. Do you have any owned, leased* or chartered aircraft? Yes____ No____
Does your excess policy cover this additional exposure? Yes____ No____

*Leased aircraft: One that is not owned by the applicant and made available for the use of the applicant under the terms of a rental or lease agreement for a period of not less than thirty (30) consecutive days, and operated by someone other than an employee of the owner or lessor of such aircraft.

13. In what states or jurisdictions does or will this applicant operate as a qualified self-insurer? _____

14. If you have ever been denied a self-insurance permit or renewal of self-insurance in any state, please indicate the name of the state and why you were not accepted or renewed. (Use separate sheet if necessary.)

15. Give the following totals for the most recent year prior experience information for each state where qualified as a self-insured entity. (Use additional sheet if necessary and identify as an attachment.) If unavailable on a state by state basis, combined totals can be given.

State :	Dates From	Dates To	Total Avg. # of Employees	Total Gross Payroll	Indemnity Paid	Medical Paid	Total* Indemnity Unpaid (Reserves)	Total* Medical Unpaid (Reserves)

*For all previous years for payment in future by Self insured and not by insurance carrier.

16. Indicate net profit or loss after taxes for the last five years:

Year	Amount
20XX	$_____
20XX	$_____
20XX	$_____
20XX	$_____
20XX	$_____

17. Please give the following information about each Utah death, disability, or disease claim in the past five (5) years with costs in excess of $25,000. (Use a separate page for full details)

Date of Loss	Number of Employees Involved	Facts of Loss, Type Injury or Disease & State Benefits Applicable	Total Estimated Cost Indemnity Paid	Medical Paid	Total Unpaid

18. Do employees receive any supplemental benefits in addition to workers' compensation benefits?_____
If yes, describe_____

19. Are there any actual or anticipated Occupational Disease exposures involved in Applicant's operations? _____ If yes, describe_____

20. Please furnish information on any substantial or unusual changes (increase or decrease) in operation in Utah that are planned or that have taken place in the last five (5) years. (Use additional sheet and identify as an attachment.)

21. If the employer is rated by Standard & Poor or Dun & Bradstreet, what are the latest ratings?

Standard & Poor_____ Dun & Bradstreet_____ Other_____

Form 109
(127E)

22. PARENT(S), AFFILIATES AND SUBSIDIARIES OF APPLICANT:

-List parents of Applicant in hierarchical order, beginning with ultimate parent company regardless of Utah operation.

-List all affiliates and subsidiaries of Applicant that are operational within Utah.

-List % of voting stock by each corporation's direct parent, and show whether the corporation is a parent, subsidiary, or division of the applicant.

-List the UI number (Utah Identification number) for each company

-List the FTID number (Federal Tax Identification number) for each company

Legal Name of Corporation	Address of all UT Locations	Sub or Div (%) or--	UI#	FTID#
Top Parent				

Form 109
(127)

23. APPLICANT DIVISIONS AND OPERATION: Year

-List each Utah operation of the Applicant (Do not list excess insurance on this chart.)

Name of Operating Unit and Location (Include Street Address)	Operation Type Main Products, Services, Activities	Utah Employees Ave. No.	Utah Employees Gross Payroll	Utah Employees Total Hours	No. Cases Entered on OSHA 200 log	**To Be Self-Ins. Yes	**To Be Self-Ins. No
TOTALS							

** If answer is no, list: 1) Full name of insurance company

2) Policy number_____, and 3) policy end date
If no, does this unit have separate employees & payrolls? Yes_____ No

24 . EXCESS INSURANCE:

-List all excess policies that cover Utah Workers' Compensation Insurance (Check which type of excess in force)

Coverage Type: Specific _____ Aggregate_____ Other

Insurance Company (Full Name)	Retention	Statutory Limit Required	Policy No	Policy Period From	Policy Period To
	$				
	$				

Form 109
(127)

25. OUTSTANDING WORKERS' COMPENSATION CLAIMS: As of _____ (Date)

-For ALL Utah self-insured claims not fully paid. (Enter Total amounts **Paid/To Be Paid** under Utah Workers' Compensation Act)

	ACTIVE OPEN CLAIMS	*ANTICIPATED CLAIMS
Total Number of Claims		
Medical Reserve to be Paid in the Future		
Indemnity Reserve to be Paid in the Future		
Medical Paid to Date		
Indemnity Paid to Date		
Total All COLUMNS :_____		

*Incurred, but not reported

26. ADDITIONAL CLAIMS INFORMATION:

(a) During the most recent calendar year, which was _____, there were _____ accidents reported. (Number)

(b) We paid a total of $_____ in Workers' Compensation indemnity payments in Utah.

(c) In addition, the total amount paid for medical benefits during the calendar year for all accidents in Utah amount to $_____.

(d) **Total of all which includes: Weekly compensation payments, travel and per diem for medical examination and/or treatment, lump sum payments, compromise settlements, hospital, appliance, and medical payments, and death and funeral benefits paid during said period were $_____.

** (b) and (c) to be included

Form 109
(127E)

27. COMPARATIVE STATEMENT OF FINANCIAL DATA FOR LAST THREE FISCAL YEARS

Include with this application a copy of the consolidated annual report to the stockholders for the most recent year of data, or if not available, the Form l0-K prepared for the Securities Exchange Commission. Also send the same for parent company (if applicable). If such reports are not printed, send the most recent year's report of an audit prepared by a certified public accountant, for Utah, or federal regulatory agency.

Instructions: Reflect three years of financial data, including the most recently completed business year and the two years before it. If applicant is a subsidiary corporation, use that financial data if available separately. If not available separately, enter the consolidated financial information of the immediate parent that includes the financial information of the applicant.

Name the company whose financial information is being presented:
Check (X) one: ☐ Actual dollar amounts are shown. ☐ 000's are omitted. ☐ 000,000's are omitted.

FISCAL YEAR ENDING	Most recent year . Year 20	. Year 20	. Year 20
INCOME/EARNINGS (Enclose losses in brackets: [ ].)			
(a) Net sales & other revenues, before extraordinary items			
(1) Cost of sales & products sold, before depreciation.			
(2) Other operating expenses including depreciation,			
but before interest & income taxes.			
(b) Net operating income: Equals (a) - (l) - (2).			
(c) Net income, after income taxes.			
SHAREHOLDERS' EQUITY/TANGIBLE NET WORTH			
(d) Shareholders' equity/tangible net worth:			
(total assets minus all liabilities).			
(l) Retained earnings.			
(2) Liquidation value of preferred stock.			
(e) No. of shares of common stock issued and outstanding.			
(f) Dividends on preferred stock.			
WORKING CAPITAL			
(g) Current Assets minus Current Liabilities.	.	.	.

Form 109
(127E)

Using the Information from the previous page and from the Annual Report, compute the following ratios:

Items	Most Recent Ratio .Year 20 (0.00)	. Ratio Year 20 (0.00)	. Ratio Year20 (0.00)
Current Ratio =			
Current Assets			
Current Liabilities			
Liquidity (Quick Ratio) =			
Quick current assets			
Current Liabilities			
Cash Flow =			
Funds from Operations			
Current Liabilities			
Inventories to Net Working Capital =			
Inventories			
Current Assets -			
Current Liabilities			
Net Income to Net Sales =			
Net Income			
Net Sales			
Working Capital Turnover =			
Net Sales to			
Net Working Capital			
Net Income to Equity =			
Net Income			
Equity			
Fixed Assets to Tangible Net Worth =			
Fixed Assets			
Shareholders Equity			

Form 109E
(127E)

AGREEMENT AND STIPULATIONS

Employer must agree to the conditions and stipulations below to qualify for self-insurer privileges. This statement must be signed by an appropriate official (or city or county official) and have applicant's corporate seal affixed before self-insurer privileges will be considered.

28. In consideration of the privilege of being a self-insurer in the State of Utah, I hereby agree:

a. That I will discharge my liability for compensation to injured employees or their dependents in accordance with the requirements of the Workers' Compensation Act of the State of Utah.

b. That I will not solicit, receive or collect any money from my employees or make any reduction from their wages and/or commissions for the purpose of discharging any part of my liability under the Act.

c. That I will promptly furnish all reports to the Utah Division of Industrial Accidents which it may lawfully require under the Utah Workers' Compensation Act and the Rules and Regulations of the Labor Commission of the State of Utah.

d. To notify the Division of Industrial Accidents in any case of contemplated liquidation, sale or transfer of ownership, or material reduction in Utah operation. Subject to the Division of Industrial Accidents approval, I will arrange for the payment of all existing liability and any liability arising thereafter for which I may become legally liable, by a surety bond, an irrevocable letter of credit, etc. as required by the Division of Industrial Accidents.

e. That I will notify the Division of Industrial Accidents for approval prior to any changes made to the excess insurance policy, self-insured retention or policy limits, and it is agreed that any proposed changes will be justified in narrative form prior to the inception of the policy or date of renewal.

f. That I will notify the Division of Industrial Accidents at least twenty (20) days in advance of any change in excess insurance carrier, and that I am familiar with the insurance laws in Utah regarding the placement of excess insurance in the admitted and non-admitted excess insurance market. Also, I am aware of the hazards of having excess workers' compensation coverage with a non-admitted insurance carrier.

g. To let the Division of Industrial Accidents know about any change in the kind or amount of services to be performed by the service company, if a company is used.

h. That I will promptly notify the Division of Industrial Accidents of any unfavorable turn in my financial condition which might reasonably reduce my ability to carry my own risk under the Utah Workers' Compensation Act.

Form 109E
(127E)

i. That the Form 40, Posting Notice, will be displayed in conspicuous places, such as employee bulletin boards as required by the Utah Workers' Compensation Law. (These notices are available at no charge from the Division of Industrial Accidents.)

j. That in case of insolvency I shall make our records available to the Division of Industrial Accidents. I will also disclose our inability to pay the injured employee.
I hereby agree to all other requirements contained in the Utah Workers' Compensation and Occupational Disease Act.

k. That I recognize that this self-insurer permit can be canceled at any time for failure to comply with the requirements set out herein.

Name of Corporation (or City or County govt.)

Signature & title of Company Official or County Entity

Typed Name

The entire contents of this application are certified to be correct to the best of my knowledge, information and belief, by the undersigned this _____ day of _____ , 20_____ .

By:_____
Signature

Printed Name of Person Filing this Form

Address:_____

Phone

Subscribed and sworn to before me this

_____ day of _____, 20___

(Notary Public)

My commission expires