



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:

- (1) 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	Gross	Total	Paid		Natl. Council
From	To	Payroll	Losses	Losses	on Compensation
				Reserves	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.

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

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.)

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		Total Unpaid
			Indemnity Paid	Medical Paid	

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 _____

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
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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

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 10-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
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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) - (1) - (2).

(c) Net income, after income taxes.

SHAREHOLDERS' EQUITY/TANGIBLE NET WORTH

(d) Shareholders' equity/tangible net worth:

(total assets minus all liabilities).

(1) 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. _____

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)
<u>Current Assets</u>	_____	_____	
Current Liabilities			
<u>Liquidity (Quick Ratio) =</u>			
<u>Quick current assets</u>	_____	_____	
Current Liabilities			
<u>Cash Flow =</u>			
<u>Funds from Operations</u>	_____	_____	
Current Liabilities			
<u>Inventories to Net Working Capital =</u>			
<u>Inventories</u>	_____	_____	
Current Assets - Current Liabilities			
<u>Net Income to Net Sales =</u>			
<u>Net Income</u>	_____	_____	
Net Sales			
<u>Working Capital Turnover =</u>			
<u>Net Sales to</u>	_____	_____	
Net Working Capital			
<u>Net Income to Equity =</u>			
<u>Net Income</u>	_____	_____	
Equity			
<u>Fixed Assets to Tangible Net Worth =</u>			
<u>Fixed Assets</u>	_____	_____	
Shareholders Equity			

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.

- 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