APPLICATION FOR SELF-INSURANCE

By submitting this application the organization listed below 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.

Organization Name:	FEIN:	Date of Filing:	
Organization Principle Address:	City:	State:	Zip Code:
Applicant is: Individual ☐	Co-partnership ☐	Ltd. Partnership ☐	Corporation ☐
Public Authority Yes ☐ No ☐ If yes please give the name:			

Organization's General Officers (if corporation)			
President Name:	Phone:		
President Address:	City:	State:	Zip Code:
Vice President Name:	Phone:		
Vice President Address:	City:	State:	Zip Code:
Secretary Name:	Phone:		
Secretary Address:	City:	State:	Zip Code:
Treasurer Name:	Phone:		
Treasurer Address:	City:	State:	Zip Code:

List the state law that the organization's business is chartered under:	Date:

Person Responsible for Self-Insurance Program:			
Address:	City:	State:	Zip Code:
Phone:	Fax:	Email:	

Will you be using a Loss Prevention Service? Yes ☐ No ☐ If no please continue to the next section.			
Name of Service Company:	Contact Name:		
Address:	City:	State:	Zip Code:
Phone:	Fax:	Email:	
List in detail what services will be provided by this company:			

Will you be using a Third Party Administrator? Yes ☐ No ☐ If yes please complete the following section.			
Name of TPA:	Contact Name		
TPA Address:	City:	State:	Zip Code:
Phone:	Fax:	Email:	
List in detail what services will be provided by this company:			
If the TPA and/or claims adjuster is not located in Utah, who is their Designated Agent?			
Agent Address:	City:	State:	Zip Code:
Phone:	Fax:	Email:	
FROI Contact:	Phone:	Email:	
Do the preceding companies have a working knowledge of the Utah Workers' Compensation Act and Rules? Yes ☐ No ☐ (Please include curriculum vitae)			

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The following section is for those who will not be using Loss Prevention or Third Party Administrators.

TEMPORARY TOTAL DISABILITY BENEFITS

Contact Name:		Title:		
Address:		City:	State:	Zip Code:
Phone:	Fax:		Email:	

Is the same person responsible for Permanent Partial Disability Benefits? Yes ☐ No ☐ If no complete the following:

Contact Name:		Title:		
Address:		City:	State:	Zip Code:
Phone:	Fax:		Email:	

ADDITIONAL BENEFITS

Question	Answer
Do workers receive full pay when work time is missed as a result of an industrial accident?	Yes ☐ No ☐
Does the company tax the indemnity benefit? (Workers' Compensation is not taxable)	Yes ☐ No ☐
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 ☐
Does the company provide long term disability insurance or any other supplementary benefits to injured workers?	Yes ☐ No ☐
If so, does that employee pay any premium on that long term disability or other compensation insurance?	Yes ☐ No ☐
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, does the employee make direct payments of premiums? (If written notice is given please enclose an example)	Yes ☐ No ☐
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 (If written instructions are given, please enclose an example).	Yes ☐ No ☐

REPORTING

Are employees told that they must report all accidents within a certain period of time? Yes ☐ No ☐

If so what is the time limit? _____________

If notices are posted indicate where and enclose an example.

If written notice is provided at time of employment, enclose an example.

Continued on next page

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Are the Employer's First Report of Injury or Illness forms filled out at the time of reporting by the person to whom the report is made or does a central office handle it? Yes ☐ No ☐

Is every accident or injury that is reported to an agent of the company also reported to the Labor Commission? Yes ☐ No ☐
If not, why? ______________________________________

Does your company have a nurse and/or physician on the premises? Yes ☐ No ☐

If so provide: Name: Phone:
Address: City: State: Zip Code:

Does that nurse and/or physician file their reports directly with the Labor Commission and a copy to the company or are their reports filed through the company? Direct ☐ Through Company ☐
If yes, why? ______________________________________

SAFETY PROGRAM

Contact Name: Title:
Address: City: State: Zip Code:
Phone: Fax: Email:

Please provide a copy of the engineering report. Which includes a description of the risks operations from raw material received to finished product and engineer's evaluation of the safety program.

Date of Last Inspection: Inspecting Agency:

MEDICAL AND HOSPITAL CARE

Do you employ a full or part-time doctor? Yes ☐ No ☐
Full-Time ☐ Part-Time ☐

Doctor Name: Title
Address: City: State: Zip Code:
Phone: Fax: Email:

Do you have a hospital on-site? Yes ☐ No ☐
First Aid Room? Yes ☐ No ☐
Registered Nurse or Nurse Practitioner? Yes ☐ No ☐

LOSS HISTORY (5 YEARS)

Liability Period	Gross Payroll	Total Losses	Paid Losses	Reserves

National Council on Compensation Experience Modification (EMOD):

APPLICATION FOR SELF-INSURANCE

STATE OF UTAH INFORMATION

W.C. Code Number	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:

Do you own, lease, or charter aircraft? Yes ☐ No ☐

Does your excess policy cover this? Yes ☐ No ☐

*Leased aircraft means 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.

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

Have you ever been denied for a self-insurance permit or renewal? Yes ☐ No ☐ if so please provide the following:

State of Denial	Reason for Denial (If needed, use an additional sheet)

Using the prior years' experience give the following totals information for each state where qualified as a self-insured entity. If this information is unavailable on a state by state basis, you may use combined totals. (If needed, use an additional sheet).

State	Period	Average Number of Employees	Gross Payroll	Indemnity Paid	Medical Paid	Indemnity Unpaid (Reserves)*	Medical Unpaid (Reserves)*

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

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

Year	Amount

List the following information about each Utah death, disability, or disease claim in the past five (5) years that costs were in excess of $25,000. (If needed, use an additional sheet).

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

Do employees receive any supplemental benefits in addition to Workers' Compensation Benefits? Yes ☐ No ☐

If yes, describe them:

Are there any actual or anticipated Occupational Disease exposures involved in the applicant's operations? Yes ☐ No ☐

If yes, describe them:

Please provide information on substantial or unusual changes (increase or decrease) in Utah operations that are planned or that have taken place in the last five (5) years. (If needed, use an additional sheet).

If the employer is rated by Standard & Poor or Dun 7 Bradstreet, what are the most recent ratings?

Standard & Poor:	Dun & Bradstreet:	Other:

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PARENT COMPANIES, AFFILIATES, AND SUBSIDIARIES OF APPLICANT

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

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

List the percent of voting stock by each corporation's direct parent. Show whether the corporation is a parent, subsidiary, or division of the applicant.

List the Utah Identification Number (UIN) for each company.

List the Federal Entity Identification Number (FEIN) for each company.

(If needed, use an additional sheet).

Legal Name of Corporation	FEIN	UIN	Address of all Utah Locations	Subsidiary or Division	Percent of Voting

APPLICATION FOR SELF-INSURANCE

APPLICANT DIVISIONS AND OPERATION

List each Utah operation of the Applicant. Do not include excess insurance on this chart.

Name and Address of Operating Unit	Operation Type Main Products Services Activities	Average Number of Employees	Gross Payroll	Total Hours	Number of Cases on OSHA 200 Log	** To be Self-Insured?
						Yes ☐ No ☐
						Yes ☐ No ☐
						Yes ☐ No ☐
						Yes ☐ No ☐
						Yes ☐ No ☐
						Yes ☐ No ☐
						Yes ☐ No ☐
						Yes ☐ No ☐
						Yes ☐ No ☐
						Yes ☐ No ☐
Totals:						

** If no, please provide the following:

Full Legal Name of Insurance Company	Policy Number	Policy Period

Does this unit have separate employees and payroll? Yes ☐ No ☐

EXCESS INSURANCE

List all excess policies that cover Utah Workers' Compensation Insurance.

Coverage Type: Specific ☐ Aggregate ☐ Other ☐

Insurance Company	Retention	Statutory Limit Required	Policy Number	Policy Period
	$			
	$			
	$			
	$			

UTAH
LABOR COMMISSION
Industrial Accidents Division

APPLICATION FOR SELF-INSURANCE

OUTSTANDING WORKERS' COMPENSATION CLAIMS

Please list all Utah self-insured claims not paid in full.

Enter total amounts that are either paid or to be paid under the Utah Workers' Compensation Act.

	Total Number of Claims	Medical Reserve	Indemnity Reserve	Medical Paid to Date	Indemnity Paid to Date	Total
Active Claims						
Anticipated Claims						

Anticipated claims are Incurred, but not reported.

ADDITIONAL CLAIMS INFORMATION

Using data from the most recent calendar year complete the following questions. Calendar Year_____________

How many accidents were reported in the most recent calendar year?	$_____________
What was the total amount paid in medical benefits?	$_____________
What was the total amount paid in indemnity benefits?	$_____________
What was the total amount paid in all benefit types? (Include indemnity and medical)	$_____________

COMPARATIVE STATEMENT OF FINANCIAL DATA

Please provide copies of consolidated annual reports to the stockholders for the last three years and the most recent year of data. If they are not available the Form 10-K prepared for Securities Exchange Commission is acceptable. Include the same materials for the parent company if applicable. You may also send the most recent year's report of an audit that was prepared by a certified public accountant, for Utah, or federal regulatory agency, if the material above is unavailable.

Complete the table below using financial data from the last three years. This includes the most recently completed business year and the two years before it. If the Applicant is a subsidiary corporation, use that financial data if it is available separately. If not, enter the consolidated financial information of the immediate parent company that includes the financial information of the Applicant.

Name of company whose financial information is being presented:

Actual Dollar Amounts are Shown ☐ 000's Omitted ☐ 000,000's Omitted ☐

Income / Earnings			
Fiscal Year			
A. Net Sales & Other Revenue (before extraordinary items)	$_____________	$_____________	$_____________
1. Cost of Sales & Products Sold (before depreciation)	$_____________	$_____________	$_____________
2. Other Operating Expenses (including depreciation but exclude interest & income taxes)	$_____________	$_____________	$_____________
B. Net Operating Income (A – 1 – 2)	$_____________	$_____________	$_____________
C. Net Income (after income taxes)	$_____________	$_____________	$_____________
SHAREHOLER'S EQUITY / TANGIBLE NET WORTH			
Year			
D. Shareholder's Equity / Tangible Net Worth (total assets minus liabilities)	$_____________	$_____________	$_____________
1. Retained Earnings	$_____________	$_____________	$_____________
2. Liquidation Value of Preferred Stock	$_____________	$_____________	$_____________
E. Number of Common Stock Shares (Issued & Outstanding)	$_____________	$_____________	$_____________
F. Dividends on Preferred Stock	$_____________	$_____________	$_____________
G. Current Assets minus Current Liabilities	$_____________	$_____________	$_____________

Using information from the previous page and your annual report, compute the following ratios.

Year			
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 minus Current Liabilities)			
Net Income to Net Sales (Net Income / Net Sales)			
Working Capital Turnover (Net Sales / Net Working Capital)			
Net Income to Equity (Net Income / Equity)			
Fixed Assets to Tangible Net Worth (Fixed Assets / Shareholders Equity)			

PLEASE CONTINUE TO THE NEXT PAGE FOR THE AGREEMENT AND STIPULATIONS.

APPLICATION FOR SELF-INSURANCE

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.

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

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

C. 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. 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. 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. I will notify the Division of Industrial Accidents of 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 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. 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. 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.

K. I hereby agree to all other requirements contained in the Utah Workers' Compensation and Occupational Disease Act.

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

I agree to the conditions and stipulations as well as certify that the entire contents of this application are correct to the best of my knowledge, information, and belief, by the undersigned on this __________ day of _______________, 20___.

Signature of Organization Official

____

Printed Name of Organization Official

____

Title

____

Name of Organization

____

Address

____

Phone

____

Subscribed and sworn to before me on this _______ day of ____________________, 20___.

____

(Notary Public Signature)

My commission expires______________________

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