

Application for Self-Insurance

Read all instructions before completing this application. Answer all questions.

Return this form to: Oregon Department of Consumer and Business Services
Workers' Compensation Division
350 Winter St. NE
P.O. Box 14480
Salem, OR 97309-0405

Applicant's legal name, mailing address, and corporate website address:

Desired self-insurance effective date:

The employer (applicant) applies for certification as a self-insured employer in the state of Oregon, as provided in Oregon workers' compensation law. An applicant may not operate as a certified self-insured employer until the division issues a *Certificate of Approval to Self-Insure*.

1. List the company representative for self-insurance:

Name: _____ Title: _____
Company name: _____
Street address: _____
City, state, ZIP: _____
Telephone: _____ Fax: _____ Email: _____

2. Corporate status:

☐ Individual ☐ Partnership
☐ Corporation ☐ LLC

Federal employer identification number (FEIN): _____

3. Nature of business:

a. Primary National Council on Compensation Insurance (NCCI) classification codes with greatest payroll in Oregon:
(NCCI codes may be found on your recent workers' compensation insurance policy – NCCI webpage: www.ncci.com):

b. Total number of employees in Oregon: _____

Attachment Required – see Page 5, Item A.

4. Incorporated or organized under the laws of the state of: _____ on _____

5. Date of start of business in Oregon: _____

6. If the applicant is a subsidiary, complete the following items:

Exact legal name of ultimate parent: _____

Date parent incorporated: _____ State: _____ FEIN: _____

If applicant is subsidiary, include a completed Form 4966 – Indemnity Agreement by the Parent Corporation for Wholly Owned or Majority Owned Subsidiary. Attachment required – see Page 5, Item B.

7. List the corporate officers for the ultimate parent or applicant if no parent (CEO, CFO, and/or Risk Manager):		
Officer name: _____	Telephone: _____	Email: _____
Officer name: _____	Telephone: _____	Email: _____
Officer name: _____	Telephone: _____	Email: _____
Attachment required – organizational chart, <i>see Page 5, Item C.</i>		
8. List the subsidiaries or legal entities to be included in the self-insurance program:		
Legal name: _____		
Legal name: _____		
Legal name: _____		
Complete <u>Form 1865</u> , <i>Endorsement to Include Legal Entity in Self-Insured Certification</i> , for each subsidiary to be added (if necessary, attach a list). Attachment required – <i>see Page 5, Item D.</i>		
9. Provide the following claims information for your proposed self-insured operations in Oregon:		
Attachment required – Detailed Loss Runs for the past three years, <i>see Page 5, Item E.</i>		
a. List the person responsible for submission of claim reports to the department and maintenance of all claim records (must be an employee of the applicant):		
Name: _____	Title: _____	
Telephone: _____	Email: _____	
b. List the name of the proposed service company (third-party administrator) to process claims in Oregon: [Must be a claims service company that has been authorized by the Department of Consumer Business Services (DCBS). Oregon law does not allow captive insurance companies to provide workers' compensation insurance or process claims in Oregon.]		
Company name: _____		
Contact person: _____		
Address: _____		
City, state, ZIP: _____		
Telephone: _____	Fax: _____	
Email: _____		
<i>Up to two additional locations within Oregon may be approved for claims processing. A written request to the division is required. Attach additional pages if more than one company.</i> Attachment required – <i>see Page 5, Item F.</i>		
c. If choosing to self-administer claims, list the Oregon certified claims examiner (must be an employee of the applicant and must include a copy of the Oregon Claims Examiner Certificate).		
Name: _____	Title: _____	
Email: _____	Fax: _____	
Telephone: _____		
Attachment required – <i>see Page 5, Item G.</i>		
d. If approved by the Workers' Compensation Division to self-administer claims at a location outside of Oregon, list the address where the records will be kept and the claims will be processed.		
Claims location address: _____		
10. Provide most recent experience rating modification (ERM) worksheet and supporting documentation.		
Most recent ERM: _____		
Attachment required – ERM worksheet, <i>see Page 5, Item H.</i>		

11. List person responsible for submitting quarterly payroll reports for the Workers' Benefit Fund assessment/premium assessment (must be an employee of the applicant):

Name: _____

Title: _____

Telephone: _____

Fax: _____

Email: _____

12. List person responsible for submitting required annual financial statements to the division (must be an employee of the applicant):

Name: _____

Title: _____

Telephone: _____

Fax: _____

Email: _____

Attachment required – Certified Audited Financial Statement for the past three years, *see Page 5, Item I*

13. List person responsible for submitting required documents pertaining to the applicant's security deposit [surety bond or irrevocable standby letter of credit (ISLOC)], and excess insurance requirements (must be an employee of the applicant):

Name: _____

Title: _____

Telephone: _____

Fax: _____

Email: _____

Attachment required – [Form 4965](#), Exemption Provision Waiver, *see Page 5, Item J*.

14. List name of the current workers' compensation insurance carrier:

Name: _____

Policy no.: _____

Effective dates: _____ to _____

Attachment required – Declaration page from your workers' compensation policy, *see Page 5, Item K*.

15. List name of the proposed excess insurance policy and desired limits:

Excess carrier: _____

Self-insurance retention (SIR): _____

Liability limit: _____

16. List type of proposed security [must be a surety bond or an irrevocable standby letter of credit (ISLOC)]:

Name of surety bond carrier: _____

Name of bank providing ISLOC: _____

APPLICATION FOR SELF-INSURANCE
AGREEMENTS

The applicant agrees with the following conditions to be certified as a self-insured employer under Oregon workers' compensation law:

1. To promptly pay compensation and other payments due to injured employees or their dependents in accordance with Oregon workers' compensation law.
2. To promptly report compensable injuries, diseases, and deaths to the Workers' Compensation Division as required by law.
3. To promptly notify the Workers' Compensation Division regarding liquidation, sale, or transfer of ownership of the **(insert name of applicant employer, self-insuring group employer, entity, business)**. Oregon Administrative Rule (OAR) 436-050-0195(1) requires notification within 30 days of taking any such actions, to enable the Workers' Compensation Division to ensure that arrangements and obligations satisfactory to the division have been made to pay all existing liabilities and any liabilities arising thereafter that are required in connection with the security deposit, loss reserve fund, common claims fund, or otherwise required by the division. Advance notice of such changes, where possible, will facilitate more rapid resolution of those arrangements and obligations.
4. To promptly furnish all reports to the Workers' Compensation Division that it may lawfully require under Oregon workers' compensation law.

This application should be signed and sworn to by the appropriate person or persons as stated below:

- If the applicant is an individual, the owner must sign.
- If the applicant is a partnership, all of the partners must sign.
- If the applicant is a corporation, its president or vice president and its secretary or assistant secretary must sign.

AFFIDAVIT

State of _____

County of _____

Each person listed below, first being sworn on oath, deposes and states that they are acquainted with the affairs of this applicant employer, including the representations and statements set forth in this application; that they have read said application and all documents submitted, knows their contents, and verifies that the representations and statements are true in substance and in fact.

Applicant's legal name

Signature of affiant and date

Signature of affiant and date

Name and title of affiant

Name and title of affiant

Subscribed and sworn to before me

on _____

Notary public

APPLICATION FOR SELF-INSURANCE LIST OF ATTACHMENTS

You must submit all of the following attachments with the application for it to be reviewed. Submitting an incomplete application may delay the review process and desired approval and effective date of self-insurance certification.

- ☐ A. Anticipated payroll by National Council on Compensation Insurance (NCCI) job classifications and descriptions for the next fiscal year. NCCI codes may be found on your recent workers' compensation insurance policy. *See question 3.*
- ☐ B. If you provide the ultimate parent financial statements instead of the applicant's, then include Form 4966, Parental Agreement – Indemnity Agreement by the Parent Corporation for Wholly-Owned or Majority Owned Subsidiary Form. *See question 6, if applicable.*
- ☐ C. An organizational chart showing the hierarchical position of all corporate entities, including the ultimate parent. Note the percentage of ownership and clearly indicate which entities with operations in Oregon are seeking coverage under the certificate of self-insurance. *See question 7.*
- ☐ D. For each legal entity to be included in the certification include Form 1865, Endorsement to Include Legal Entity in Self-Insured Certification. *See question 8.*
- ☐ E. A statement of losses for the past three fiscal or calendar years to include all Oregon open claims: including claimant name, date of injury, and total paid and total outstanding reserve. *See question 9.*
- ☐ F. If using a service company (third-party administrator), you must provide a service agreement to be approved by the director at least 14 days before the desired effective date of certification under Oregon Administrative Rule (OAR) 436-050-0160(1)(f)(A). *See question 9b, if applicable.*
- ☐ G. If choosing to self-administer claims, include copies of the Oregon claim examiner certificates (see OAR 436-055). *See question 9c, if applicable.*
- ☐ H. The most current experience rating modification factor. *See question 10.*
- ☐ I. Copies of certified audited financial statements for the past three fiscal or calendar years (provide hard copies, online access, or Web address). *See question 12.*
- ☐ J. If authorized broker or agent will be providing documents or discussing confidential information regarding your application, include Form 4965, Exemption Provision Waiver, as required under Oregon Revised Statute 192.501 (5). *See question 13.*
- ☐ K. Provide declaration page from most recent workers' compensation policy and endorsement of statement showing classifications of operations for Oregon. *See question 14.*
- ☐ L. A narrative description of applicant's safety program [see OAR 436-050-0160(1)(h)].