CONFIDENTIAL APPLICATION

FOR

GOVERNMENTAL

SELF-INSURING

EMPLOYERS

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

Governmental Employer's Application for the Privilege of Self-Insuring the Payment of Compensation as Provided for in the Georgia Workers' Compensation Act

Georgia State Board of Workers' Compensation
270 Peachtree St. NW
Atlanta, GA 30303

TO: APPLICANTS FOR SELF-INSURED STATUS

RE: INSTRUCTIONS FOR COMPLETING APPLICATION

- Application must be printed or typewritten and all questions answered.
- Allow 60 days from date of receipt of filing for approval
- Make sure all requested documents are included with application.
- Please call 404-651-7839 if you have questions.
- Make sure signature page is signed and notarized.
- DO NOT BEGIN A SELF-INSURED PROGRAM PRIOR TO APPROVAL FROM THE GEORGIA STATE BOARD OF WORKERS' COMPENSATION.
- Send completed application to:
    - Tim Milsten
      Director, Licensure and Self-Insurance
      State Board of Workers' Compensation
      270 Peachtree St., NW
      Atlanta, Georgia 30303-1299

Applicant's Name: _____

Questions Concerning this application should be directed to:

Contact Person: _____

Title/Position: _____

Applicant Address: _____

City/State/Zip: _____

Telephone Number: _____

Contact Person/Applicant's E-Mail Address: _____

If the applicant is being assisted by an agent, consultant, broker, attorney or third-party administrator, please identify:

Name: _____

Address: _____

Telephone Number: _____ E-Mail:_____

The applicant, who is a county, municipality, or other political subdivision subject to the provisions of the Georgia Workers' Compensation Act, hereby applies for the privilege of being self-insured under the Act, and submits the following facts under oath, to the Georgia State Board of Workers' Compensation for determination of applicant's qualification for self-insurance program.

Note: If additional space is required to respond to any of the items which follow, please attach additional pages to the application, indicating the specific item for which additional information is provided:

1. Name of Applicant:_____ FEIN: _____

2. Street/Mailing Address:_____

3. City/State/Zip:_____

4. Telephone:_____ County:_____

5. (a) Has the governing body of the applicant voted to apply to the Georgia State Board of Workers' Compensation to self-insure the workers' compensation exposure of this applicant? Yes _____ No _____ (If no, list date of vote _____).

   (b) List Mayor, City Council Members, County Commissioners or Authority Members as appropriate for governmental entity submitting application:

Name of Office Held Address

_____
_____
_____
_____

6. Nature of Employment:

- Location of Facility
- Kind of Employment
- Estimated Number of Employees for coming year
- Estimated Payroll of all employees for coming year

_____

Location Type Employment # Employees Payroll

_____

Location Type Employment # Employees Payroll

_____

Location Type Employment # Employees Payroll

7. State applicant's gross payroll for last three years. Attach a copy of annual payroll and rate classifications for the next calendar year.

Year	Payroll
_____	$_____
_____	$_____
_____	$_____

8. Number of years applicant has been incorporated as a governmental entity:_____

9. How has applicant provided payment of workers' compensation liability for the past three years? _____

- If provided by insurance policy, please provide the following information for the past three (3) years:

Year	Carrier	Policy Number	Policy Period From	To	Amt. Premiums	Audited Payroll

10. Attach a copy of the DECLARATION PAGE of the most recent policy showing the expiration date.

11. What is your experience modification for the last three years?

Year_____	$_____
Year_____	$_____
Year_____	$_____

12. Has applicant's application for workers' compensation insurance ever been rejected or policy cancelled? Yes_____ No_____ If yes, answer below: When_____ By Whom_____ Reason_____

13. Please list the following for <u>each</u> death, disability or occupational disease claim in the past 5 years, with total incurred in excess of $25,000.00.

- Date of Loss
- Facts of Loss/Type of Injury or Disease
- Indemnity Paid
- Medical Paid

- Outstanding Reserves
- Total Incurred

14. State the accident experience for the last three (3) years.

	Year_____	Year_____	Year_____
Number of Deaths	_____	_____	_____
Number of Dismemberments	_____	_____	_____
Total Number of Medical Only Claims	_____	_____	_____
Total Number of Indemnity Claims	_____	_____	_____
Total Number of Accident of All Kinds	_____	_____	_____

15. Total Medical Benefits paid in last calendar year (regardless of date of injury).
$_____

16. Total Indemnity Benefits paid in last calendar year (regardless of date of injury).
$_____

17. Total Current Outstanding Reserves for all claims (regardless of date of injury).
$_____

18. Who establishes reserve amount?
- Name:_____
- Title: _____
- Employer:_____
- Who Controls the reserve account? _____

19. Safety & Environmental Conditions:
    - Is your place of business inspected other than by a State Authority? _____
    - If yes, by whom? _____

20. Do you have a safety committee to review claims activity on a regular basis and make safety suggestions to assure compliance with the Georgia Department of Labor or general orders of the State Board of Workers' Compensation as to safety and environment? Yes _____ No_____

Identify the Safety Committee Chair and position he/she holds:

Name: _____ Position: _____

21. Do you have an outside Safety Consultant? Yes_____ No_____

If yes, please identify the Consultant.

Name: _____ Company/Firm: _____

22. Is there any special or catastrophic hazard in connection with your business? If yes, give a full description, stating the maximum number of employees at one time exposed to such hazard: _____

_____

_____

23. Please list third party administrator or servicing agent to be used if applicant is approved for self-insurance. **(Attach a copy of servicing agent's GEORGIA TPA LICENSE).**

    Name of TPA/Servicing Company: _____

    Contact Person: _____

    Mailing Address: _____

    City/State/Zip Code: _____

    Telephone: _____ E-Mail:_____

24. Complete if applicant will be self-managing claims, if approved for self-insurance

    Name of Adjuster: _____

    Mailing Address: _____

    City/State/Zip Code: _____

    Telephone: _____ E-Mail:_____

    List Experience and Training for person handling workers' compensation claims.

    _____

    _____

    _____

25. Who will be your excess insurance carrier?

- Name of Carrier:_____
- Mailing Address:_____
- Contact Person:_____
- Retention Level:_____

26. Do you purchase aggregate insurance? Yes_____ No _____

    If yes, please give name of carrier: _____

27. Has applicant complied with Board Rules concerning selection of physician, as required by O.C.G.A. §34-9-201? Yes_____ No_____

28. Does applicant have a posted Bill of Rights as described in O.C.G.A §34-9-81.1? Yes_____ No_____

29. By which plan does applicant propose to finance the compensation of self-insurance liability?
    a. To set up a separate account or fund into which will be paid the projected cost of future benefits payable? Yes_____ No _____

    b. To use a fixed percentage of the payroll? Yes_____ No_____

    c. To treat the liability as a current expense? Yes_____ No_____

    d. To transfer the incurred liability into a reserve account Yes___ No___

    e. To establish the liability as determined by the present value of incurred losses? Yes_____ No_____
    f. Adopt other Procedure (Describe)_____

30. Applicant MUST enclose full financial statements, audited by an independent CPA according to generally accepted accounting principles, for the last three (3) years.

This application is filed with the understanding and the agreement of the applicant herein that upon approval and in consideration thereof, applicant herby agrees as follows:

i. All reports required by the Workers' Compensation Act will be promptly filed with the Georgia State Board of Workers' Compensation
ii. All Workers' Compensation liabilities will be paid promptly in cash or negotiable instrument (servicing organization handling claims for self-insurers must designate an office in the State of Georgia for the handling of claims, or if claims are handled out-of-state, shall designate an agent located in the State of Georgia and shall be authorized to execute instruments for the payments of compensation in an emergency (Rule 127), or if necessary.
iii. No funds will be solicited, received, or collected from employees or deductions made from their wages for the purpose of discharging applicant's liability under the Workers' Compensation Act.

Date Applicant wants to assume self-insured status: _____.

Applicant must attach a certified copy of the official minutes or a resolution from the governing authority of the applicant authorizing the application for certification as a self-insurer under the workers' compensation laws and the authorization for the individual named below to execute this document.

I, _____, after being duly sworn, do hereby depose and state under oath, and certify under penalty of law that I am thoroughly familiar with the operation and affairs of the applicant to whom the responsibilities and statements set forth in the foregoing application, attachments, and exhibits relate; that I have read and studied said application, attachments and exhibits, and know the contents thereof; that I am authorized by the applicant to execute and submit this application with all attachments, exhibits, and supporting documents, as well as to individually execute this affidavit; and that said application, representations, and statements therein contained, together with all supporting attachments, exhibits, and documents, are true and correct to the best of my knowledge, information and belief.

Subscribed and sealed this _____ day of _____, 20__.

_____
Signature of Designated Official as Affiant

_____
Name (Typed or Printed)

_____
Title/Position with Applicant

Sworn to and Subscribed before me by above affiant this the date above shown:

_____ _____
Signature of Notary Public Name of Notary Public (Typed or Printed)

My Commission Expires: _____ _____
Address of Notary

_____
(SEAL OF NOTARY HERE) City/State/Zip Code and Phone Number