CURRENT WORKERS' COMPENSATION PROGRAM

Currently Insured with State Fund Policy # ___________________ Expiration Date: ____________

Currently Self Insured, Certificate # ____________________

Other (describe): ____

CLAIMS ADMINISTRATION

Who will be administering your agency's workers' compensation claims? (Check one)

JPA will administer

Third Party Administrator, TPA Certificate # _________________

Public entity will self-administer Insurance Carrier will administer

Name of Third Party Administrator:

Name: _____________________________________ Title: _______________________________

Company Name: ____

Address: ____

City: ________________________________ State: __________ Zip + 4: __________ - _________

Phone: _____________________________ E-Mail: _______________________________________

# of claims reporting locations to be used to handle Agency's claims: ________

Does applicant currently have a California Certificate of Consent to Self Insure? Yes No

If yes, what is the current Certificate Number: ___________

Total Number of Affiliate's California employees to be covered by Group: _____________________

AGENCY EMPLOYER

Current # of Agency Employees: _________ # of Public Safety Employees (police//fire): _________

If school District, # of certificated employees: _________

Will all Agency employees be covered by this self insurance plan? Yes No

If 'No', explain who is not covered and how workers' compensation coverage will be provided to the excluded employees:

____

JOINT POWERS AUTHORITY

Will applicant be a member of a JPA for workers' compensation ?

Yes No (If 'yes', complete the following)

Effective date of JPA Membership: ____________________ JPA Certificate # ______________________

Name of JPA: ____

AGENCY SAFETY PROGRAM

Does the Agency have a written Injury and Illness Prevention Program (IIPP)? Yes No

Individual responsible for Agency workplace safety and IIPP program:

Name: _____________________________________ Title: _______________________________

Company Name: ____

Address: ____

City: ________________________________ State: __________ Zip + 4: __________ - _________

Phone: _____________________________ E-Mail: _______________________________________

SUPPLEMENTAL COVERAGE

1.) Will your program be supplemented by any insurance or pooled coverage under a STANDARD workers' compensation insurance policy? Yes No (If 'Yes', complete the following):

Name of Excess Pool/Carrier: ____

Policy #: _________________________ Effective Date of Coverage: ____________________________

2.) Will your program be supplemented by any insurance or pooled coverage under a SPECIFIC EXCESS workers' compensation insurance policy? Yes No (If 'Yes', complete the following):

Name of Excess Pool/Carrier: ____

Policy #: _________________________ Effective Date of Coverage: ____________________________

Retention Limits: ____

3.) Will your program be supplemented by any insurance or pooled coverage under an AGGREGATE EXCESS (stop loss) specific excess workers' compensation insurance policy? Yes No (If 'Yes', complete the following):

Name of Excess Pool/Carrier: ____

Policy #: _________________________ Effective Date of Coverage: ____________________________

Retention Limits: ____

RESOLUTION FROM GOVERNING BOARD

Attach a properly executed Governing Board Resolution. See attached sample resolution on page 5.

CERTIFICATION

The undersigned on behalf of the applicant hereby applies for a Certificate of Consent to Self Insure the payment of workers' compensation liabilities pursuant to Labor Code Section 3700. The above information is submitted for the purpose of procuring said Certificate from the Director of Industrial Relations, State of California. If the Certificate is issued, the applicant agrees to comply with applicable California statutes and regulations pertaining to the payment of compensation that may become due to the applicant's employees covered by the Certificate.

X____ DATE: ________________________________
SIGNED: Authorized Official / Representative

____
Printed Name

____
Title

____
Agency Name

RESOLUTION NO.: __________ DATED: __________________________

A RESOLUTION AUTHORIZING APPLICATION
TO THE DIRECTOR OF INDUSTRIAL RELATIONS, STATE OF CALIFORNIA
FOR A CERTIFICATE OF CONSENT TO SELF INSURE
WORKERS' COMPENSATION LIABILITIES

At a meeting of the ____
(Enter Name of the Board)

of the ____
(Enter Name of Public Agency, District, Etc.)

a _________________________________ organized and existing under the
(Enter Type of Agency, i.e., County, City, School District, etc.)

laws of the State of California, held on the _______ day of ______________, 20___,

the following resolution was adopted:

RESOLVED, that the above named public agency is authorized and empowered to make application to the Director of Industrial Relations, State of California, for a Certificate of Consent to Self Insure workers' compensation liabilities and representatives of Agency are authorized to execute any and all documents required for such application.

IN WITNESS WHEREOF: I HAVE SIGNED AND AFFIXED THE AGENCY SEAL.

X____ DATE: ________________________________
SIGNED: Board Secretary or Chair

____
Printed Name

____
Title

Affix Seal Here

____
Agency Name