

State of California
Department of Industrial Relations
Office of Self-Insurance Plans
1750 Howe Avenue, Suite 215
Sacramento, Ca. 95825
Phone (916) 464-7000
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State of California
Department of Industrial Relations
OFFICE OF SELF-INSURANCE PLANS

**APPLICATION FOR CERTIFICATE OF CONSENT
TO SELF-INSURE AS A PRIVATE EMPLOYER SELF-INSURER**

All questions must be answered. If not applicable, enter "N/A".

To the Director of the Department of Industrial Relations: The private employer identified below submits the following information to obtain a Certificate of Consent to Self-Insure the payment of workers' compensation under California Labor Code Section 3700.

NAME OF APPLICANT EMPLOYER: _____

Address: _____

City: _____ State: _____ Zip + 4: _____ - _____

Federal Tax ID # of Applicant: _____

State of Incorporation: _____ Date of Incorporation (mm-dd-yyyy): _____

WHO SHOULD CORRESPONDENCE REGARDING THIS APPLICANT BE ADDRESSED TO:

Name: _____ Title: _____

Company Name: _____

Address: _____

City: _____ State: _____ Zip + 4: _____ - _____

Phone: _____ E-Mail: _____

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

If yes, what is the current Certificate Number: _____

What is the desired effective date of self-insurance if the application is approved _____

Will a policy covering any of applicant employer's California workers' compensation liability other than excess insurance be carried? Yes No If yes, what is the nature and scope of coverage?

Describe the general nature of the business of the company:

Applicants primary 3-digit NAICS Code: _____

Is applicant or any subsidiaries in the professional employer (PEO) or staffing industries? Yes No

Total number of applicant's California employees: _____

Will the number of California employers change more than 20% during the next 12 months?

No Yes (If yes, briefly describe by how many and why):

Complete the following for the California workers' compensation policies for the most recent 3 years' experience by policy period:

Year	Payroll	Premium Before Dividend	Losses Incurred	Mod Factor
	\$	\$	\$	
	\$	\$	\$	
	\$	\$	\$	
Total For Past 3 Full Years:			\$	

Name of current workers' compensation carrier: _____

Policy Number: _____ Current Policy Termination Date: _____

Is there any pending litigation or legal proceeding which might substantially adversely affect the business or financial condition of the Applicant: No Yes (If Yes, explain)

SECURITY DEPOSIT

Upon approval of this application, what form does the applicant anticipate posting its required deposit in?

Cash Surety Bond Letter of Credit Approved Securities

WORKPLACE SAFETY

Please identify the person primarily responsible for applicant's workplace safety and health programs:

Name: _____ Title: _____

Phone: _____ E-Mail: _____

LEGAL STRUCTURE

TYPE OF ENTITY OWNERSHIP: Corporation Partnership Sole Proprietorship
(Complete appropriate section below)

CORPORATION

Closely Held

Publically Traded (Trading Symbol: _____, Exchange _____ NYSE _____ NASDAQ _____ Other: _____)

State of Incorporation (if Corporation): _____

Is the Applicant a wholly owned subsidiary of another firm? Yes No

If yes, please identify the Parent:

PARTNERSHIP

Name of all Partners and identify if they are general, special, limited, etc.:

NAME

ADDRESS

TYPE

SOLE PROPRIETORSHIP

Owner's Full Name: _____

Address _____

City _____ State _____ Zip +4 _____

CLAIMS ADMINISTRATION

List the third party administrator the applicant proposes to use:

Name: _____ Title: _____

Company Name: _____

Address: _____

City: _____ State: _____ Zip + 4: _____ - _____

Administrative Agency's Certificate to Administer #: ____ _

Will ALL claims be administered at the ONE adjusting location above? Yes No

If No, and there will be multiple adjusting locations, identify additional locations below.
Attach additional pages if necessary.

Name: _____ Title: _____

Company Name: _____

Address: _____

City: _____ State: _____ Zip + 4: _____ - _____

Administrative Agency's Certificate to Administer #: ____ _

Name: _____ Title: _____

Company Name: _____

Address: _____

City: _____ State: _____ Zip + 4: _____ - _____

Administrative Agency's Certificate to Administer #: ____ _

AGREEMENT

I am acquainted with the affairs of the applicant to which representations made in the foregoing application and subsequent attachments and supporting documentation. I have read the application and attachments and believe them to be true to the best of my knowledge.

X _____ DATE: _____
SIGNED: Authorized Representative

Printed Name Title

Telephone Number E-mail

For questions or assistance in completing the application process, please feel free to initially call to discuss your application with one of OSIP's Senior Compliance Officers at (916) 464-7000.

CHECK LIST FOR A COMPLETE SELF-INSURED APPLICATION

The California Code of Regulations, Title 8, Chapter 8, Subchapter 2, provides the requirements for submitting a complete Self-Insurer's Application. The following forms and documents are required by this section to be included with the application.

In addition to a complete application (Form A-1), all of the following forms and attachments are required to complete the application.

FILING FEE - \$500.00:

A check must accompany the application before processing will begin.

Make checks payable to: Department of Industrial Relations-Office Self-Insurance Plans and mail to:

1750 Howe Avenue, Suite 215, Sacramento, CA 95825

COMPLETE APPLICATION CHECKLIST:

Form #	Description
A – 1	Application
A – 4	Agreement and Assumption
A – 5	Resolution to Self-Insure
A – 5B	Parental Guarantee (If required)
A – 6	Agreement and Undertaking of Security Deposit
	3 Years Audited Financial Statements
	Certificate of Status (see below)
	Filing Fee Check

OTHER REQUIREMENTS:

- An original Certificate of Status or other appropriate license or registration documents showing the applicant is licensed or registered to do business in California.

SUBSIDIARY ENTITIES (IF NEEDED):

- For each additional subsidiary entity other than the primary master applicant that requires an individual certificate issued in their name, complete Form A-3B for each and attach the appropriate fees. All combined fees may be paid by a single check.

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