INDUSTRIAL COMMISSION OF ARIZONA

Initial Application for Authority to Self-Insure

Read A.A.C.§ R20-5-1501- 1541 located here prior to filing the application

All questions must be answered. If question is not applicable, use N/A

Attach supplemental information and required forms

Workers' compensation insurance must be maintained until authorization is effective

The named Company or Pool listed in question #1, hereby applies for Authorization to Self-Insure the payment of workers' compensation as pursuant to A.R.S. § Section 23-961. The following information is submitted for the purpose of procuring a Resolution of Authorization of Authorization from the Industrial Commission of Arizona, which may be given upon satisfactory proof of the ability of the applicant to administer and incur the liability of its workers' compensation claims.

1. **Company or Pool Name**: _____

   _____

2. Requested effective date for authority to self-insure: _____

3. Applicant's Corporate Office Information:

   Home office Address: _____

   _____

   Phone: _____ Fax: _____

   Arizona office Address: _____

   _____

   Phone: _____ Fax: _____

4. State under which applicant is incorporated: _____

5. Incorporation Date or Pool formation date: _____

6. Name of parent company if applicant is a subsidiary: _____

   _____

7. List all covered Arizona subsidiary company names or pool members legal names with join dates. May use an attachment.

8. Name, address and status of partners (general, special and limited), if applicant is a partnership: _____

9. Length of time in business in Arizona (must be five years to qualify-time can be met through a subsidiary or member): _____

10. Type of business in Arizona: _____

11. Type of Industry: _____

12. Industry SIC: _____

13. Current and prior three calendar year payroll by classification code for applicant's employees working in Arizona: _____

14. Total Arizona (W2) employee count for current and prior three calendar years: _____

15. Attach the current workers' compensation insurance carrier, policy number and expiration date: _____

16. If applicant's application for workers' compensation insurance has ever been rejected or policy of insurance cancelled, state why: _____

_____

17. List states where self-insurance was denied: _____

_____

18. List states where applicant is currently self-insured: _____

_____

_____

19. U.S. Department of Transportation #: _____

20. Will the applicant have an excess insurance policy: ◯ Yes ◯ No

21. Name of excess insurance carrier: _____

_____

22. Self-Insurance Retention Amount: $_____

23. Arizona claims history for three years preceding application date:

	A	B	C	D	E	
Year	Total # of Medical Only Claims	Total # of Indemnity Claims (medical and indemnity)	Total # of Temporary Disability Claims	Total # of Permanent Disability Claims	Total # of Fatality Claims	Total # of All Claims (Sum A - E)

24. Arizona loss history and experience modification rates for three years preceding application date:

	A	B	C	D	E		
Year	Medical Only Losses Paid	Indemnity Losses Paid (medical and indemnity-Do not include Disability claims)	Total Paid for Temporary Disability Claims (medical and indemnity)	Total Paid for Permanent Disability (medical and indemnity)	Total Paid for all Claims (Sum A - E)	Experience Modification Rate	Net Premiums

25. Attach a loss run of all applicant's prior claims incurred in Arizona from the most current complete calendar year and three prior calendar year. The loss fund must include the following information for each claim: Payroll Classification Code, Commission claim number, employee name, date of injury, total paid medical, reserve medical, reserves, total paid indemnity (including death benefits), and indemnity reserves.

_____

26. Check the type of statutory deposit the applicant intends to use to satisfy the statutory deposit requirements:

- ◯ Continuous Surety Bond
- ◯ Letter of Credit
- ◯ United States Treasury Notes
- ◯ Local Government Investment Pool (municipalities only)
- ◯ Waiver (municipalities only)

27. Name of Surety issuing bond or Bank issuing letter of credit, if known: _____

_____

28. Will the applicant direct medical care?

◯ **Yes**

If Yes is checked complete the following:

A. Complete and attach the Self-Provider of Medical Benefits form
B. Provide a detailed explanation regarding how care is directed, attach to application
C. Provide copies of contracts or a list of medical providers, attach to application

◯ **No**

29. Select a premium tax plan:

- ◯ Fixed Premium Plan
- ◯ Guaranteed Cost Plan
- ◯ Ex-Medical Plan (Must own a medical facility to qualify)

30. Attach copies of the most current and prior two years audited financial statements. If the applicant is a subsidiary, attach copies of the most current and prior two years financial statements of the Parent Company.

_____

_____

31. If the applicant is a subsidiary attach a completed Parent Company guaranty form signed by a designated representative of the Parent Company that guarantees the administration of the subsidiary's obligations:

_____

32. Attach a resolution of the Parent Company's board of directors or governing body authorizing the designated representative to complete, sign, and file the Parent Guaranty Form.

_____

33. Name address and telephone number of authorized self-insurer primary contact:

Name: _____

Title: _____

Address: _____

_____

Telephone #: _____

Email: _____

34. Name address and telephone number of authorized self-insurer secondary contact:

Name: _____

Title: _____

Address: _____

_____

Telephone #: _____

Email: _____

35. Name address and telephone number of authorized self-insurer primary tax contact:

Name: _____

Title: _____

Address: _____

_____

Telephone #: _____

Email: _____

36. Name address and telephone number of authorized self-insurer secondary contact:

Name: _____

Title: _____

Address: _____

_____

Telephone #: _____

Email: _____

37. Name address and telephone number of third-party administrator or individual responsible for processing Arizona workers' compensation claims:

Name: _____

Title: _____

Address: _____

_____

Telephone #: _____

Email: _____

38. Complete Application to self-Administer and attach to this initial application.

*Training must be completed and approved by the ICA Claims Division

_____

39. Name and address of Arizona agent upon whom legal notices may be served:

Name: _____

Title: _____

Address: _____

_____

Telephone #: _____

Email: _____

40. Name, title, address, telephone number and email address of Pool Administrator primary contact:

Name: _____

Title: _____

Address: _____

_____

Telephone #: _____

Email: _____

41. Name, title, address, telephone number and email address of Pool Administrator secondary contact:

Name: _____

Title: _____

Address: _____

_____

Telephone #: _____

Email: _____

42. Contact information where Arizona workers' compensation claims will be processed:

Name: _____

Title: _____

Address: _____

_____

Telephone #: _____

Email: _____

43. Attach a completed ICA Preferred Communication Form, where claims will be notified.

The form can be found here: **ICA Preferred Communication Form**

ATTESTATION

Upon signing this application to renew _____ self-insurance authority, I attest that all information and assertions contained in the application and the documents accompanying the application are factually correct and true. I further attest that I have the authority to sign and file this application on behalf of _____.

Submitter Name: _____ Date Submitted: _____

Submitter Email Address: _____

Authorized Signer Name: _____ Date Signed: _____

Signer Email Address: _____

Signature: _____

Required Additional Information- All Employers

(1) If the Applicant's Experience Modification Rate specific to Arizona for the most recent complete fiscal year is greater than 1.10, a written statement describing the causes of the inflated Experience Modification Rate and outlining remedial measures the Applicant has taken or will take to lower the Experience Modification Rate.
(2) List of all sites covered by self-insurance authority. List must include name, FEIN (if a subsidiary), address, phone number and fax number.

Required Additional Information- Private Employers

(1) If applicant holds its financial information free from public inspection, applicant can request financial information be kept confidential pursuant to A.R.S. § 23-107 (D) - Contact Self-Insurance@azica.gov.

Required Additional Information- All Pools

(1) Copy of Articles of Incorporation
(2) Copy of the Pool By-Laws
(3) Copy of the signed agreement between the pool administrator and the pool board
(4) Copy of the Resolution signed by the member and the pool board approving membership into the pool.
(5) Copy of each member's signed coverage agreement
(6) Copy of each member's signed indemnity agreement
(7) Description of the pool's loss control program
(8) Actuarial feasibility study
(9) Copy of the Resolution signed by the members governing body approving the application for Pool membership.