FORM-SI-EMPLOYER

OKLAHOMA WORKERS' COMPENSATION COMMISSION

1915 NORTH STILES AVENUE
OKLAHOMA CITY, OKLAHOMA 73105
(405) 522-3222 or In-State Toll Free (800) 522-8210

APPLICATION FOR INDIVIDUAL OWN RISK EMPLOYER PERMIT

Date_____

The undersigned, an employer subject to the provisions of the Administrative Workers' Compensation Act, hereby applies for permission to carry its own risk without insurance. To enable the Workers' Compensation Commission to determine whether or not the applicant possesses sufficient financial ability to render certain the payment of any award made by the Commission, said applicant hereby states the following:

1. Employer's Name_____Own Risk #_____

2. Employer's Federal Identification Number_____

3. Home Office Address_____

4. Oklahoma principal office address_____

5. Incorporated or organized under the laws of the State of _____

6. If foreign corporation, give date licensed to do business in Oklahoma_____

7. Nature of business_____

8. General Information on Company:

   a. Years engaged in continuous business_____, In Oklahoma_____

   b. Payroll in each of the preceding three (3) years:

      Year:_____, $_____; Year:_____, $_____;
      Year:_____, $_____

      Payroll in Oklahoma in each of the preceding three (3) years:

      Year:_____, $_____; Year:_____, $_____;
      Year:_____, $_____

   c. Number of employees presently employed_____
      In Oklahoma_____

   d. Estimated payroll in Oklahoma for the next twelve (12) months_____

9. Excess Insurance Information, if any at the time of this application:

   a. Name of carrier_____ Policy #_____

   b. Policy dates: Effective_____ Expiration _____

   c. Under this policy: Self Insured Retention_____ Limits of Liability_____

NOTE: The Commission may require an individual own risk employer to provide proof of excess coverage with such terms and conditions as are commensurate with the employer's ability to pay the benefits required by the Administrative Workers' Compensation Act.

10. Estimated manual premium for your company_____

11. a. In the section below, state the loss history for the past five (5) calendar years. Copy the requested information from your loss runs (if the hard copy of your loss runs are required you will be notified). **Also include the current year's history, indicating how many months of the current year are included:**

Total incurred losses in Oklahoma (include for all injuries, both open and closed claims)

CY or FY	$ Medical Paid	$ Indemnity Paid	$ Total Paid	$ Total Reserves Outstanding
2014 mo				
2013				
2012				
2011				
2010				
2009				

CY or FY	Cases Opened	Cases Reopened	Cases Closed	Death Cases
2014 mo				
2013				
2012				
2011				
2010				
2009				

   b. List of Death and Permanent Total Disability (PTD) Claims for all years of self insurance (use separate sheet if necessary): _____
   _____

   c. Total Self Insurance Reserves Outstanding: $_____
   (for all years of self insurance)

   Total Self Insured Open Cases: _____
   (for all years of self insurance)

12. a. Enclose current audited financial report or financial statement signed by two authorized company executives, including balance sheets, income statements and notes.

b. A governmental entity must provide a definite statement of the amount it has specifically appropriated for workers' compensation claims for the latest and the next fiscal year.

Amount appropriated for current fiscal year _____
Next fiscal year (if available) _____

13. a. Is the applicant a subsidiary of another employer? _____ If yes, submit the parent company's financial statements in accordance with Paragraph 12(a) above.

b. Does the applicant have subsidiary companies that it wants to include under this permit?_____

(Attach a list of the names and addresses of ALL entities to be included under this permit, including subdivisions.)

c. If you answered yes to either question 13a or 13b, attach a copy of a written agreement whereby the ultimate parent employer guarantees that it will be fully responsible for any liabilities that its subsidiaries may incur under the Administrative Workers' Compensation Act.

14. a. Name, address and email address of the company's Third-Party Administrator for the servicing of the self insurance claims.

_____

_____

b. If an approved Third-Party Administrator is not employed, please submit qualifications of benefits administrator.

15. In consideration of the approval of this application, the applicant hereby expressly agrees as follows:

a. The applicant's privilege to carry its own risk without insurance may be revoked at any time for good cause by the Workers' Compensation Commission.

b. The applicant agrees to comply with all applicable statutes and the rules of the Workers' Compensation Commission.

Include an annual, nonrefundable, application fee of $1,000, made payable to the Oklahoma Workers' Compensation Commission.

I declare under penalty of perjury that I have examined this application and all statements contained herein, and to the best of my knowledge and belief, they are true, correct and complete.

Signed this _____ day of _____, 20_____.

_____
Print Name and Title (note: person signing should be authorized to bind the applicant to the agreements contained herein)

_____
Signature

_____

Mailing Address

_____

Street Address, if different from Mailing Address

_____

City State Zip Code

_____

Telephone Number

_____

E-mail Address

Administrative Workers' Compensation Act, 85A O.S., §6(A)(1)(a): "Any person or entity who makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who employs any device, scheme, or artifice, or who aids and abets any person for the purpose of: (1) obtaining any benefit or payment … shall be guilty of a felony."

Any person who commits workers'' compensation fraud, upon conviction, shall be guilty of a felony punishable by imprisonment, a fine or both.

Send application to:

Insurance Division
Oklahoma Workers' Compensation Commission
1915 North Stiles Avenue
Oklahoma City, OK 73105-4918