

WORKER'S COMPENSATION BOARD OF INDIANA
402 WEST WASHINGTON STREET, ROOM W196
INDIANAPOLIS, IN 46204-2753
www.in.gov/wcb

STATE FORM 18488 9R13/3-990
FORM SI-1 (Revised 2011)
Approved by State Board of Accounts

WORKER'S COMPENSATION AND OCCUPATIONAL DISEASES ACTS
EMPLOYER'S APPLICATION FOR PERMISSION TO
CARRY RISK WITHOUT INSURANCE

The undersigned, an employer subject to the provisions of the "Indiana Worker's Compensation and Occupational Diseases Acts", hereby applies for a certificate to pay compensation directly, without insurance, to injured employees or to the dependents of employees who die in consequence of illness or injury for the period of September 1, 2011 to midnight, August 31, 2012; and, for the purpose of enabling the Worker's Compensation Board of Indiana to determine whether it possesses sufficient financial ability to render certain the payment of such compensation and medical expenses. This employer, under the penalties of perjury, hereby states the following facts:

1. EMPLOYER INFORMATION

_____ New Applicant

_____ Renewal Applicant

Applicant Name: _____

Address: _____

Nature of Business: _____

Website Address: _____

FEIN: _____

If rated for credit standing by Dunn & Bradstreet, what is the rating?

If traded publicly, what is the stock symbol? _____

2. EMPLOYMENT INFORMATION/SUBSIDIARY INFORMATION

Indiana Location(s)	Kind of Employment	# of Employees
a.	_____	_____
b.	_____	_____
c.	_____	_____
d.	_____	_____
e.	_____	_____

SUBSIDIARIES INCLUDED UNDER SELF-INSURANCE AUTHORITY

FEIN #	TITLE NAME	CONTACT INFORMATION
a.	_____	_____
b.	_____	_____
c.	_____	_____
d.	_____	_____
e.	_____	_____

3. LOSS HISTORY

Please find two alternative loss history charts. Only one chart is required to be filled out.

Under Amount Paid, please provide the total paid for each category during the calendar year, regardless of the date of injury. Under # of Injuries, please provide the number of injuries which occurred during the calendar year that fell within, or resulted in payments in, each category (regardless of when paid). Some injuries will be counted in more than one category. The second alternative only requires you to breakdown number of injuries based on medical and indemnity.

If this information is not provided on a calendar year basis, please specify the appropriate dates: _____ through _____.

	2008		2009		2010	
	Amount Pd	# Injuries	Amount Pd	# Injuries	Amount Pd	# Injuries
Medical						
TTD						
TPD						
PTD						
PPI						
Death Benefits						
Burial Expenses						
Settlements						
First Report of Injury						
Amputation						
Prosthetic Device						
TOTAL	\$		\$		\$	

4. BOND CALCULATION

(a) Determine three-year average of total medical/compensation paid per "Loss History"	
2008 Total Paid	\$ _____
2009 Total Paid +	\$ _____
2010 Total Paid +	\$ _____
Three-Year Total Paid	\$ _____ divided by 3 = \$ _____ 3yr average
(b) Multiply 3 year average by 2	
	\$ _____
(c) Enter total unpaid compensation liability for fatalities	
	\$ _____
(d) Add lines (b) and (c)	
	\$ _____
(e) Enter greater of \$500,000 or line (d)	
	\$ _____
(f) Increase/decrease in line (d) from prior year	
	\$ _____

5. SECURITY

a. SURETY BOND

Amount of Bond \$ _____ Cost of Bond \$ _____ (Required)
(\$500,000.00 Minimum) (Annual Premium)

Surety Name: _____ Telephone: _____

Address: _____

Bond # _____ (Application cannot be processed if blank)

b. EXCESS COVERAGE:

Specific \$ _____ Self-Insured Retention \$ _____
Aggregate \$ _____ Cost of Excess \$ _____ (Required)
(Annual Premium)

c. Does the employer have a system to establish a reserve to pay claims for medical treatment or compensation? _____

d. List other states, if any, in which the employer is self-insured

6. SELF-INSURANCE ADMINISTRATION

It is the obligation of the employer to timely advise the Board of any changes in the information provided below which occur during the self-insured period. Please note that the Board now sends all notices related to Self-Insurance via email.

- (a) Identify the person within the employer's organization who is primarily responsible for the self-insurance program. This person will receive all notices as it relates to the self-insurance program, please list an alternative if you would like two individuals to receive notices:

Name: _____

E-Mail: _____

Address: _____

Telephone: _____

Fax: _____

Alternative:

Name: _____

E-Mail: _____

Address: _____

Telephone: _____

Fax: _____

- (b) Identify the person who is primarily responsible for the adjustment of Indiana employee claims made pursuant of the self-insurance program (within your company or at your third-party administrator):

Name: _____

E-Mail: _____

Address: _____

Telephone: _____

Fax: _____

Number of years of experience in the adjustment of worker's compensation and occupational disease claims: _____

(c) Identify the person who is primarily responsible to receive hearing notices and other official communications from the Worker's Compensation Board regarding Indiana disputed claims:

Name: _____

E-Mail: _____

Address: _____

Telephone: _____

Fax: _____

(d) All companies who carry risk without insurance must file first reports of injury electronically according to standards prescribed by the Board. Please indicate whether the applicant is able to comply with this mandate.

_____ Yes _____ No _____ A copy of the approved plan is attached.

7. ATTACHMENTS

All applicants must attach the following items to this application:

_____ (a) An audited financial statement signed by an officer of the employer, such statement to become part of this application. A copy of the employer's last annual report to its stockholders may be accepted in lieu of a financial statement, if prepared within the last six (6) months. This information shall be treated as confidential by the Board and used only in evaluating this application. It will not be provided to any other entity.

_____ (b) Loss runs from the prior year to verify the information provided in the Loss History and Bond Calculation sections of the application. Detailed loss information is included, specifically claimants name and total payment amounts.

_____ (c) Information concerning involvement or membership in organizations or seminars specifically directed toward self-insured workers compensation issues.

_____ (d) Additional information concerning the knowledge of the Act, education and claims experience of the person responsible for receiving notices from injured employees, and the amount of time this person devotes to the workers compensation process (if self-administered).

_____ (e) Please provide information regarding training that those individuals responsible for the administration of self-insurance, have received in the past year regarding Indiana worker's compensation administration, laws, regulations, or other.

Additionally, new applicants must attach the following information:

_____ (i) Premium payments made the last three years and to what carrier(s).

_____ (ii) Loss runs from the prior three years to verify the information provided in the Loss History and Bond Calculation sections of the application.

_____ (iii) NCCI experience modification for the last three years.

_____ (iv) Audited financial statements, as described above, for the past three years.

_____ (v) Administrative costs anticipated in association with self-insuring, particularly if the applicant intends to utilize a third-party administrator.

8. CONDITIONS

The applicant hereby expressly understands and agrees as follows:

- a. That this privilege may be revoked at any time at the discretion of the Worker's Compensation Board of Indiana ("Board").
- b. That the applicant will fully discharge by immediately negotiable instrument payment of all installments of compensation for disability or impairment promptly when due, as well as liability for physician's fees, hospital services, hospital supplies, and burial.
- c. That if the Board so requires, the applicant, within thirty (30) days after its continuing liability to pay compensation to an injured employee for a definite period for a permanent injury or to the dependents of a deceased employee has been determined, by agreement or award, will make a special deposit, with a bank or trust company within the State of Indiana approved by the Board, of the full amount of such definite continuing liability. Such special deposit to be made upon such terms as are prescribed by the Board.
- d. That the applicant will promptly notify the Board of any change in condition which could ultimately affect its ability to pay medical expenses or compensation or administer its self-insurance program.
- e. That the applicant will discharge all amounts due for statutory assessments under the Acts.
- f. That the applicant will furnish and file with the Board any security agreement, surety bond, indemnity agreement, and/or excess insurance coverage, which may be required as a condition for approval of this application.
- g. That the applicant, upon approval by the Board, recognizes, understands and agrees that in all cases the total assets of the applicant and its subsidiaries, if any, are pledged and available for the payment of any valid compensation or occupational disease claims made pursuant to Indiana law.

- h. That the applicant understands that if its surety bond is canceled and no replacement bond is filed with the Board, its self-insured status shall terminate upon the effective date of the bond cancellation without further notice from the Board.
- i. That the applicant understands and agrees that the surety posted will not be released until all possibility of additional losses has terminated and the Worker's Compensation Board has approved the bond's release, but in no event will the bond's release be granted prior to three years from the last date of self-insurance.
- j. That the applicant understands and agrees that the surety bond posted will not be reduced until after two years from the last date of self-insurance and that the decision to reduce the bond will be based upon currently active claims and claims that have been closed within the two years prior to the date of the request for reduction of the bond.

The statements made herein are true and accurate to the best information and knowledge of the undersigned and are made for the express purpose of inducing the Worker's Compensation Board of Indiana to grant the applicant self-insured status as allowed by IC 22-3-5-1.

This application is executed at _____ this _____ day of _____, _____.

FOR THE APPLICANT:

 Company)

BY: _____
 (Signature)

 (Printed Name)

TITLE _____
 (Must be an Officer of Applicant)

TELEPHONE NUMBER: _____

FOR BOARD USE ONLY:

_____ APPROVED _____ DENIED

COMMENTS: _____

DATED: _____

WORKERS COMPENSATION BOARD OF INDIANA

BY: Linda Peterson Hamilton, Chairman

Application Type	Amount Due	Payment Information
New application	\$500.00	
Renewal Application	\$250.00	
Late: filed after 7/31/11 or incomplete renewal application		