Clear Print

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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Our File: _____

APPLICATION FOR A CERTIFICATE OF CONSENT TO ADMINISTER WORKERS' COMPENSATION SELF INSURANCE CLAIMS

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

The undersigned administrative agency hereby applies for a Certificate of Consent to Administer workers' compensation claims for permissibly self-insured employers in accordance with the provisions of California Labor Code Section 3702.1.

1. Date: _____

2. Type of Application:

☐ New ☐ Addition of Reporting Location(s) Only

☐ Renewal of Existing Certificate to Administer No.: ☐☐☐ (Three Digits)

3. Name of Administrative Agency: _____

Street Address: _____

Mail Address: _____

City: _____ State: _____ Zip: _____

Email: _____

4. Type of Entity:

☐ Corporation ☐ Partnership ☐ Proprietorship ☐ JPA

5. Is the applicant a workers' compensation insurance carrier? ☐ Yes ☐ No

If yes, is the applicant a separate subsidiary to administer claims? ☐ Yes ☐ No

6. Name of Owner(s): _____

7. List the manager's name and adjusting location addresses and phone numbers below:

1. Name of Manager: _____

Administrative Agency: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ FAX: _____

Email: _____

Two-digit SIP Adjusting Location Number Assigned to This Office: ☐☐

7. (Continued) List the manager's name and adjusting location addresses and phone numbers below:

2. Name of Manager: _____

Administrative Agency: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ FAX: _____

Email: _____

Two-digit SIP Adjusting Location Number Assigned to This Office: ☐

3. Name of Manager: _____

Administrative Agency: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ FAX: _____

Email: _____

Two-digit SIP Adjusting Location Number Assigned to This Office: ☐

4. Name of Manager: _____

Administrative Agency: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ FAX: _____

Email: _____

Two-digit SIP Adjusting Location Number Assigned to This Office: ☐

5. Name of Manager: _____

Administrative Agency: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ FAX: _____

Email: _____

Two-digit SIP Adjusting Location Number Assigned to This Office: ☐

7. (Continued) List the manager's name and adjusting location addresses and phone numbers below:

6. Name of Manager: _____

Administrative Agency: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ FAX: _____

Email: _____

Two-digit SIP Adjusting Location Number Assigned to This Office: ☐

7. Name of Manager: _____

Administrative Agency: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ FAX: _____

Email: _____

Two-digit SIP Adjusting Location Number Assigned to This Office: ☐

8. Name of Manager: _____

Administrative Agency: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ FAX: _____

Email: _____

Two-digit SIP Adjusting Location Number Assigned to This Office: ☐

9. Name of Manager: _____

Administrative Agency: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ FAX: _____

Email: _____

Two-digit SIP Adjusting Location Number Assigned to This Office: ☐

7. (Continued) List the manager's name and adjusting location addresses and phone numbers below:

10. Name of Manager: _____

Administrative Agency: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ FAX: _____

Email: _____

Two-digit SIP Adjusting Location Number Assigned to This Office: ☐

8. List below the name of the city of each adjusting location in number 7 above; then the name of each self-insured employer serviced at that adjusting location; the number of the Certificate to Self Insure for each self-insured employer; and the name of the claims adjuster-who has demonstrated their individual competence by passing the Self Insurance Administrator's examination-who is responsible for the self insurer's claims at that adjusting location:

Adjusting Location (City)	Name of Self-insured Employer	Certificate Number	Name of Competent Person

8. (Continued)

Adjusting Location (City)	Name of Self-insured Employer	Certificate Number	Name of Competent Person

9. Period of Time for Certificate Issuance Requested:

☐ 1 Year ☐ 2 Years ☐ 3 Years

10. Fees Due with this Application (not applicable to joint powers authorities and insurance carriers):

(a) Base Fee $1000 for each Administrative Agency per year (includes initial adjusting location):

$1000 x years = $

(b) Adjusting Location Fee of $200 for second and subsequent adjusting locations per year:

$200 x additional locations x years = $

(c) Fees Submitted with Application: $

The information submitted in this application is true and correct to the best of my knowledge.

Signature of Person Completing Application: _____

Typed Name of Person Completing Application: _____

Title of Person Completing Application: _____

Phone number: _____

Date: _____