



State of California
Department of Industrial Relations
OFFICE OF SELF-INSURANCE PLANS

APPLICATION FOR AFFILIATE CERTIFICATE OF CONSENT
TO SELF-INSURE AS A MEMBER OF A GROUP SELF-INSURER
All questions must be answered. If not applicable, enter "N/A".

To the Director of the Department of Industrial Relations: The employer identified below submits the following information to obtain an Affiliate Certificate of Consent to Self-Insure as a member of a group self-insurer to secure the payment of workers' compensation under California Labor Code Section 3700.

NAME OF APPLICANT EMPLOYER: _____

IF A PARTNERSHIP, LLC OR LLP (Name all partners and designate whether they are general, special, limited, etc.):

Table with 3 columns: Name, Address, Designation. Multiple rows for listing partners.

Does the applicant have any corporate subsidiaries (if so, subsidiary must file own application)?

Yes No

Table with 3 columns: Subsidiary Name, Address, Operation. Multiple rows for listing subsidiaries.

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

If yes, what is the current Certificate Number? _____

Number of Affiliate's California employees to be covered by this self-insurance plan: _____

Will the number of California employees covered under the proposed self-insurance plan materially change in the next 12 months? Yes No

If yes, by how many _____ Increase _____ Decrease

Indicate net profit or loss after taxes for the last 3 years.

Year	Amount
20 ____	\$ _____
20 ____	\$ _____
20 ____	\$ _____

Name of current carrier _____

Current policy termination date _____

Complete the following for the applicant's California workers' compensation policies for the most recent 3 years' experience by policy period (include most recent partial year through last quarter):

Year	Payroll Premium	Before Dividend	Experience Modification	Losses Incurred	Loss Ratio
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Will a policy covering any of the applicant employer's California workers' compensation liability other than excess insurance be carried? Yes No

If yes, what will be the nature and scope of this coverage?

Name of individual responsible for workplace injury and illness prevention program:

Name _____ Title _____

Address _____

Telephone Number _____

REQUIRED ATTACHMENTS:

- Groups Affiliate Member Interim Application Form S-2A (if not previously submitted).
- Executed Resolution to be Self-Insured as a Member of Group Self-Insurer Form S-3.
- Executed Indemnity Agreement Form S-4.

I certify under penalty of perjury that I am acquainted with the affairs of the said applicant employer to which representations made in the foregoing application, that I have read the application and attachments, know the contents thereof and that said representations and statements contained therein are true to the best of my knowledge, information and belief.

X _____
SIGNED: Group Authorized Representative

Printed Name & Title