Form: S-2B (1-2016)

State of California
Department of Industrial Relations
Office of Self-Insurance Plans
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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.)**:**

Name	Address	Designation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

☐ Yes ☐ No

Subsidiary Name	Address	Operation
_____	_____	_____
_____	_____	_____
_____	_____	_____

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