State of California
Department of Industrial Relations
Office of Self-Insurance Plans
1750 Howe Avenue, Suite 215
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State of California
Department of Industrial Relations
OFFICE OF SELF-INSURANCE PLANS

APPLICATION FOR CERTIFICATE OF CONSENT TO SELF-INSURE AS A PRIVATE EMPLOYER SELF-INSURER

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

To the Director of the Department of Industrial Relations: The private employer identified below submits the following information to obtain a Certificate of Consent to Self-Insure the payment of workers' compensation under California Labor Code Section 3700.

NAME OF APPLICANT EMPLOYER: _____

Address: _____

City: _____ State: _____ Zip + 4: _____ - _____

Federal Tax ID # of Applicant: _____

State of Incorporation: _____ Date of Incorporation (mm-dd-yyyy): _____

WHO SHOULD CORRESPONDENCE REGARDING THIS APPLICANT BE ADDRESSED TO:

Name: _____ Title: _____

Company Name: _____

Address: _____

City: _____ State: _____ Zip + 4: _____ - _____

Phone: _____ E-Mail: _____

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

If yes, what is the current Certificate Number: _____

What is the desired effective date of self-insurance if the application is approved_____

Will a policy covering any of applicant employer's California workers' compensation liability other than excess insurance be carried? ☐ Yes ☐ No If yes, what is the nature and scope of coverage?

_____

Describe the general nature of the business of the company:

_____

Applicants primary 3-digit NAICS Code: _____

Is applicant or any subsidiaries in the professional employer (PEO) or staffing industries? ☐ Yes ☐ No

Total number of applicant's California employees: _____

Will the number of California employers change more than 20% during the next 12 months?

☐ No ☐ Yes (If yes, briefly describe by how many and why):

Complete the following for the California workers' compensation policies for the most recent 3 years' experience by policy period:

Year	Payroll	Premium Before Dividend	Losses Incurred	Mod Factor
	$	$	$	
	$	$	$	
	$	$	$	
		Total For Past 3 Full Years:	$ 0	

Name of current workers' compensation carrier: _____

Policy Number: _____ Current Policy Termination Date: _____

Is there any pending litigation or legal proceeding which might substantially adversely affect the business or financial condition of the Applicant: ☐ No ☐ Yes (If Yes, explain)

SECURITY DEPOSIT

Upon approval of this application, what form does the applicant anticipate posting its required deposit in?

☐ Cash ☐ Surety Bond ☐ Letter of Credit ☐ Approved Securities

WORKPLACE SAFETY

Please identify the person primarily responsible for applicant's workplace safety and health programs:

Name: _____ Title: _____

Phone: _____ E-Mail: _____

LEGAL STRUCTURE

TYPE OF ENTITY OWNERSHIP: ☐ Corporation ☐ Partnership ☐ Sole Proprietorship
(Complete appropriate section below)

CORPORATION

☐ Closely Held

☐ Publically Traded (Trading Symbol: ____, Exchange ____ NYSE ____ NASDAQ ____ Other: ____

State of Incorporation (if Corporation): _____

Is the Applicant a wholly owned subsidiary of another firm? ☐ Yes ☐ No

If yes, please identify the Parent:

_____

PARTNERSHIP

Name of all Partners and identify if they are general, special, limited, etc.:

NAME	ADDRESS	TYPE

SOLE PROPRIETORSHIP

Owner's Full Name: _____

Address _____

City _____State _____ Zip +4 _____

CLAIMS ADMINISTRATION

List the third party administrator the applicant proposes to use:

Name: _____ Title: _____

Company Name: _____

Address: _____

City: _____ State: _____ Zip + 4: _____ - _____

Administrative Agency's Certificate to Administer #: ___ ___ ___

Will ALL claims be administered at the ONE adjusting location above? ☐ Yes ☐ No

If No, and there will be multiple adjusting locations, identify additional locations below.
Attach additional pages if necessary.

Name: _____ Title: _____

Company Name: _____

Address: _____

City: _____ State: _____ Zip + 4: _____ - _____

Administrative Agency's Certificate to Administer #: ___ ___ ___

Name: _____ Title: _____

Company Name: _____

Address: _____

City: _____ State: _____ Zip + 4: _____ - _____

Administrative Agency's Certificate to Administer #: ___ ___ ___

AGREEMENT

I am acquainted with the affairs of the applicant to which representations made in the foregoing application and subsequent attachments and supporting documentation. I have read the application and attachments and believe them to be true to the best of my knowledge.

X_____ DATE: _____
SIGNED: Authorized Representative

_____ _____
Printed Name Title

_____ _____
Telephone Number E-mail

For questions or assistance in completing the application process, please feel free to initially call to discuss your application with one of OSIP's Senior Compliance Officers at (916) 464-7000.

CHECK LIST FOR A COMPLETE SELF-INSURED APPLICATION

The California Code of Regulations, Title 8, Chapter 8, Subchapter 2, provides the requirements for submitting a complete Self-Insurer's Application. The following forms and documents are required by this section to be included with the application.

In addition to a complete application (Form A-1), all of the following forms and attachments are required to complete the application.

FILING FEE - $500.00:

A check must accompany the application before processing will begin.

Make checks payable to: Department of Industrial Relations-Office Self-Insurance Plans and mail to:

1750 Howe Avenue, Suite 215, Sacramento, CA 95825

COMPLETE APPLICATION CHECKLIST:

Form #	Description
A – 1	Application
A – 4	Agreement and Assumption
A – 5	Resolution to Self-Insure
A – 5B	Parental Guarantee (If required)
A – 6	Agreement and Undertaking of Security Deposit
	3 Years Audited Financial Statements
	Certificate of Status (see below)
	Filing Fee Check

OTHER REQUIREMENTS:

- An original Certificate of Status or other appropriate license or registration documents showing the applicant is licensed or registered to do business in California.

SUBSIDIARY ENTITIES (IF NEEDED):

- For each additional subsidiary entity other than the primary master applicant that requires an individual certificate issued in their name, complete Form A-3B for each and attach the appropriate fees. All combined fees may be paid by a single check.

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