

**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