

OKLAHOMA INSURANCE DEPARTMENT STATE OF OKLAHOMA



3625 N.W. 56th Street, Suite 100
Oklahoma City, OK 73112
(405) 521-3966 • FAX (405) 522-4160

QUALIFIED EMPLOYER ELECTION FORM

(85A O.S. §202 et seq.)(Please read and type all information)

This coverage pertains to employees performing work within Oklahoma only. Should an employer desire to provide coverage for employees performing work outside the state of Oklahoma then additional and/or other states' coverage must be acquired.

Proposed Effective Date of Election: _____

(No election shall be effective prior to February 1, 2014. All elections require confirmation from the Oklahoma Insurance Department. Employers are responsible for maintaining workers' compensation coverage until Qualified Employer status is confirmed.)

Employer Information:

1. Name of Company: _____ Telephone: _____

Mailing Address: _____

Email: _____ Fax: _____

2. Contact Person: _____ Title: _____ Telephone: _____

Email: _____

3. Federal Employer Identification Number: _____

4. Number of persons employed in Oklahoma:
 Less than 100 100 or more
5. Net assets of your company:
 Less than \$1,000,000 \$1,000,000 +
6. Will your benefit plan be a part of an ERISA employee welfare benefit plan?
 Yes No
7. Is your Claims Administrator (check one):

- In-House Third-Party Insurer

Claims Administrator: _____ Title: _____ Telephone: _____

Third-Party Administrator's Oklahoma Insurance Department License Number:

Mailing Address:

Email: _____ Fax: _____

8. Will a Captive Insurance Company fund your Qualified Employer program?
 Yes No

If so, please provide the name and domicile of your Captive Insurance Company.

Name: _____ Domiciled: _____

Business Locations:

List all Oklahoma business locations of the employer:

1. Name: _____ Telephone: _____
 Address: _____
 Email: _____ Fax: _____

Federal Employer Identification Number: _____

2. Name: _____ Telephone: _____

Address: _____

Email: _____ Fax: _____

Federal Employer Identification Number: _____

3. Name: _____ Telephone: _____

Address: _____

Email: _____ Fax: _____

Federal Employer Identification Number: _____

Include as an attachment to this form any additional Oklahoma business locations.

INCLUDE THE FOLLOWING AT THE TIME OF FILING THIS FORM:

- A. The Employer's annual nonrefundable filing fee of \$1,500.00. (Payable to the Oklahoma Insurance Department.)
- B. Copy of the Employer's **NOTICE TO EMPLOYEES CONCERNING QUALIFIED EMPLOYER**.
- C. Effective date and copy of Employer's written benefit plan. (**Note:** Must comply with the requirements of 85A O.S. § 203. Please refer to the written benefit plan compliance requirements of 85A O.S. § 203, 85A O.S. §§ 45, 46 and 47.)
- D. If the Employer insures all or part of the benefits under its written benefit plan, a copy of the insurance policy or proof of coverage, which satisfies its compensation obligation. (**Note:** Insurance coverage must be from an admitted or surplus lines insurer with an AM Best Rating of B+ or better.)

IF YOU ARE SELF-INSURING THEN YOU MUST ADDITIONALLY PROVIDE ATTACHMENTS E & F:

- E. Copy of the Employer's most recent annual financial statement
- F. Employers with less than 100 employees or less than \$1,000,000 in net assets, deposit with the Oklahoma Insurance Department **securities**, an **irrevocable letter of credit** or **surety bond payable to the state** in an amount equal to the Employer's average yearly claims history for the last three (3) years or as determined by the Commissioner.

Employers with 100 or more employees and \$1,000,000 or more in net assets, secure a **surety bond payable to the state**, or an **irrevocable letter of credit** in an amount equal

to the Employer's average yearly claims history for the last three (3) years or as determined by the Commissioner.

An Employer may also provide proof of excess coverage with such terms and conditions commensurate with its ability to pay the required benefits for its employees' occupational injuries.

Certification

The undersigned hereby certifies that the above and foregoing information is true and correct to the best of his/her knowledge and that the written benefit plan or any insurance coverage information provided will satisfy the requirements of Title 85A of the Oklahoma Statutes, section 201 to 211.

Signature of Director or Officer

Title

Name

Date

Name of Agent or Broker (if applicable)

The Oklahoma Insurance Department must be informed of any changes in a Qualified Employer's written benefit plan, certifying Director(s) or Officer(s), insurance coverage, or if a Qualified Employer chooses to re-enter the Workers' Compensation Administrative System.

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