

OKLAHOMA WORKERS' COMPENSATION COMMISSION
1915 NORTH STILES AVENUE
OKLAHOMA CITY, OK 73105
(405) 522-3222 or In-State Toll Free (855) 291-3612

APPLICATION FOR INDIVIDUAL OWN RISK EMPLOYER PERMIT

Date _____

The undersigned, an employer subject to the provisions of the Administrative Workers' Compensation Act, hereby applies for permission to carry its own risk without insurance. To enable the Workers' Compensation Commission to determine whether or not the applicant possesses sufficient financial ability to render certain the payment of any award made by the Commission, said applicant hereby states the following:

1. Employer's Legal Business Name _____
2. If the Employer does business, or has done business under another name in Oklahoma , including any trade name, list those other names _____

3. Own Risk # (if a renewal applicant) _____
4. Employer's Federal Identification Number (FEIN) _____
5. Home Office Mailing Address _____

(Please include City, State, Zip)
6. Home Office Physical Address (if different) _____

(Please include City, State, Zip)
7. Oklahoma Principal Office Address (if different) _____

(Please include City, State, Zip)
8. If the Employer is an out-of-state company, give year licensed to do business in Oklahoma _____
9. Nature of business _____
10. Name of the Employer's Medicare Reporting contact (*If managed through a third party vendor, list company's name and contact*) _____

11. Primary contact for Employer (*Whom we should contact for additional information about this application*)

Name

Title

Email address Telephone Number

12. Secondary contact for Employer (*Whom we should contact if the primary contact is not available*)

Name Title

Email address Telephone Number

13. General Company Information:

a. Years engaged in continuous business _____ In Oklahoma _____

b. Number of employees presently employed _____ In Oklahoma _____

c. Estimated payroll in Oklahoma for the next twelve (12) months _____

d. Payroll in each of the preceding three (3) years:

Overall

In Oklahoma

Year: _____, \$ _____

Year: _____, \$ _____

Year: _____, \$ _____

Year: _____, \$ _____

Year: _____, \$ _____

Year: _____, \$ _____

14. a. Is the Employer applying for an Oklahoma Own Risk License owned by another employer or parent company? (Check appropriate answer) Yes No

If yes, list owner name: _____

b. Does the Employer want to cover other employers/companies under the permit? (Check appropriate answer) Yes No

If yes, list other employers/companies; _____
Attach a list of other employers/companies, with the employer/company FEIN, address, and covered locations.

c. Does the Employer own other employers/companies that it does not want to cover under the permit? (Check appropriate answer) Yes No

If yes, list other employers/companies; _____
Attach a list of other employers/companies, with the employer/company FEIN, address, and covered locations.

15. a. Does the Employer use a Third-party Administrator (TPA) or an In-house Benefit Administrator to service self insurance claims? (Check appropriate answer) TPA In-house Benefit Administrator

b. If the Employer uses a TPA, provide the name and address (including City, State, and Zip) of the TPA, contact name, contact phone number, and contact email address: _____

c. If the Employer uses an In-house Benefit Administrator, provide the name and Oklahoma adjuster's license number: _____

16. In the section below, state the loss history for the past five (5) years. Copy the requested information from your loss runs. **Also include the current year's history, indicating how many months of the current year are included.**

Note: An actuarial report may be requested by the Commission.

a. Total incurred losses in Oklahoma (include for all injuries, both open and closed claims):
(Please report by date of injury, not date reported or date paid)

Calendar Yr or Fiscal Yr Ending	Medical \$ Paid	Indemnity \$ Paid	Total \$ Paid (including any expenses)	\$ Total Reserves Outstanding
2017 __ # mos.				
2016				
2015				
2014				
2013				
2012				

Calendar Yr or Fiscal Yr Ending	# of Cases Opened	# of Cases Reopened	# of Cases Closed	# of Cases Currently Open
2017 __ # mos.				
2016				
2015				
2014				
2013				
2012				

b. Total Self Insurance Net Reserves Outstanding for All Years of Self Insurance: _____
(Net Reserves Outstanding = Current Reserves Minus Any Expected Excess Carrier Reimbursements)

c. Total Self Insured Open Cases for All Years of Self Insurance: _____

d. Estimated manual premium: _____
(This information may be available from the Employer's excess insurance carrier, agent or broker)

17. Excess Insurance Information:

a. Name of Carrier _____ Policy # _____

b. Policy dates: Effective _____ Expiration _____

c. Self Insured Retention _____

d. Does the Employer carry Aggregate Excess Insurance? (Check appropriate answer) Yes No

If yes: Aggregate Retention _____ Aggregate Limits _____

Note: A certificate of excess insurance or a valid binder issued by said carrier must be attached to this application. If coverage renews during the permit year, please send a copy of the certificate for the renewed coverage.

18. For governmental entities:

a. Amount appropriated for the current fiscal year _____

b. Amount appropriated for the next fiscal year (if available) _____

c. Amount any other reserved funds allocated for payment of prior years' open claims: _____

19. Include the **nonrefundable annual application fee of \$1,000**, made payable to the **OK Workers' Compensation Commission**, and any required attachments indicated below with this application. All items may be emailed to InsuranceDepartment@wcc.ok.gov. However, we **must** receive the original parental guaranty via mail or courier.

Signed Application

Nonrefundable annual application fee **\$1000** made payable to: **Oklahoma Workers' Compensation Commission**

Proof of Excess Insurance (the most current certificate; a current certificate is required for final approval) **The Workers' Compensation Commission should be listed as the Certificate Holder or Regulatory Authority.**

A completed **Designation of Service Agent** CC-Form 7 (even if there are no changes from last year)

The Employer's most recent audited financial statements, including balance sheet, income statement, statement of cash flows, and notes (If the company does not have audited financial statements, unaudited financial statements signed by two company executives may be submitted)

If the Employer is owned by another company, the audited financial statements for the parent company

The most recent interim financial statements available for the Employer and any parent company, including balance sheet, income statement, and statement of cash flows.

If the Employer has employees at multiple Oklahoma locations, a list of all locations, with the full address for each location.

A list of any additional employers/companies to be included under the permit, including their Federal Identification Number (FEIN) and list of covered Oklahoma locations.

If the Employer owns other employers/companies that should **not** be included on the permit, a list of the names, addresses, and federal employer identification numbers (FEIN) of ALL employers/companies to be excluded from the permit, including subdivisions. Advise whether those employers/companies are included under another Own Risk License, or if workers' compensation obligations are Insured and by what Insurance Carrier Name.

Loss runs for the past five years. **Loss runs should contain a summary for each year, containing total \$ paid (including any expenses) and total reserve \$ outstanding. Data that identifies individual employees may be redacted.** Actuarial reports are not required but are helpful if available.

If the renewing Employer has a parental guaranty of funds and there are **any changes to the named insureds** on the permit applicant/renewal; then **you must provide a new, notarized original parental guaranty** from the parent or principal employer.

For Governmental Entities A copy of the minutes from the board meeting where the budgeted amount was approved.

For Governmental Entities If the financial statement or CAFRA does not indicate that the appropriated funds are placed into a segregated fund, in compliance with Commission Rule 810:25-9-11, please provide documentation that the funds are placed in a segregated fund.

20. **PLEASE READ CAREFULLY –**

In consideration of the approval of this application, **the applicant hereby expressly agrees as follows:**

- a. The applicant's privilege to carry its own risk without insurance may be revoked at any time for good cause by the Workers' Compensation Commission.
- b. The applicant agrees to notify the Commission of any change in its financial condition or ownership in the interim period between applications, such as a net financial loss, which may impact the applicant's financial ability to pay its workers' compensation obligations.
- c. The applicant agrees to comply with all applicable statutes and the rules of the Workers' Compensation Commission.

Administrative Workers' Compensation Act, 85A O.S., §6(A)(1)(a): "Any person or entity who makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who employs any device, scheme, or artifice, or who aids and abets any person for the purpose of: (1) obtaining any benefit or payment ... shall be guilty of a felony."

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony punishable by imprisonment, a fine or both.

I declare under penalty of perjury that I have examined this application and all statements contained herein, and to the best of my knowledge and belief, they are true, correct and complete.

Signed this _____ day of _____, 20_____.

Signature

(NOTE: the person signing MUST be authorized to bind the Own Risk Employer to the agreements contained herein)

Print Name of Person Signing Above

Title of Person Signing Above

Mailing Address

City

State

Zip Code

Street Address, if different from Mailing Address

City

State

Zip Code

E-mail Address of Person Signing Above

Telephone Number of Person Signing Above

Send application to:
OKLAHOMA WORKERS' COMPENSATION COMMISSION
 PERMITTING SERVICES DIVISION
 1915 NORTH STILES AVENUE, SUITE 231
 OKLAHOMA CITY, OK 73105