

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 Name _____

2. Own Risk # (if a renewal applicant) _____

3. Employer's Federal Identification Number _____ SIC Code _____

4. Home Office Mailing Address _____
(Please include City, State, Zip)

5. Home Office Physical Address _____
(Please include City, State, Zip)

6. Oklahoma principal office address _____
(Please include City, State, Zip)

7. If a foreign corporation, give date licensed to do business in Oklahoma _____

8. Nature of business _____

9. Name of the Employer's Medicare Reporting contact _____

10. Primary contact for employer _____
Name Title

Email address Telephone Number

11. Secondary contact for employer _____
Name Title

Email address Telephone Number

12. 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) fiscal years:

<u>Overall</u>	<u>In Oklahoma</u>
Year: _____, \$ _____	Year: _____, \$ _____
Year: _____, \$ _____	Year: _____, \$ _____
Year: _____, \$ _____	Year: _____, \$ _____

13. Is the applicant a subsidiary of another employer? (Check appropriate answer) Yes No
 If yes, list parent company name: _____

14. Name, address and email address of the employer’s Third-Party Administrator for the servicing of the self insurance claims, if any: _____

15. In the section below, state the loss history for the past five (5) calendar 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 year of injury, not year reported or year paid)

Calendar Yr or Fiscal Yr	Medical \$ Paid	Indemnity \$ Paid	Total \$ Paid	Loss Adj. Expense	Total Experience
2015 mos.					
2014					
2013					
2012					
2011					
2010					

Calendar Yr or Fiscal Yr	Number of Form 2’s Received	Cases Currently Open	Number of Cases in Litigation	Total Number of Claims
2015				
2014				
Totals				

Calendar Yr or Fiscal Yr	Current Reserve \$ Outstanding	Total Reserve \$ Initially Calculated	Reserve \$ Net of Excess
2015			
2014			
2013			
2012			
2011			
2010			
For All Years Self Insured			

- b. Total Self Insurance Reserves Outstanding for All Years of Self Insurance: _____
(Net of Excess Carrier Reimbursements)
- c. Estimated manual premium: _____
16. For governmental entities:
- a. Amount appropriated for the current fiscal year _____
- b. Amount appropriated for the next fiscal year (if available) _____
17. Please include the following with the application:
- a. A nonrefundable \$1,000 application fee, payable to the Oklahoma Workers' Compensation Commission.
 - b. Completed form CC-Form 7, Designation of Service Agent, available at wcc.ok.gov.
 - c. A copy of the employer's current excess insurance certificate. If the certificate expires prior to Own Risk Permit renewal, update upon binding.
 - d. If multiple locations of the employer or a subsidiary of the employer are to be covered under the permit, a list of locations to be covered.
 - e. Loss runs for the past five years, by calendar year, to support the paid and outstanding loss amounts. (Claimant data should not be included).
 - f. If an in-house benefits administrator is used to administer claims instead of an approved Third-Party Administrator, submit a copy of the unrestricted Oklahoma Claims Adjuster License.
 - g. The most recent audited annual financial report, including: balance sheet, statement of income, statement of cash flows, and notes.
 - 1) Please submit the actual financial statements, NOT draft audit reports, Powerpoint presentations, or press releases.
 - 2) Financial statements are required to be submitted in hard copy. However, it would facilitate the permit review process to also submit the financial statements as unlocked Excel spreadsheets via email to InsuranceDepartment@wcc.ok.gov or via a cd delivered with the application.
 - 3) If audited financials are not prepared in the standard course of business, financial statements for the past two (2) complete years (including balance sheet, statement of income, and statement of cash flows), signed by two company executives, and federal tax returns for the past two (2) years.
 - h. Interim financial statements for the most recent quarter, including: balance sheet, statement of income, and statement of cash flows. Statements should be presented in GAAP format. (Does not apply to governmental entities)
 - i. If the company is a subsidiary of another company:
 - 1) The parent company's financial statements.
 - 2) A copy of a written agreement whereby the ultimate parent employer guarantees that it will be fully responsible for any liabilities that its subsidiaries may incur under the Administrative Workers' Compensation Act. If a parental agreement was submitted in a prior year, only include a parental guaranty if there is a change to the named insureds on the permit.
 - j. If the employer has subsidiaries to be covered under the permit:
 - 1) A list of the names, addresses, and federal employer identification numbers (FEIN) of ALL entities to be included under this permit, including subdivisions. The additional employers' workers' compensation losses, payroll and employee counts must be aggregated with the primary permit holder and included on this application.
 - 2) A copy of a written agreement whereby the ultimate parent employer guarantees that it will be fully responsible for any liabilities that its subsidiaries may incur under the Administrative Workers' Compensation Act.
 - l. If there are subsidiaries to be excluded from the permit:
 - 1) A list of the names, addresses, and federal employer identification numbers (FEIN) of ALL entities to be excluded under this permit, including subdivisions.
 - m. For **Governmental entities**:
 - 1) A letter from an official listing the amount it has specifically appropriated for workers' compensation claims for the latest and the next fiscal year.

2) Copies of minutes from the board meeting where the budgeted amounts were approved.

18. 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 compensation.
- 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 of Corporate Executive Officer or Elected Official

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

Print Name of Corporate Officer or Elected Official

Title of Corporate Officer or Elected Official

Mailing Address

City

State

Zip Code

Street Address, if different from Mailing Address

City

State

Zip Code

E-mail Address of Corporate Officer or Elected Official

Telephone Number of Corporate Officer or Elected Official

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