NORTH CAROLINA DEPARTMENT OF INSURANCE
RALEIGH, NORTH CAROLINA
INDIVIDUAL EMPLOYERS SELF-INSURED FOR WORKERS' COMPENSATION
APPLICATION TO SELF-INSURE

The undersigned, an employer subject to the current and future provisions of the North Carolina Workers' Compensation Act (the "Act"), hereby applies for the privilege of becoming a self-insurer for the payment of compensation provided in the Act, and submits the following facts under penalty of perjury to the North Carolina Department of Insurance to enable it to determine the applicant's qualification for self-insured status:

- **Application (Form 10-WC) must be completed in its entirety, either typed or written in ink. All items must be answered, <u>even if the response is "0" or "Not Applicable" (N/A).</u>**
- **If extra space is required to respond to any of the items in the application package, please attach additional pages indicating the specific items for which additional information is provided.**
- **Please submit application to: SpecialEntitiesSubmissions@ncdoi.gov.**
- ***In accordance with N.C. Gen. Stat. § 97-170(b), please also mail a copy of the application submitted to the North Carolina Department of Insurance to: North Carolina Self-Insurance Security Association (NCSISA), Attn: Dewey R. Preslar, Jr., 1620 South MLK Jr. Ave., Suite 107, Salisbury, NC 28144.***
- ***Please also submit a letter of approval for membership by the North Carolina Self-Insurance Security Association.***

DESIRED DATE OF SELF-INSURANCE: ______________________________

PART A – APPLICANT EMPLOYER:

Name: ____

Street Address of Main Headquarters: ______________________________

City: ____________ State: ____________ Zip Code: ____________

Federal Tax Identification Number: ____________________

If the applicant is a subsidiary, complete the following:

Exact legal name of ultimate **parent:** ______________________________

Date parent incorporated/organized: ____________________

State: ____________________ FEIN: ____________________

APPLICANT EMPLOYER CONTACT PERSON:

Name: ______________________________

Title: ______________________________

Company Name: ______________________________

Street Address: ______________________________

Mail Address: ______________________________

City: ____________ State: ____________ Zip Code: ____________

Telephone Number: ____________ Fax Number: ____________

Email Address: ______________________________

APPLICANT EMPLOYER IS A (CHECK ONE):

Sole Proprietorship: ☐ Corporation: ☐

Partnership: ☐ Limited Partnership: ☐ Other: ☐

Explain: ☐

- If a Corporation, Partnership or Limited Partnership, under the laws of which State / Country was the applicant employer incorporated or organized?

  Date of incorporation or organization: ____________

- Has a worker's compensation insurance application ever been refused or policy cancelled?

  Yes ☐ No ☐

  If yes, provide an explanation of circumstances including date, name of jurisdiction, and name of carrier.

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- Is the applicant self-insured in any other jurisdiction? (If yes, see Part F, no. 5)

  Yes ☐ No ☐

- Has an application for self-insurance ever been denied or certificate revoked?

  Yes ☐ No ☐

  If yes, provide an explanation of circumstances including date and name of jurisdiction.

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- If applicant is rated by Moody's, Standard & Poor's, or Fitch Ratings provide the latest ratings including the date of the rating. If NOT rated, mark N/A:

	Rating	Date
Moody's Investor Service		
Standard & Poor		
Fitch Ratings		

- Name of current Insurance Carrier (immediately prior to proposed self-insurance effective date): ____________________________

- How long has the applicant employer been engaged in business in North Carolina? __________

- Has the applicant employer ever sought relief in Federal Bankruptcy Court or gone out of business?

  Yes ☐ No ☐

  If yes, provide detail.

- At the date of this application, is there any litigation or legal proceeding pending, or threatened, the result of which might substantially adversely affect the financial condition, business or operations of the applicant employer or any of its subsidiaries?

  Yes ☐ No ☐

  If yes, provide details.

PART B – DESCRIPTION OF SELF-INSURED OPERATIONS IN NORTH CAROLINA:

List below the current North Carolina locations, a brief description of the nature of self-insured operations, and number of employees by location:

Location and Address:	Nature of Self-Insured Operations:	No. of Employees:

List below a summary by risk classification of annual payroll and number of employees within North Carolina:

Job Class:	Job Description:	Number of Employees:	Estimate Annual Payroll for Current Year:

Total Number: _____ **Total: $_________**

- Total book value of fixed assets located in North Carolina? ___________________________

PART C – SAFETY CONDITIONS

- Are the locations of the applicant employer inspected other than by the NC Department of Labor?

  Yes ☐ No ☐

  If yes, by whom? ____________________

- Does the applicant employer have a safety committee whose duty is to recommend safety devices and to secure compliance with statutes or general order of the NC Department of Labor?

  Yes ☐ No ☐

  If yes, is the committee independent from the applicant employer?

  Yes ☐ No ☐

- Has the applicant employer fulfilled all safety requirements of the NC Department of Labor?

  Yes ☐ No ☐

- Is there, in connection with the self-insured operations of the applicant employer, or in the manufacturing or handling of products, and special or catastrophic hazard associated with such operations?

  Yes ☐ No ☐

  If yes, provide a full description, stating the maximum number of employees at one time exposed to such hazard.

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PART D – SUMMARY OF NORTH CAROLINA ACCIDENT EXPERIENCE:

Last Three (3) Calendar Years Ending: ___________________________

No. of accidents of all kinds: __________

No. of injuries causing disability of Seven days or longer: _________

No. of dismemberment's: __________

No. of deaths: __________

Total compensation paid: __________

Total liability for all open North Carolina claims as of: _____________ (MM/DD/YYYY) _____________ (Amount)

(Note: Information submitted must be within the last 90 days.)

PART E – SUMMARY OF SELF-INSURED REQUIREMENTS IN NORTH CAROLINA:

- Proposed form of security deposit (e.g., surety bond, letter of credit, approved securities, cash):

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- Proposed excess insurance coverage: ____________________________________

- Insurance Carrier: ______________________________

  Specific Retention: ___________________ Aggregate Retention: ___________________

  Specific Limit: _______________________ Aggregate Limit: _______________________

- Proposed administration of self-insured workers' compensation claims will be by: (Check One)

  Third Party Administrator: ☐

  Insurance Carrier Claims Department: ☐

  Self-Administered by Applicant Employer: ☐

Name: ____

Title: ____

Company Name: ____

Mail Address: ____

City: ______________________________ State: ___________________ Zip Code: _________

Telephone Number: _________________ Fax Number: ____________________

PART F – ATTACHMENTS:

ATTACHMENTS

Attachments detailed below are required and must be provided before application is considered complete. Failure to comply may result in your application processing being delayed.

1. Provide a complete set of certified audited financial statements with accompanying footnotes and auditor's opinion for the two most recent years, prepared in accordance with US GAAP or International Financial Reporting Standards (IFRS), for the applicant employer.

2.
   - If applicant employer is a **Corporation**, provide a list with the name, title and office address of top three (3) officers;
   - If applicant employer is a **Partnership or Limited Partnership**, provide a list with name and resident address of each partner.
   - If applicant employer is a **Sole Proprietorship**, provide the name and resident address of the sole proprietor.

3. The biographical affidavit must be completed in its entirety. All items must be answered, even if the response is "none" or Not Applicable". Duplicate copies of the form are to be made as needed. The biographical affidavit (See Form No. 19-WC) is to be completed for each applicant as follows:

   Corporations:
   - Three (3) officers of the company that will be directly involved with the proposed self-insurance program
   - Management position(s) that will be directly involved with the proposed self-insurance program

   Partnerships:
   - Partners with greater than 10% ownership in the company
   - Management position(s) that will be directly involved with the proposed self-insurance program

   Sole Proprietorship:
   - Owner
   - Management position(s) that will be directly involved with the proposed self-insurance program

4. If the applicant is part of a holding company system, submit an organization chart, which includes the hierarchical position of the applicant employer.

5. Provide a list of all other Self-Insured Jurisdictions, the amounts of security deposits on file, and the outstanding workers' compensation liabilities for the most recent fiscal year end.

6. A properly executed copy of a binder for **specific and aggregate** excess workers' compensation policy containing an endorsement to the North Carolina Department of Insurance, Financial Analysis & Receivership Division, Special Entities, 1203 Mail Service Ctr., Raleigh, NC 27699-1203. This policy must be placed with a North Carolina licensed insurance company or an approved insurance company eligible for the placement of surplus lines business. In addition, please note this policy is to include the following language, as required by N.C. Gen. Stat. §97-190(b)(1) & (2), stating that the policy shall:

   (1) Provide for at least 30 days' written notice of cancellation by registered or certified mail, return receipt requested, to the self-insurer and to the Commissioner.

   (2) Be renewable automatically at its expiration, except upon 30 days' written notice of nonrenewal by certified mail, return receipt requested, to the self-insurer and the Commissioner.

AFFIDAVIT OF APPLICANT EMPLOYER

In consideration of the approval of this application, the applicant employer hereby expressly agrees to the following:

- ***That the applicant employer will pay all benefits required by the North Carolina Workers' Compensation Act.***
- ***That the applicant employer agrees to deposit with the North Carolina Department of Insurance an acceptable security deposit to secure payment of workers' compensation obligations.***
- ***That all reports required by North Carolina law will be promptly filed with the North Carolina Department of Insurance.***
- ***That the applicant employer agrees to comply with the claims administration provisions of Article 47 of Chapter 58 of the General Statutes.***
- ***That this privilege may be revoked at any time as provided in North Carolina law.***
- ***That the applicant employer shall at all times maintain active membership status in the North Carolina Self-Insurance Security Association (NCSISA), and applicant employer further agrees to maintain such membership in accordance with the current and any future provisions of Chapter 97 of the North Carolina General Statutes.***
- ***That the applicant employer shall comply with all applicable provisions of the North Carolina's Workers' Compensation Act as well as any other laws, statutes, or regulations applicable to individual employers self-insured for workers' compensation.***

I, ______________________________ do hereby certify that I am thoroughly familiar with the operation and affairs of the applicant employer to whom the responsibilities and statements set forth in the foregoing application, attachments and exhibits relate; that I have read and studied said application, attachments and exhibits, and know the contents thereof; that I am authorized by the applicant employer to execute and submit this application with all attachments, exhibits and supporting documents, as well as to individually execute this affidavit; and that said application, representations and statements therein contained, together with all supporting attachments, exhibits and documents are true and correct to the best of my knowledge, information and belief. I am authorized by the applicant employer to bind the applicant employer to all terms of this application and all attachments, exhibits, and supporting documents, as well as the terms of this Affidavit.

This the__________day of_____________, ________.

Attest (if a corporation)

______________________________	______________________________
Signature of Corporate Secretary	Signature of owner, partner or designated corporate official
______________________________	______________________________
Name of Corporate Secretary (Typed or Printed)	Name (Typed or Printed)
	______________________________
	Title / Position with Applicant Employer