



**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, even if the response is "0" or "Not Applicable" (N/A).
- 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 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.*

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.

- 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.

- 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: _____

- 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.

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:

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

(MM/DD/YYYY)

(Amount)

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):

- 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, 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
 - 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