COMMONWEALTH OF VIRGINIA

VIRGINIA WORKERS' COMPENSATION COMMISSION
333 E. FRANKLIN STREET, RICHMOND VA 23219

Employer's Application for Individual Self-Insurance Under the Virginia Workers' Compensation Act

Note - Under rule, adopted by the Commission, November 20, 1918, all information given in this application is strictly confidential.

To the Virginia Workers' Compensation Commission:

The undersigned, an employer subject to the provisions of the Virginia Workers' Compensation Act, hereby applies for the privilege of being exempt from the necessity of insuring the payment of compensation provided in that act, and submits the following facts under oath to the Virginia Workers' Compensation Commission to enable it to determine if sufficient financial ability exists to render certain the payment of such compensation:

1. Applicant:

   Name: ______________________________

   Address: ______________________________

   City, State, Zip: ______________________________

2. Corporate information:

   2a. The applicant is a: ______________________________
   (Sole proprietorship, partnership, limited partnership, corporation, trustee.)

   Federal tax identification number (FEIN): ____-__________

   2b. If a corporation, indicate the State and date of the charter:

   State: __________ Date: __________

   2c. If a subsidiary, indicate the name and address of the parent company:

   Name: ______________________________

   Address: ______________________________

   City, State, Zip: ______________________________

   2d. If a limited partnership, give date of formation and duration:

   Date: __________ Duration: __________

   2e. List the names of all subsidiaries and/or operating entities doing business in Virginia:

   2f. List below the names and residences of officers, directors, partners, or the sole proprietor:

   Name **Address**

THIS FORM IS REQUIRED UNDER THE PROVISIONS
OF THE VIRGINIA WORKERS' COMPENSATION ACT.

3. Description of operations:

3a. Describe briefly the general character of the operations performed and the articles manufactured or compounded at or away from the plant or premises of the applicant:

3b. Indicate the Standard Industrial Code Number for this business: __________

3c. List below the Virginia locations, including a brief description of the nature of operations, and the number of employees:

Location	Type of operations	Number of employees

3d. List below the Virginia payroll, broken down by NCCI payroll classification codes:

NCCI code	Estimated annual payroll

4. Summary of financial situation for the past three years:

	20__	20__	20__
Total assets			
Total liabilities			
Net worth			

A complete set of audited financial statements for the last three years must accompany this application.

5. Safety conditions:

5a. Is your plant inspected otherwise than by State authority? Yes _______ No _______

If so, by whom? ____

5b. Have you fulfilled all safety requirements of the State Department of Labor and Industry?
Yes _______ No _______

5c. Do you have a safety committee whose duty it is to recommend safety devices and to secure compliance with statutes or general orders of the Department of Labor and Industry as to safety and sanitation?
Yes _______ No _______

6. Summary of claims experience for the last three years:

	20__	**20__**	**20__**
Total number of injuries			
Number of injuries with 7 or more days lost time			
Number of dismemberments			
Number of fatal cases			
Total compensation paid			
Total medical paid			
Total compensation incurred			
Total medical incurred			

A detailed report reflecting your claims history for the last <u>three</u> years must accompany this application.

7. Insurance information:

7a. Date self-insurance is to become effective (must be at least 90 days after application is filed): __________

7b. Indicate the limits of planned excess insurance coverage:

Specific retention ___________ Aggregate retention __________

Specific limit ___________ Aggregate limit __________

7c. Indicate below any other states in which you are operating as a self-insurer for workers' compensation:

7d. Provide the following information regarding your current workers' compensation insurance coverage:

Insurance carrier: ____

Policy number: ____

Policy period: ____

7e. List below other insurance that you carry (type and amount):

8. Claims administration:

8a. Proposed claims administrator (use additional sheets if there are multiple locations):

____
(Individual)

____
(Name of Company)

____
(Mailing Address)

____
(City, State, Zip)

____
(Telephone Number)

8b. In-state designated representative:

____
(Individual)

____
(Name of Company)

____
(Mailing Address)

____
(City, State, Zip)

____
(Telephone Number)

9. *In consideration of the approval of this application, the applicant hereby expressly agrees to the following:*

9a. *The applicant will pay all benefits required by the Virginia Workers' Compensation Act.*

9b. *If the Virginia Workers' Compensation Commission so requires, the applicant will deposit with the said Commission acceptable security, indemnity or bond to secure payment of compensation liabilities as they are incurred. Additional security, indemnity or bond may be required in the future.*

9c. *If the applicant is a subsidiary company or a partnership, the applicant will, if required by the Commission, provide certification that the parent company (or a partner or partners) guarantees that the applicant will fully and promptly pay all sums which are or may become payable under the provisions of the Virginia Workers' Compensation Act and under the terms of the agreement contained in this application.*

9d. *This privilege may be revoked at any time in the discretion of the Virginia Workers' Compensation Commission, as provided in Section 65.2-808 of the Act.*

9e. *The applicant will comply with the Regulations Governing Individual Self-Insurance, as provided in 16 VAC 30-80-10 of the Act.*

____
Signature of Applicant

____
Official Title

City/County of ________________________:

____, being first duly sworn, appeared personally and declared that the facts set forth in the foregoing application are true to the best of his or her knowledge, information and belief.

Subscribed and sworn to before me, this _______ day of ________________________________, ____________.

(Seal) (Seal)

____
Notary Public

My commission expires on the ______ day of _______________________, ___________.