STATE OF TENNESSEE
DEPARTMENT OF COMMERCE AND INSURANCE
Financial Affairs Section / Analytical Unit 0576
500 James Robertson Parkway, 4TH Floor
Nashville, Tennessee 37243
(615) 741-1633

SELF-INSURERS' QUALIFICATION REQUIREMENTS
EFFECTIVE: November 28, 2006

A company applying to be a workers' compensation self-insurer in the State of Tennessee must provide the following information:

1. A $500 non-refundable application fee, pursuant to Tenn. Code Ann. § 50-6-405(b) and Tenn. Comp. R. & Reg. Ch. 0780-1-83-.04(1)
2. Completed, signed, and notarized application.
3. Premium Tax will be assessed at the rate of 4.4% pursuant to Tenn. Code Ann. § 56-4-207. Please note that applications for self insurance received by this division prior to June 30 require submission of prior year end payroll reports and applications received after June 30 requires submission of estimated payroll reports for that year.
4. Minimum security of $500,000. The security may be in the following specified forms: negotiable securities, certificate of deposit, surety bond, or a letter of credit. A depository agreement must be completed for certificates of deposit or negotiable securities pursuant to Tenn. Code Ann. § 50-6-405(b)(1).
5. An excess insurance policy is required and should contain both specific and aggregate features. Pursuant to Tenn. Comp. R. & Reg. Ch. 0780-1-83-.06(1), "an employer shall obtain and maintain excess insurance, both specific and aggregate in an amount sufficient to cover its liabilities for losses not paid by the employer and as set by a qualified actuary."
6. Three most recent years of loss runs as of December 31, 20XX.
7. Three most recent years of Audited Financial Statements.
    a. Must have positive working capital
    b. Must have positive net worth
8. Three most recent years of experience modifications ("EM") if the company has been in business in Tennessee for more than 3 years. If the company is new and has just established business in Tennessee, the EM rating will set at 1.00 rather than considering the interstate rating. All EM must be on a calendar year basis and effective January 1.
9. Actuarial Opinion – Feasibility study
10. Listing of all locations, addresses including zip codes, and number of employees at each location.
11. Name, address, phone, and e-mail of the person in Tennessee who is responsible for handling claims, pursuant to Tenn. Code Ann. § 50-6-413.
12. Third party administrator (if applicable), pursuant to Tenn. Comp. R. & Reg. Ch. 0780-1-81-.02(13).
13. If the applicant is a subsidiary, an indemnity agreement must be completed.
14. Completed Anti-Fraud Plan.
15. Self-insurer should have a minimum workers compensation premium of $350,000.
16. Federal Employer Identification Number (FEIN).
17. Biographical Affidavit on all Officers and Director listed on the application (Item # 4). Biographical Affidavits can be found at http://www.naic.org/documents/industry_ucaa_form11.pdf.

Self-Insured Workers Compensation -- Single Employer
Admission Application Checklist

Company Name_____ FEIN # _____
Address _____
City _____ ST _____ Zip_____
Contact Person _____ Phone:_____ E-mail_____
Incorporated in TN _____ Self-Insurance Effective Date _____

Items filed	DESCRIPTIONS
☒ 1	Application fee $500, TCA 50-6-405(b) and Tenn. Comp, R. & Reg. Ch. 0780-1-83-.04(1)
☒ 2	Completed Application Form
☒ 3	Completed Payroll Report
☒ 4	Security--minimum requirement at $500,000, TCA 50-6-405(b)(1)
☒ 5	Excess Policy, Tenn. Comp, R. & Reg. Ch. 0780-1-83-.06(1)
☒ 6	Three most recent years of loss run reports
☒ 7	Three most recent years of Audited Annual Statements
☒ 8	Three most recent years of experience modifications or 1.00 rating
☒ 9	Actuarial Opinion – Feasibility study
☒ 10	List of all locations including address and number of employees at each location.
☒ 11	Name, address, phone, e-mail of person in TN who is handling claims, TCA 50-6-413
☒ 12	If using TPA, Tenn. Comp. R. & Reg. Ch. 0780-1-81-.02(13)
☒ 13	Indemnity agreement if applicant is a subsidiary
☒ 14	Completed Anti-Fraud Plan
☒ 15	Self-insurer should have minimum workers compensation premium of $350,000. This is a nationwide amount.
☒ 16	Federal Employer Identification Number
☒ 17	Biographical Affidavit on all Officers and Director listed on the application (Item # 4).

DEPARTMENT OF COMMERCE AND INSURANCE

Insurance Division– Self-Insurance Section
500 James Robertson Parkway, 4TH Floor
Nashville, Tennessee 37243-1132
Phone: (615) 741-1633
Fax: (615) 532-2788

Date:_____

Gentlemen:
The undesigned employer (applicant) submits the following statements and reports of qualifications to carry his own risk under provisions of the Workers Compensation Act of Tennessee.

1. Name of applicant:_____ Phone No._____

2. Address: _____
Street City County State Zip

3. The Applicant is:_____ _____
(State whether a corporation, public authority, other) (FEIN#)

4. List below the title, names and addresses of officers and directors of the corporation

Title	Name	Address

5. Date of commencement of business:_____
6. Chartered under the Laws of the state of_____ on _____
Date
7. If a foreign corporation, give date of registration in office of the Tennessee Secretary of State:_____
Date
8. Has there been any change in corporate structure within the last two years? _____

If yes, explain: _____

9. Has applicant any affiliates, subsidiaries, or divisions?_____ If so, give following information regarding same:

State whether affiliate, division or subsidiary	Name and office address	Character and location of business

10. Is Applicant a subsidiary? _____ If so, give name and address of Parent Company, and list all subsidiaries of same:
   1. Parent Company is:_____
   2. Its Subsidiaries are:

Name of subsidiary	Name and office address	City, State, Zip Code

11. Description of employment: For year ending _____

Locations in Tennessee	Kind of employment	Average number of employees in Tennessee	Actual payroll for all employees in Tennessee

Attach additional pages if necessary

12. Date when self-insurance is desired: _____

13. Name of current workers' compensation carrier: _____

14. Current workers' compensation premium paid in Tennessee: _____

15. What is the expiration date of you present policy? _____

16. What is your latest experience rating? _____ Please attach a copy of this rating.

17. Name of Service Company proposing to administer your program? _____

18. Statement of Assets and Liabilities

Assets			Liabilities			
Cash on hand and on deposit		$	Notes Payable(ScheduleB)		$	
Stocks (Schedule B)	$		Accounts Payable			
Bonds (Schedule B)			Accrued Taxes			
Mortgages (Schedule A)		$	Delinquent Taxes			
Notes Receivable			Other Payable (including accruals)			
Less allowances for notes past due		$	Deferred revenue or income			
Accounts Receivables			Total Current Liabilities		$	
Less allowances for accounts past due		$	Mortgage Indebtedness – Specify (showing maturities):			
Other receivables (including accruals)		$		$		
Inventories (note question 21)		$				
Prepayment, insurance, rent taxes etc.		$				
Total Current Assets		$			$	
Investments (long-term) Specify:			Bond Indebtedness – Specify (showing maturities):			
	$			$		
Other Assets and Deferred Charges Specify:			Deposit and other Trust Funds:			
	$			$		
					$	
			Reserves – Specify:			
		$		$		
				$	$	
Plant and Equipment	$		Other Liabilities – Specify:			
Real Estate (book value)				$	$	
Building (cost)			Net Worth:			
Machinery and Equipment (cost)			Capital Stock – preferred	$		
Furniture and Fixtures (cost)			Capital Stock – common			
Automobile, trucks, other vehicles (cost)			Paid-in surplus			
Total		$	Earned surplus			
Less depreciation			Total Net Worth			$
Total Assets		$	Total Liabilities and Net Worth			$

Answer all the following questions and fill in all schedules.

19. Inventories

Class	Method of Inventory	Date Taken	Amount

Attach additional pages if necessary

20. Are any assets mortgaged or pledged, in addition to those listed in Schedule B, C and D?_____
Yes or No

If yes, Amount _____ Explain:_____

21. Contingent Liabilities – (not included in the above financial or periodical statement) – Specify each:
(a) Notes re-discounted _____ _____
(b) Accommodations endorsements _____ _____
(c) Suretyships _____ _____
(d) Other guaranties _____ _____
(e) Goods held on consignment _____ _____
(f) _____ _____

22. Have your books been audited by a certified public accountant?_____ If so please submit a copy.
Yes or No

SCHEDULES SUPPLEMENTAL TO FINANCIAL OR PERIODICAL STATEMENT

SCHEDULE-A
NOTES AND LOANS RECEIVABLE

Name of Maker	Address	Secured? By What?	Amount

SCHEDULE-B
STOCKS AND BONDS OWNED

Description (Specify)	Book Value	Current Market Value	Actual Cost	Are these in default as to principal or interest?

Attach additional pages if necessary.

SCHEDULE-C
REAL ESTATE AND OTHER PHYSICAL ASSETS LOCATED IN TENNESSEE OWNED BY APPLICANT

Description and Location of Tennessee Property	Book Value	Assessed Value	Fire Insurance Carried on buildings	Amount of Liens on Property if any

Attach additional pages if necessary

SCHEDULE-D
NOTES PAYABLE

Payable to whom	Maturity	Secured? By What?	Amount

Attach additional pages if necessary

23. For three fiscal years, inclusive of latest completed year. (Covering applicant's business as a whole.)

Items: (Omit cents)	Year ended ____20____	Year ended ____20____	Year ended ____20____
Sales			
Total Assets			
Liabilities			
Net Worth			
Annual Profits or losses			
Dividends declared and paid			
Total Payroll			

24. Is the applicant in default or in arrears on any obligations (including cumulative dividends) to its mortgage holders, bond holders, or stockholders?_____ Amount?_____If so, specify or explain_____

25. Financial statements are prepared, (check): Quarterly_____ Semi-Annually_____Annually_____
On what calendar dates do such periodical statements become available?_____

26. Past three year's Accident Experience

	Date	Date	Date
Number of deaths			
Number of dismemberments			
Number of temporary disabilities exceeding 7 days duration			
Number of accidents of all kinds			

27. What arrangements have you made for first aid to insured employees?_____

28. What hospital facilities have you for injured employees?_____

29. To what doctors will you send your injured employees? _____

30. Describe provisions of contract for medical services, if any_____

31. Give Names and position of regular salaried employees who will handle your compensation cases?

Name	Position

32. Do you require applicant employees to submit to a medical examination by a physician or surgeon before assignment to permanent force?_____ If so, what deficiencies are sufficient for rejection?_____

33. Is there in connection with your business, or in the manufacturing or handling of products, any special or catastrophe hazard?_____If so, give full description, stating the maximum number of employees at one time exposed to such hazards. _____

What power is used to operate your machinery?_____

BUILDING OCCUPIED:

Number of Stories	What floors do you occupy?	Maximum Number of Employees of Any one floor. Give Location.	Fire Escapes

Number of Elevators, State whether passenger or freight.	Give Number of Boilers and locations	Stairways to Exits. Give width.

34. Who will be the Excess Insurance Company to protect you from any incurred liability under the Workers Compensation Act of Tennessee and what will be your proposed self-insured retention: _____

Has a photocopy of this policy been placed on file in The Department of Commerce and Insurance?_____

35. Is you plant inspected by other than State Authority?_____

36. Do you have a department or individual that pays particular attention to safety methods of operation? If so, is that department or individual supplied with the Safety Orders promulgated by the Tennessee Department of Labor with reference to your business?_____

_____

37. In consideration of the approval of this application, the applicant herebyexpressly agrees as follows:
   a. That this privilege may be revoked by the Commissioner of Labor, as provided in Section 50-6-407, Tennessee Code Annotated.
   b. That the applicant, who is carrying catastrophe or excess coverage insurance, will file a photocopy of the policy with The Department of Commerce and Insurance.
   c. That upon request by The Commissioner of The Department of Commerce and Insurance, the applicant will deposit with said Commissioner an acceptable surety bond amounting to not less than the minimum requirement.
   d. That I will not solicit, receive or collect any money from my employees or make any deduction from their wages for the purpose of discharging any part of my liability under the Workers Compensation Act and that I will not permit any person with my knowledge to sell or try to sell medical or hospital tickets to my employees for medical, surgical or hospital treatment required by law to be furnished by me to injured employees.

38. RATING AGENCY: Indicate whether your company or parent company is rated my the following rating agencies:

Standard & Poors Corporation	
Moody's	
Dun & Bradstreet	
Other (specify)	

Signed_____ Employer

By_____

_____
(Official Position)

AFFIDAVIT

(The person subscribing the affidavit below should be the employer himself; or if the employer be a partnership, one of the partners; or if the employer be a corporation, its president, vice-president, secretary or treasurer.)

State of_____

_____ County

_____, first being sworn on oath, deposes and says that he is the person who signed the forgoing application for the employer therein named, and that he is acquainted with the affairs of said applicant employer, to which the representations and statements set forth in the forgoing application, knows the contents thereof and that said representations and statements therein contained are true to the best of his knowledge, information and belief.

_____ _____
(Affiant's Signature) (Official Position)

Subscribed and sworn tobefore me at_____ ,this _____day

Of _____ , A.D., 20_____.

_____
(Notary Public)

IMPORTANT

When the applicant is a subsidiary company or a partnership, the Commissioner requires that the parent company, or any other company or persons holding stock in the applicant company, or a partner or partners in the applicant partnership, shall give a satisfactory guarantee that the applicant will fully and promptly pay all sums which are or may become payable under the provisions of the Tennessee Workers' Compensation Law and under the terms of the agreement contained in this application.

STATE OF TENNESSEE
THE DEPARTMENT OF COMMERCE AND INSURANCE
4TH FLOOR, SELF-INSURANCE SECTION
500 JAMES ROBERTSON PARKWAY, 4th FL.
NASHVILLE, TENNESSEE 37243-1132

SELF-INSURERS PAYROLL REPORT

ITEM 1. TO THE COMMISSIONER OF THE DEPARTMENT OF COMMERCE AND INSURANCE: _____ 20 _____.

The undersigned, an employer operating under the provisions of the Tennessee Worker's Compensation Act, as Self-Insurer, submits the following information for the purpose of enabling the Insurance Commissioner to determine the amount of tax due the State of Tennessee under provision of Section 50-6-405, Tennessee Code Annotated.

ITEM 2. Name of Employer .....

Address .....

ITEM 3. Figures contained in this report are for the purpose of adjusting the tax assessment made for the period of January 1, 20 ....., to December 31, 20....., and for making the assessment for the period of January 1, 20....., to December 31, 20 _____.

ITEM 4.

CODE	CLASSIFICATION OF OPERATIONS USE TYPEWRITER EXCEPT FOR SIGNATURES.	AVERAGE NUMBER OF EMPLOYEES IN TENNESSEE FOR YEAR ENDING DEC. 31, 20 ___	ACTUAL/ESTIMATED PAYROLL OF ALL EMPLOYEES IN TENNESSEE FOR PERIOD OF _____ 20 ___ TO _____ 20 ___
	TOTAL		

NOTE IMPORTANT

1. CLERICAL OFFICE EMPLOYEES. — This classification shall include those employees with office duties only and having no other duty of any other nature in or about the employer's premises.
2. Unless the payroll below is subdivided into proper classifications, the highest rate will be used in calculating the premium.
3. If employer has multiple locations, please consolidate classifications.

RETURN TOP COPY TO THIS OFFICE — RETAIN YELLOW FOR YOUR FILES

ITEM 5. The foregoing enumeration and description of employees includes all persons employed in the services of this employer in Tennessee in connection with the business operations above described to whom remuneration of any nature in consideration of service is paid, in whole or in part by bonuses, commissions, vacation pay, holidays or sickness periods, or on basis of piecework, or by store certificates, merchandise credits, or any substitute for money. Such form of payment shall be considered as wages to be included in the actual remuneration earned, *and the total remuneration earned by each employee shall be reported excluding only the part of overtime as set forth in the basis of premium.* This remuneration shall also include the President and Vice-President, Secretary or Treasurer of this employer in every instance where the Executive Officer actually performs such duties as are ordinarily undertaken by a Superintendent, Foreman, or worker, or whose duties include direct charge of the actual performance of any obligations of the risk. The entire payroll of such an Executive Officer shall be assigned without division to the highest rated classification which applies to any such duties undertaken by such Executive Officer for any part of his time. The Department of Insurance reserves the right to examine the books of this Employer at any time during the current or following year and any extension thereof so far as they relate to the remuneration earned by any employee of this employer.

.....
Name of Company.

I, ... (Title), of the above named company do hereby solemnly swear that the items of the foregoing account are correct and that they constitute the total amount of remuneration received by all employees in the State of Tennessee for the period stated therein to the best of my knowledge and belief.

.....
Official and Title.

Subscribed and sworn to before me this .....day of....., 20.....

My Commission Expires .....

.....
Notary Public.

STATE OF TENNESSEE
DEPARTMENT OF COMMERCE AND INSURANCE
Financial Affairs Section / Analytical Unit 0576
500 James Robertson Parkway, 4th Floor
Nashville, Tennessee 37243
(615) 741-1633

Bond # _____

Effective Date _____

BOND OF EMPLOYER CARRYING HIS OWN RISK

KNOW ALL MEN BY THESE PRESENTS: That _____ a corporation duly incorporated under the laws of the State of _____, _____ as principal, and _____, a corporation duly incorporated under the laws of the State of _____, as surety, are held and firmly bound unto the State of Tennessee for the use and benefit of the employees of the principal and to the dependents of such employees, in the sum of _____ Dollars, current money of the United States to be paid to the State of Tennessee, to the payment whereof we hereby bind ourselves and each of us, our and each of our heirs, executors, successors and assigns, jointly and severally, firmly, by these presents.

Sealed with our seal and dated, this _____ day of _____, A.D., 20 _____.

WHEREAS, the above bounden _____ did on the _____ day of _____, 20 _____, file with the Commissioner of Insurance of the State of Tennessee, his, her, their or its application for the privilege, under Section 50-6-405, Tennessee Code Annotated, and any amendments thereto, being a part of the Worker's compensation Insurance Law, Chapter 6, of Title 50, Tennessee Code Annotated, of paying compensation and operating under said Law without insuring the same; and

WHEREAS, the Commissioner of Commerce and Insurance did, on the _____ day of _____, 20 _____, grant this privilege upon the condition that the said principal enter into a bond in the penalty sum of _____ Dollars, conditioned, among other things, that said principal shall abide by and perform the requirements of the aforesaid Law and any amendments thereto, with reference to paying compensation and furnishing medical, surgical and other services and funeral expenses to said employees and their dependents;

NOW, THEREFORE, the condition of this obligation is such that if the above bounden _____ shall well and truly, from time to time, and at all times thereafter, abide by and perform all requirements of the aforesaid Law and any amendments thereto, respecting the payment of compensation and furnishing at its own cost and expense, of medical, surgical and other services and funeral expenses to said employees and their dependents, then this obligation shall be void, otherwise to remain in full force and effect virtue in law.

This bond is and shall be construed to be a direct obligation by the principal and surety herein either jointly or severally, to the person who may be entitled to such sum for medical, surgical and other services, funeral expenses or compensation and may be sued upon and enforced in the name or names of such person or persons pursuant to the aforesaid Law.

This bond may be cancelled at any time by the surety upon giving ninety (90) days written notice to the Commissioner of Commerce and Insurance of the State of Tennessee, and by providing a copy of the notice to the principal, in which event the liability of the surety shall, at the expiration of the said ninety days, cease and determine, except as to such liability of the principal on account of injury or death to any of its employees, as may have accrued prior to the expiration of said ninety days, it being understood that the surety shall be liable, within the penal sum mentioned herein, for the default of the principal in fully discharging any liability on its part accruing during the life of this obligation.

IN WITNESS WHEREOF, The said employer has caused these presents to be signed in its name by its President, and its corporate seal attached hereto, attested by its Secretary and the said Surety has likewise caused these presents to be signed in its name by its President, and its corporate seal attached hereto, attested by its Secretary.

_____ Per _____
Secretary — President

_____ Per _____
Secretary — President or Authorized Officer of Surety Co.

I, _____, Secretary of the employer corporation aforesaid hereby certify that by resolution adopted on _____ day of _____, 20 _____, the Board of Directors of the employer aforementioned directed and empowered the execution of this Bond.

In witness whereof I hereunto set my hand and affix my official seal.

_____
Secretary

(PLEASE ATTACH POWER OF ATTORNEY)

(USE THIS FORM OF ACKNOWLEDGMENT IF THE EMPLOYER IS A CORPORATION)

STATE OF _____,
_____ COUNTY.

This _____ day of _____, A.D. 20 _____, personally came before me, _____, Notary Public of _____ County, State of _____, _____ who being by me duly sworn says that he knows the common seal of _____ and is acquainted with _____ who is president of said corporation, and that he, the said _____, is the secretary of the said corporation and saw the said president sign the foregoing instrument, and saw the said common seal of said corporation affixed to said instrument by said president (or that he, the said _____ secretary as aforesaid, affixed said seal to said instrument), and that he, the said _____ signed his name in attestation of the execution of said instrument in the presence of said president of said corporation.

Witness my hand and official seal, this the _____ day of _____, 20 _____.

_____
Notary Public

My Commission Expires _____

White — Self-Insurance Section, Yellow — Surety Company, Pink — Self-Insured

INDEMNITY AGREEMENT

KNOW ALL MEN BY THESE PRESENT, that we _____, a corporation, organized and existing under and by virtue of the laws of the State of _____, for and in consideration of the State of Tennessee authorizing _____, a corporation, to operate as a self-insurer under the provisions of the Workers' Compensation Law of the State of Tennessee do hereby guarantee the payment by said _____ of any and all valid claims for compensation and other benefits made against it under the said Workers' Compensation Law for injury or death to any of its employees or former employees and in the event that said _____ shall not pay or cause to be paid directly to claimants the benefits due or that may become due under said Law, then the undersigned _____, covenants and agrees that it will pay to all such claimants the benefits due, including a reasonable attorney fee incurred by said claimants in any action brought on this agreement, with the expressed knowledge and understanding that the execution and acceptance of this agreement is for the benefit of unknown and unnamed employees and former employees of said _____, and that said _____ does hereby recognize this agreement as a direct financial guarantee to said employees or former employees.

PROVIDED HOWEVER, that _____, shall have a right to cancel and terminate this agreement at any time upon giving the State of Tennessee at least sixty (60) days written notice of its desire to do so; provided further, that such cancellation shall not affect its liability as to any benefits payable for injuries occurring prior to the date of cancellation specified in such notice.

This agreement shall be effective as of _____, 20____.

Signed, sealed and delivered this _____day of _____, 20____.

_____

By:_____

_____

(Official Position)

ATTEST:

_____

Secretary

CORPORATE SEAL

SUMMARY REPORT FORM FOR
WORKERS' COMPENSATION ANTI-FRAUD PLAN

Company Name: _____

Report prepared by: _____

Firm: _____

Address: _____ St:_____
ZIP:_____

==========

Reporting period:

==========

1. Describe the resources committed to the combating of fraud in this reporting period (number of employees, investigations performed by contracted investigators, costs of the resources used, etc.).

2. List the number of instances and amount of fraud discovered in this reporting period.

3. List the number and amount of recovery during this reporting period.

4. Describe, in as much detail as possible, any and all discovered criminal activities of an organized nature.

5. List the claim costs for discovered fraud from claims activity.

6. Describe the internal activities taken to detect fraud among company employees.

THIS FORM MUST BE SIGNED AND DATED

Signed: _____ Date: _____

This form must be filed on or before March 31.

REGISTRATION FORM FOR
WORKERS' COMPENSATION ANTI-FRAUD PLAN*

==========

Mark one box: Γ Original Filing Γ Re-filing of Modified Plan

==========

Company Name: _____

Contact Person: _____

Position Title: _____

Phone: (_____)-_____-_____

Location Address: _____

City:_____ ST: _____ ZIP: _____

Mailing Address: _____

City: _____ ST: _____ ZIP: _____

==========

Mark one box: Γ Insurance Company Γ Self-insured Employer
Γ Self-insured Group

==========

If Self-insured Employer or Group are you using a TPA to manage your plan? Γ Yes Γ No

TPA Name: _____

Address: _____

City: _____ ST: _____ ZIP: _____

Contact Person: _____

Phone: (_____)-_____-_____

==========

Signed at: _____ By: _____

Date: _____ Title: _____

*This form, or the information required by this form, must be a cover to your anti-fraud plan.