



APPLICATION FOR SELF-INSURANCE WORKERS' COMPENSATION LAW

Email completed form to: selfinsurance@wcb.ny.gov

An application to self-insure is not transferable to subsidiaries or successors. Each entity must file its own application. Additional applications can be found on the Board's website: www.wcb.ny.gov.

PLEASE NOTE: Submission of an application does not guarantee approval for self-insurance. Coverage must be maintained until you have received a Notice of Qualification. If deemed a candidate for self-insurance, a conditional approval will be issued. Notice of Qualification as a self-insurer will not be issued until all conditions have been met including, but not limited to submitting and maintaining an adequate security deposit and the submission of an Agreement and Undertaking for Paying Benefits as a Self-Insurer (Form SI-3).

The undersigned makes application as a self-insurer under Sec. 50, subd. 3 of the Workers' Compensation Law of New York State. In connection with such application the applicant makes the following declarations and makes the following affirmations for the purpose of enabling the Chair, Workers' Compensation Board, to determine that the applicant possesses sufficient financial ability and has adequate resources to render certain the payment of workers' compensation benefits to their employees as specified in the Law.

Attach the following documents to your application (Incomplete applications will not be considered):

- a. Independently audited financial statements covering three years immediately prior to application
b. Certified copy of foundation document (certificate of incorporation; partnership agreement; etc.)
c. Copy of the applicant company's safety program
d. Incurred loss history of the applicant for the last 5 years
e. A listing, by address, of factories, offices or other workplaces in New York State and estimated number of employees engaged in each place to be covered by the self-insurance privilege herein applied for.

Applicant _____ FEIN _____

Address (Principal Office) _____ Requested Effective Date: _____

Requested Retention Level Excess Policy \$ _____

1. Filing Status:

- Single entity Parent Company with subsidiaries (separate application required for each subsidiary) Subsidiary to consolidate with self-insured parent

Name of parent: _____

FEIN of parent: _____ Insurer ID No.: W _____

2. Nature of business:

a) Briefly describe the general character of the operations performed on the premises of the employer.

b) Briefly describe all classes of work performed away from the employer's premises.

3. What company is currently carrying:

- a) your workers' compensation insurance?
b) your disability insurance?
c) your paid family leave insurance?

4. Type of Entity:

- Corporation: Partnership: Sole Proprietorship:

a) Enter date when incorporated: _____

a) Name all partners and designate whether they are general, special, limited, etc.

a) Enter home address of proprietor _____

b) Under laws of what state _____

c) If not a New York corporation, enter the date of registration in New York state: _____

d) Has applicant any affiliates or subsidiaries with operations in New York state? Yes No

e) Did you succeed anyone? Yes No

f) If so, whom did you succeed? _____

g) If a subsidiary, enter name and address of parent company: _____

b) Enter date when partnership established: _____

h) Enter parent's percentage of stock ownership % _____

c) Attach certified copy of partnership agreement []

5. Names of Officers:

President: _____ Vice-President: _____

Secretary: _____ Treasurer: _____



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6. Report full payrolls for all employees. Include interstate, maritime, homeworkers, value of meals and lodgings, etc., received by employees and sub-contractor's employees' payrolls unless compensation is definitely provided by sub-contractors. Show bonus and overtime to employees separately by each classification below.

Table with 4 columns: Payroll Class No., Job Description of Payroll Classification, Estimated Average Number of Employees, Estimated Annual Wages Received by Each Class of Employees. Includes rows for 7380, 8742, 8751, 8809, 8810 and a TOTAL row.

By signing this Application, the signer certifies that they are authorized to execute this instrument on behalf of the [Insert Business Name] for the purposes set forth herein, and that, pursuant to that authority, they are executing this instrument in the name of and on behalf of said entity as an act and deed of said entity.

Signature of Authorized Official Title Date
Print Name of Authorized Official Phone # Email