Application for ExcessWorkers Compensation
Group Self-Insurance

☐ New Application Effective Date: _____

☐ Renewal of Policy Number: EWC00 _____ To Be Quoted By: _____

1. Name of Applicant (as shown on self-insurance permit):

   _____

2. Acronym or commonly used abbreviation for the group: _____

3. Address: _____ Zip: _____

4. Group Administrator Information:
   a. Contact Name: _____
   b. Phone No.: _____
   c. Service Company Name, if applicable: _____
   d. Service Company Address: _____ Zip: _____

5. Federal Employers Identification Number: _____

6. Date qualified as a group self-insured: _____

7. How is the applicant currently satisfying the security deposit requirements for self-insurance?

   _____
   a. If a bond is used for security, who is the current surety? _____
   b. What is the bond amount? _____

8. States to be self-insured: _____

9. Website Address: _____

10. Describe all types of operations insured by the group:

11. Describe any substantial or unusual changes in operations that are planned or have taken place in the last five years:

12. Within the last five years, has the applicant assessed its members in order to meet financial obligations? ☐ Yes ☐ No
    If yes, provide details:

13. Does the group have out of state or cross border coverage needs? ☐ Yes ☐ No
    If yes, how are those needs handled currently? _____

14. Do the group's members utilize volunteer or donated labor? ☐ Yes ☐ No
    If yes, describe: _____

15. Do any of the group's members utilize or provide contract staffing for other entities under leasing or PEO arrangements? If yes, describe: ☐ Yes ☐ No
    _____

16. Do any of the group's members have foreign operations or employees who travel to foreign countries? ☐ Yes ☐ No
    If yes, describe: _____

17. Do any of the group's members plan to perform work at international disaster recovery sites, such as the 2010 Haiti earthquake area, during the policy term? ☐ Yes ☐ No
    If so, explain the nature of the work to be performed, including the number of employees to perform it and the length of time involved.

18. Do any of the group's members have any employees who may be subject to the U.S. Longshore and Harbor Workers' Compensation Act, Jones Act or Federal Employer's Liability Act? (Unless endorsed, our policy does NOT include federal acts coverage.) ☐ Yes ☐ No

If yes, describe: _____

19. Do any of the group's members use nanotechnology in their operations or research? ☐ Yes ☐ No
(If yes, Nanotechnology Supplement must be completed.)

20. Do any of the group's members engage in the manufacture, production, refining, storage, distribution, or transportation of gases, gasoline or flammables? If yes, describe: ☐ Yes ☐ No

_____

21. Are there any occupational disease exposures involved in the group's members' operations? (asbestos; silica; dusts; toxic, injurious or hazardous chemicals; caustics, fumes, radiation, communicable diseases or any other O.D. exposures) If yes, describe steps taken to control: ☐ Yes ☐ No

22. Do any of the group's members perform underground, subaqueous, or tunneling operations? ☐ Yes ☐ No
If yes, describe: _____

23. Do any of the operations of the group's members include wrecking or demolition of structures? ☐ Yes ☐ No
If yes, describe: _____

24. Do any of the operations of the group's members involve exposure to heights? ☐ Yes ☐ No
If yes, describe: _____

25. Do any of the group's members now (or have future plans to) own, lease or charter watercraft? ☐ Yes ☐ No
If yes, describe watercraft, use, number of crew members, passenger capacity and whether craft is owned, leased, or chartered.

26. Do any of the group's members own, lease, or charter aircraft? (If yes, Aircraft Supplement required) ☐ Yes ☐ No

27. Complete the following information on owned or leased vehicles:

a. Number of: passenger cars _____ buses _____
trucks/tractors vans

b. With respect to the group's members' vehicles:

i. States in which members' vehicles operate: _____

ii. Do any of the group's members ever transport more than six employees at one time? ☐ Yes ☐ No
If yes, provide full details:

iii. Do any of the group's members transport chemicals, hazardous materials, explosives, explosive material, flammable material, or any petroleum products? ☐ Yes ☐ No
If yes, provide full details:

28. Policy Coverages and Limits.

a. Current Carrier: _____

b. Type of Coverage: _____

c.

Policy Limits	Present Program	Coverage Desired
Excess Rate		
Specific Excess Limit		
Employers Liability Limit		
Group Self Insured Retention		
Aggregate Excess Limit		
Aggregate Loss Fund %		
Estimated Loss Fund		
Minimum Term Loss Fund		
Manual Premium		
Standard Premium		
Normal Premium		

d. Do any of the group's members have any operations covered by a large deductible policy? ☐ Yes ☐ No
If yes, details: _____

e. Do any of the group's members have any operations covered by a guaranteed cost policy? ☐ Yes ☐ No
If yes, details: _____

f. Do any of the group's members non-subscribe or opt-out of a state workers' compensation system for any of their operations? If yes, details: ☐ Yes ☐ No
_____

29. Loss Prevention.

a. Name of Loss Prevention Service Company: _____

b. Are Loss Prevention personnel employees of the group? ☐ Yes ☐ No

c. Describe the group's Loss Control program including the number of representatives, whether or not pre-inspections are conducted, and how loss control visits are allocated to the membership.

30. Claims Handling. (If no service company, the MEC Claim Administration Questionnaire must be completed.)

a. Service Company Information:

i. Name of Service Company: _____
ii. Address of Service Company: _____
_____
iii. Phone Number: _____
iv. Contact Name for This Account: _____

b. How long has the group been with the current TPA? _____

c. Does the group anticipate making a change in their service company (including becoming self-administered) within the next two years? ☐ Yes ☐ No

d. Does applicant agree to let the excess carrier know about any changes in the service company or in the kind or amount of services to be performed by the service company? ☐ Yes ☐ No

e. Does the group encourage or require an alternative duty return to work program? ☐ Yes ☐ No

f. Does the group require members to report within 24 hours? ☐ Yes ☐ No

g. Does the group conduct regular or quarterly claim reviews with their claim servicing company? ☐ Yes ☐ No

h. Check all managed care programs utilized by the group:

☐ PPO ☐ Contracted Pricing ☐ Other _____
☐ Fee Scheduling ☐ Nurse Case Management

Information to be Included with Submission

I.1. Group Documents.

a. Bylaws
b. Most Recent Audited Financials
c. Actuarial Reserve Study (corresponding to the audited financials for the same period)
d. A Sample of a Member Loss Control Inspection Report
e. The Group's Underwriting Guidelines
f. A Sample of the Group's Underwriting Analysis Worksheet
g. Completed MECC Membership Concentration of Risk Spreadsheet (via an electronic Excel file)

I.2. Gross Payroll Distribution by Classification Code.

a. How are the group's class code rates determined?

b. Has there been a significant change to the payroll distribution by classification code in the last five years? If yes, describe the reason(s) for the change(s): ☐ Yes ☐ No
_____

c. Projected and Historical Payroll. Provide at least ten years, if available. Attach payroll detail, by policy period, including the following data elements:

- ☑ State
- ☑ Classification Code
- ☑ Classification Description
- ☑ Classification Rate
- ☑ Payroll Amount

I.3. Loss Experience and Historical Activity.

- The following loss information must be provided electronically via a data dump or full loss runs. The electronic (Excel) file should detail at least ten years (if available) of the group's loss experience, by policy period, and must include the following data elements:

  Data elements for all claims should include open/closed status, payment activity including paid/reserved/total incurred amounts split by medical and indemnity.

- If you are unable to perform a data dump, provide the following detail:

  a. Total Incurred Losses

  - ☑ Indemnity Paid / Reserved (include allocated claims expenses as part of indemnity)
  - ☑ Medical Paid / Reserved
  - ☑ Total Incurred
  - ☑ Valuation Date (must be within the last six months of the effective date)
  - ☑ Self Insured Retention

  b. Employers Liability Claims

  - ☑ Total Paid / Reserved
  - ☑ Total Incurred
  - ☑ Total Expense
  - ☑ Valuation Date (must be within the last six months of the effective date)

  c. Claim Counts

  - ☑ Open Claims
  - ☑ Closed Claims
  - ☑ Claims without Payment

  d. Individual Claims in Excess of $50,000 Incurred

  - ☑ Date of Loss
  - ☑ Description of Accident
  - ☑ Number of Employees Involved in Loss
  - ☑ Total Paid / Reserved / Incurred

Fraud Warning Statements

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects that person to criminal and civil penalties (In Oregon, the aforementioned actions may constitute a fraudulent insurance act which may be a crime and may subject the person to penalties). (In New York, the civil penalty is not to exceed five thousand dollars ($5,000) and the stated value of the claim for each such violation). (Not applicable in AL, AR, AZ, CO, DC, FL, KS, LA, ME, MD, MN, NM, OK, RI, TN, VA, VT, WA and WV).

Applicable in AL, AR, AZ, DC, LA, MD, NM, RI and WV: Any person who knowingly (or willfully in MD) presents a false or fraudulent claim for payment of a loss or benefit or who knowingly (or willfully in MD) presents false information in an application for insurance is guilty of a crime and may be subject to fines or confinement in prison.

Applicable in Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company, penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

Applicable in Florida and Oklahoma: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (In FL, a person is guilty of a felony of the third degree).

Applicable in Kansas: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact materially thereto commits a fraudulent insurance act.

Applicable in Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Applicable in Utah: Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

THE UNDERSIGNED IS AN AUTHORIZED REPRESENTATIVE OF THE APPLICANT AND REPRESENTS THAT REASONABLE INQUIRY HAS BEEN MADE TO OBTAIN THE ANSWERS TO QUESTIONS ON THIS APPLICATION. HE/SHE REPRESENTS THAT THE ANSWERS ARE TRUE CORRECT AND COMPLETE TO THE BEST OF HIS/HER KNOWLEDGE.

Date	Applicant's Signature	Title
	Print Applicant's Name	