INDUSTRIAL COMMISSION OF ARIZONA
800 W WASHINGTON STREET
PHOENIX, ARIZONA 85007
(602) 542-4661

Initial Application for Authority to Self-Insure

Read Instructions before completing
All questions must be answered. If not applicable, use symbol N/A
If necessary, attach supplemental sheets
Workers' compensation insurance must be maintained until authorization is effective

To the Director of the Industrial Commission:

The undersigned, an employer, hereby applies for Authorization to Self-Insure the payment of workers' compensation as provided by A.R.S. Section 23-961 of the Workers' Compensation Law of the State of Arizona.

The following information is submitted for the purpose of procuring a Resolution of Authorization of The Industrial Commission of Arizona, which may be given upon proof, satisfactory to The Industrial Commission, of ability to self-insure and pay compensation that may become due to employees.

1. Company Name:

   Effective date for authority to self-insure:

2. Applicant's mailing address and telephone:

   Home office:

   Phone:

   Arizona office:

   Phone:

3. State under which applicant is incorporated:

4. Name of parent company, if applicant is a subsidiary:

   List of Arizona subsidiary companies:

5. Name, address and status of partners (general, special and limited), if applicant is a partnership:

6. Length of time in business in Arizona and elsewhere, if applicable:

7. Type of business in Arizona:

8. Current and prior three years payroll for applicant's employees working in Arizona:

9. Total Arizona employee count for current and prior three years:

10. Current workers' compensation insurance carrier, policy number and expiration date:

11. If applicant's application for workers' compensation insurance has ever been rejected or policy of insurance cancelled, state why:

12. Listing of states where self-insurance was denied, if any, and where the applicant is currently self-insured:

13. Arizona claims history for three years preceding application date:

Year	Medical-Only Claims	Indemnity Claims	Total Number of Claims	Disability under one year	Permanent Disability	Death

14. Arizona loss history and experience modification rates for three years preceding application date:

Year	Net Premium	Medical Only Losses	Indemnity Losses	Total Losses	Experience Modification Rate

15. Name of excess insurance carrier:

16. Name address and telephone number of third-party administrator or individual responsible for processing Arizona workers' compensation claims:

    Name:

    Address:

    Telephone:

17. Name and address of Arizona agent upon whom legal notices may be served:

    Name:

    Address:

18. Selection of tax plan:

    ◯ Plan A – Fixed Premium Plan ◯ Plan C – Guaranteed Cost Plan

    ◯ Plan B – Ex-Medical Plan ◯ Plan R – Retrospective Rating

19. Name, address, telephone number, facsimile number and e-mail address of person responsible for completing the premium tax information:

    Name:

    Address:

    Telephone:

    Fax:

    Email:

20. Name, address, and telephone number of claims office where Arizona workers' compensation claims will be processed:

    Name:

    Address:

    Telephone:

21. Name, address, telephone number, facsimile number and e-mail address of the primary and secondary points of contact (POC) for the application and self-insurance process:

Primary POC:

Name:

Address:

Telephone:

Fax:

Email:

Secondary POC:

Name:

Address:

Telephone:

Fax:

Email:

I attest that all information and assertions contained in the application and the documents accompanying the application are factually correct and true.

Signature: _____

Seal

Submitter First Name:

Submitter Last Name:

Date Submitted:

Submitter Email Address:

Submitter Title:

Attachments (R20-5-1107):

A. Private Entity? Yes ◯ No◯

(1) Statement from Board of Directors authorizing the filing of the application and designating the person given authority to sign the application (signature must be an officer of the company);

(2) Statement classifying the applicant's Arizona employees by workers' classification codes;

(3) Hospital or medical agreement or a detailed statement concerning these arrangements;

(4) Audited financial statements for the most current and prior two fiscal years; and

(5) If the applicant is a subsidiary company:

(a) Completed Parent Company Guaranty form and a certified copy of the resolution of the parent company's board of directors authorizing signature of the Parent Company Guaranty form; and

(b) Copy of the parent company's audited financial statements for the most current and prior two fiscal years.

B. Public Entity? Yes ◯ No ◯

(1) Statement from Governing body authorizing the filing of the application and designating the person given authority to sign the application (signature must be that of an officer of the public entity);

(2) Statement classifying the applicant's Arizona employees by workers' classification codes;

(3) Comprehensive Financial Audit Reports for the most current and prior fiscal years.