



Our File: \_\_\_\_\_

## APPLICATION FOR A PUBLIC ENTITY CERTIFICATE OF CONSENT TO SELF INSURE

NOTE: All questions must be answered. If not applicable, enter "N/A".  
Workers' compensation insurance must be maintained until certificate is effective.

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### APPLICANT INFORMATION

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Legal Name of Applicant (show exactly as on Charter or other official documents):  
\_\_\_\_\_

Street Address of Main Headquarters:  
\_\_\_\_\_

Mailing Address (if different from above):  
\_\_\_\_\_

Federal Tax ID No.:  
\_\_\_\_\_

City, State, Zip Code  
\_\_\_\_\_

TO WHOM DO YOU WANT CORRESPONDENCE REGARDING THIS APPLICATION ADDRESSED?

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Company Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip + 4: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Email: \_\_\_\_\_

**Type of Public Entity (check one):**

City and/or County     School District     Police and/or Fire District     Hospital District     Joint Powers Authority

Other (describe): \_\_\_\_\_

**Type of Application (check one):**

New Application     Reapplication due to Merger or Unification     Reapplication due to Name Change

Other (describe) \_\_\_\_\_

Date Self Insurance Program will begin: \_\_\_\_\_

**CURRENT PROGRAM FOR WORKERS' COMPENSATION LIABILITIES**

Currently Insured with State Compensation Insurance Fund, Policy Number:

Policy Expiration Date: \_\_\_\_\_ Yearly Premium: \$ \_\_\_\_\_

Current Yearly Incurred (paid & unpaid) Losses: \$ \_\_\_\_\_ (FY or CY)

Currently Self Insured, Certificate Number: \_\_\_\_\_

Name of Current Certificate Holder: \_\_\_\_\_

Other (describe): \_\_\_\_\_

**JOINT POWERS AUTHORITY**

Will the applicant be a member of a workers' compensation Joint Powers Authority for the purpose of pooling workers' compensation liabilities?

Yes       No      If yes, then complete the following:

Effective date of JPA Membership: \_\_\_\_\_ JPA Certificate No.: \_\_\_\_\_

Name and Title of JPA Executive Officer:

\_\_\_\_\_  
Name of Joint Powers Authority Agency:

\_\_\_\_\_  
Mailing Address of JPA:

\_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip + 4: \_\_\_\_\_

\_\_\_\_\_  
Telephone Number: \_\_\_\_\_

**PROPOSED CLAIMS ADMINISTRATOR**

Who will be administering your agency's workers' compensation claims? (check one)

JPA will administer, JPA Certificate No.: \_\_\_\_\_

Third party agency will administer, TPA Certificate No.: \_\_\_\_\_

Public entity will self administer       Insurance carrier will self administer

Name of Individual Claims Administrator:

\_\_\_\_\_  
Name of Administrative Agency:

\_\_\_\_\_  
Mailing Address:

\_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip + 4: \_\_\_\_\_

\_\_\_\_\_  
Telephone Number: \_\_\_\_\_ FAX Number: \_\_\_\_\_

Number of claims reporting locations to be used to handle the agency's claims: \_\_\_\_\_

Will all agency claims be handled by the administrator listed on previous page?  Yes  No

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AGENCY EMPLOYMENT

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Current Number of Agency Employees: \_\_\_\_\_

Number of Public Safety Officers (law enforcement, police or fire): \_\_\_\_\_

If a school district, number of certificated employees: \_\_\_\_\_

Will all agency employees be included in this self insurance program?  Yes  No

If no, explain who is not included and how workers' compensation coverage is to be provided to the excluded agency employees:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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INJURY AND ILLNESS PREVENTION PROGRAM

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Does the agency have a written Injury and Illness Prevention Program?  Yes  No

Individual responsible for agency Injury and Illness Prevention Program:

Name and Title:

\_\_\_\_\_  
Company or Agency Name:

Mailing Address:

\_\_\_\_\_  
City: State: Zip + 4:

Telephone Number: \_\_\_\_\_

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SUPPLEMENTAL COVERAGE

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Will your self insurance program be supplemented by any insurance or pooled coverage under a standard workers' compensation insurance policy?  Yes  No

If yes, then complete the following:

Name of Carrier or Excess Pool: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_

Will your self insurance program be supplemented by any insurance or pooled coverage under a specific excess workers' compensation insurance policy?  Yes  No

If yes, then complete the following:

Name of Carrier or Excess Pool: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_

Retention Limits: \_\_\_\_\_

Will your self insurance program be supplemented by any insurance or pooled coverage under an aggregate excess (stop loss) workers' compensation insurance policy?  Yes  No

If yes, then complete the following:

Name of Carrier or Excess Pool: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_

Retention Limits: \_\_\_\_\_

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RESOLUTION OF GOVERNING BOARD

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See Attached Resolution-Page 5

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CERTIFICATION

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The undersigned on behalf of the applicant hereby applies for a Certificate of Consent to Self Insure the payment of workers' compensation liabilities pursuant to Labor Code Section 3700. The above information is submitted for the purpose of procuring said Certificate from the Director of Industrial Relations, State of California. If the Certificate is issued, the applicant agrees to comply with applicable California statutes and regulations pertaining to the payment of compensation that may become due to the applicant's employees covered by the Certificate.

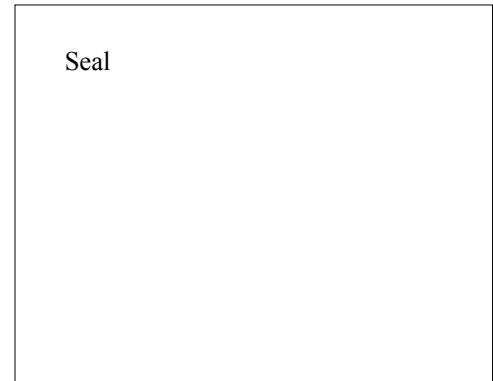
Signature of Authorized Official:

Date:

\_\_\_\_\_  
Typed Name:

\_\_\_\_\_

\_\_\_\_\_  
Title:



\_\_\_\_\_  
Agency Name:

\_\_\_\_\_

(Emboss seal above or Notarize signature)

RESOLUTION NO.: \_\_\_\_\_ DATED: \_\_\_\_\_

A RESOLUTION AUTHORIZING APPLICATION  
TO THE DIRECTOR OF INDUSTRIAL RELATIONS, STATE OF CALIFORNIA  
FOR A CERTIFICATE OF CONSENT TO SELF INSURE  
WORKERS' COMPENSATION LIABILITIES

At a meeting of the Board of \_\_\_\_\_  
(enter title)

of the \_\_\_\_\_  
(enter name of public agency, district)

a \_\_\_\_\_ organized and existing under the laws of  
(enter type of agency)

the State of California, held on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, the

following resolution was adopted:

**RESOLVED, that the** \_\_\_\_\_  
(enter position titles)

**be and they are hereby severally authorized and empowered to make application to the Director of Industrial Relations, State of California, for a Certificate of Consent to Self Insure workers' compensation liabilities on behalf of the**

\_\_\_\_\_ (enter name of district)

**and to execute any and all documents required for such application.**

I, \_\_\_\_\_, the undersigned \_\_\_\_\_  
(enter name) (enter title)

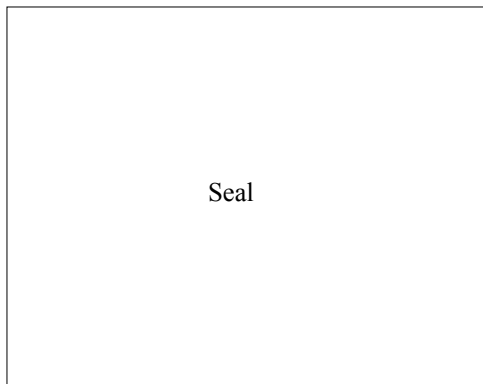
of the Board of the said \_\_\_\_\_  
(enter name of agency)

a \_\_\_\_\_, hereby certify that I am the \_\_\_\_\_  
(enter type of agency) (enter title)

of said \_\_\_\_\_, that the foregoing is a full, true and correct copy of the resolution duly  
(enter type of agency)

passed by the Board at the meeting of said Board held on the day and at the place herein specified and that said resolution has never been revoked, rescinded, or set aside and is now in full force and effect.

**IN WITNESS WHEREOF: I HAVE SIGNED MY NAME AND AFFIXED THE SEAL OF THIS**



\_\_\_\_\_ (enter type of agency)

THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
(Signature)