

**STATE OF ALASKA**  
**DIVISION OF WORKERS' COMPENSATION**  
**P. O. Box 25512**  
**Juneau, AK 99802-5512**

**APPLICATION FOR CERTIFICATE OF SELF-INSURANCE**

All questions must be answered, and requested material submitted. If not applicable, use symbol N/A. Workers' compensation insurance must be maintained until self-insurance authorization is effective.

1. Legal name of Alaska employer \_\_\_\_\_

2. Mailing address of Alaska employer \_\_\_\_\_  
\_\_\_\_\_

3. Name and address of person responsible for the self-insured program

Name \_\_\_\_\_ Title \_\_\_\_\_ Company Name \_\_\_\_\_

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

Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

4. Type of business structure of Alaska employer (Check One)  Corporation  Partnership

Joint Venture  Limited Partnership  Limited Liability Company  Limited Liability

Partnership  Municipality or Public Authority  Other (explain below)

5. If Alaska employer is a wholly owned or majority owned subsidiary, provide the legal name and address of the parent or controlling company \_\_\_\_\_  
\_\_\_\_\_

6. If Alaska employer is a joint venture, provide the legal name and address of the person having controlling interest in the venture \_\_\_\_\_  
\_\_\_\_\_

7. Provide the Standard Industrial Classification (SIC) Code number that the Alaska employer conducts its affairs under and a brief description of its business activities in Alaska

SIC Code \_\_\_\_\_ Description of business activities in Alaska \_\_\_\_\_

8. Alaska employer's federal employer identification number \_\_\_\_\_

9. Provide the Alaska employer's Alaska State Business License number and, if applicable, the Alaska Department of Commerce and Economic Development ID number

Business License Number \_\_\_\_\_ Commerce ID Number \_\_\_\_\_

10. Date business started in Alaska \_\_\_\_\_

11. Current number of employees in Alaska \_\_\_\_\_ Company total \_\_\_\_\_

12. Is Alaska employer self insured in other jurisdictions?  Yes  No

If yes, provide

Self-insurance retention limits \_\_\_\_\_

The amount of total incurred losses \_\_\_\_\_

Amount of loss within retention limit \_\_\_\_\_

Amount of loss subject to excess coverage \_\_\_\_\_

Loss amount subject to subrogation \_\_\_\_\_

If no, provide

Name of current Workers' Compensation insurance provider \_\_\_\_\_

Insurance Policy Number \_\_\_\_\_ Effective dates From \_\_\_\_\_ To \_\_\_\_\_

13. Has the Alaska employer ever been denied workers' compensation insurance? If so, state why and when \_\_\_\_\_

14. Has the Alaska employer ever been denied an application for self-insurance in another jurisdiction? If so, state why and when \_\_\_\_\_

15. List past three years compensation experience in Alaska

	19____	19____	19____
Number of medical claims	_____	_____	_____
Number of indemnity claims	_____	_____	_____
Number of fatalities	_____	_____	_____
Total incurred losses	_____	_____	_____
Paid losses	_____	_____	_____
Outstanding loss reserves	_____	_____	_____
Annual payroll	_____	_____	_____
Annual compensation premium	_____	_____	_____
NCCI experience modification rating	_____	_____	_____

16. Description of proposed excess insurance

	Specific	Aggregate
Self-insurance retention	_____	_____
Policy limit	_____	_____
Specified limitations to excess coverage	_____	_____

\_\_\_\_\_  
Name of excess insurance carrier \_\_\_\_\_

17. Date when self-insurance is desired From \_\_\_\_\_ To \_\_\_\_\_

18. Name and address of the Alaska Employer's proposed adjuster to be located in the State of Alaska

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

19. Applicant must provide the following documents with this application for Certificate of Self-Insurance

- Audited Financial Statements for the three years preceding the filing of the application. If the employer is a joint venture, financial statements must be submitted for each general partner.
- If a wholly owned subsidiary or a joint venture, a written parent company's guarantee of the subsidiaries' liabilities under the Alaska Workers' Compensation Act.
- A written detailed outline of the company's loss prevention program.
- A binder of the proposed excess insurance coverage.
- A list of subsidiaries to be covered under this application, including the names, mailing addresses, and ownership information for each subsidiary.

20. In consideration of the approval of this application, the applicant expressly agrees

- To comply with any additional excess insurance coverage stipulated by the Alaska Workers' Compensation Board and/or comply with any security requirements stipulated by the board
- That this privilege may be revoked at any time at the discretion of the Alaska Workers' Compensation Board
- That the applicant will promptly provide benefits within the time limits specified by the Alaska Worker' Compensation Act
- That the applicant will discharge liability for compensation to injured employees or their dependents in accordance with the requirements of the Alaska Workers' Compensation Act
- That the applicant or its adjuster will provide annual reports no later than March 1<sup>st</sup> of each calendar year
- That a request for renewal of the employer's Certificate of Self-Insurance will be made annually on a form prescribed by the Alaska Workers' Compensation Board
- That the applicant will notify the board within 30 days of any change in conditions which would affect the applicant's ability to administer its self-insurance program, including sale, merger, or other organic changes in ownership interest

\_\_\_\_\_  
(Signature of Authorized Person)

\_\_\_\_\_  
(Title of Authorized Person)

State of \_\_\_\_\_  
County of \_\_\_\_\_

\_\_\_\_\_, being first duly sworn, appeared personally and declared that the facts set forth in the foregoing application are true to the best of his/her knowledge, information and belief.

Sworn to and affirmed this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
(Notary Public)

(Notary seal)

My commission expires on \_\_\_\_\_