CONFIDENTIAL APPLICATION

FOR PRIVATE

SELF-INSURING EMPLOYERS

AND

HOSPITAL AUTHORITIES

STATE BOARD OF WORKERS' COMPENSATION

AND

GEORGIA SELF-INSURERS GUARANTY TRUST FUND

EFFECTIVE DATE: October 12, 2005

2870380/1
(last revision 05/23/22)

TO: APPLICANTS FOR SELF-INSURED STATUS

Effective July 1, 1990, the Georgia Legislature established the Georgia Self-Insurers Guaranty Trust Fund. O.C.G.A. 34-9-382(c) now requires application and acceptance into the Georgia Self-Insurers Guaranty Trust Fund as a condition precedent to obtaining self-insured status.

Attached you will find a Confidential Application for admission into the Georgia Self-Insurers Guaranty Trust Fund. This application must be typewritten and filed in duplicate (original plus one copy). After it is completed, SEND THE APPLICATION AND A CHECK IN THE AMOUNT OF $500.00, MADE PAYABLE TO THE GEORGIA SELF-INSURERS GUARANTY TRUST FUND FOR YOUR APPLICATION FEE to:

Mr. Tim Milsten
State Board of Workers' Compensation
270 Peachtree Street, N. W.
Atlanta, GA 30303-1299

Your application will be reviewed by the State Board of Workers' Compensation and the Georgia Self-Insurers Guaranty Trust Fund. In order to assure sufficient time to process your application, PLEASE MAIL YOUR APPLICATION AND APPLICATION FEE TO THE STATE BOARD OF WORKERS' COMPENSATION AT LEAST TWO (2) MONTHS PRIOR TO YOUR INTENDED SELF-INSURANCE DATE.

Employers who are granted authorization to self-insure will be required to pay an initial assessment of $8,000.00 payable to the Georgia Self-Insurers Guaranty Trust Fund. Thereafter, you will be assessed annually at the rate of one and one-half percent of the previous year's total medical and indemnity payments, as provided in O.C.G.A. 34-9-386.

In addition, all self-insurers are required to post a surety bond or letter of credit in an amount to be determined by the State Board of Workers' Compensation and the Georgia Self-Insurers Guaranty Trust Fund, along with proof of specific excess insurance. If you post a surety bond, the bonding company is required to have an A. M. Best Company rating of "A" or better.

If you have any questions regarding the Georgia Self-Insurers Guaranty Trust Fund or self-insurance in Georgia, please email gafund@deflaw.com, or call the Fund at 404-872-6148 or the State Board of Workers' Compensation at 404-651-7839.

Matthew A. Nanninga
Administrator
Georgia Self-Insurers Guaranty Trust Fund

THIS APPLICATION IS NOT TO BE USED BY PUBLIC EMPLOYERS OR GOVERNMENTAL ENTITIES, EXCEPT HOSPITAL AUTHORITIES.

To: The State Board of Workers' Compensation and The Georgia Self-Insurers Guaranty Trust Fund

The applicant, who is an employer subject to the provisions of the Georgia Workers' Compensation Act, hereby applies for acceptance into the Georgia Self-Insurers Guaranty Trust Fund and submits the following information under oath to the Fund and the State Board of Workers' Compensation to enable them to determine the applicant's qualification for self-insured status.

Note: If additional space is required to respond to any of the items which follow, please attach additional pages to the application, indicating the specific item for which additional information is provided.

1. Name of Applicant: _____

   Street Address: _____

   City, State, Zip Code: _____

   Telephone Number: _____ County: _____

   Tax Identification Number: _____

   Facsimile Number: _____ E-Mail Address: _____

2. Which of the following describes the applicant:

   Sole Proprietorship _____ Corporation _____ Other _____
   Partnership _____ Receiver _____ (explain)
   Limited Partnership _____ Trustee _____

   If a sole proprietorship, state the name and residence address of the sole proprietor:

   _____

   _____

   _____

3. List below the names and addresses of partners, if a partnership, or officers and directors, if a corporation.

Title ("partner", "president", "director", etc.)	Name	Office Address

4. If a corporation, partnership, or limited partnership, under the laws of which State was the applicant organized? _____

   Date of incorporation or organization: _____

5. If applicant was organized or incorporated in a State other than Georgia, state the name and address of the Home Office of the applicant.

   Name: _____

   Address: _____

   City, State, Zip Code: _____

6. Is the applicant a subsidiary? _____

   If so, state the name and address of the parent or holding company: _____

   _____

   _____

7. If the applicant operates under a trade name, has proper registration been filed with the Clerk of the Superior Court in the County in which business is conducted? _____

   If so, name of County: _____

   Date of Registration: _____

   Trade Name: _____

IMPORTANT

The parent company, shareholders of the applicant company, or a partner or partners in the applicant partnership, may, at the discretion of the State Board of Workers' Compensation and the Georgia Self-Insurers Guaranty Trust Fund, be required to personally guarantee prompt payment of all sums payable under the provisions of the Georgia Workers' Compensation Act and under the terms of the agreement contained in this application.

8. List the subsidiaries of the applicant company (named in Item 1) to be included in this application which are presently doing business in Georgia.

Names of Subsidiaries	Street Address, City, State, Zip

9. List the affiliates of the applicant company (named in Item 1) to be included in this application which are presently doing business in Georgia. (NOTE: Only affiliates sharing 51% common ownership with the applicant may be included in this application.)

Names of Affiliates	Street Address, City, State, Zip

10. What is your company's principal Standard Industrial Classification (SIC) Code: _____

Describe briefly the nature of the applicant's business: _____

11. Description of employment in Georgia:

Locations of Facilities in Georgia	Kind of Employment	Average Number of Employees	Estimated Payroll for Coming Year

12. State the average total number of employees of the applicant outside the State of Georgia: _____

13. Does the applicant have any employees who are subject to the:
    a) Longshore and Harbor Workers' Compensation Act? _____
    b) Jones Act? _____
    c) Federal Employers Liability Act? _____

    If yes, explain: _____

    _____

    _____

14. How long has the applicant been engaged in business in Georgia? _____

15. How long has the applicant been engaged in business elsewhere? _____

16. Has the applicant ever sought relief in Federal Bankruptcy Court or gone out of business? _____

    If so, give details _____

    _____

    _____

    _____

    _____

17. How has the applicant heretofore provided security for payment of workers' compensation in Georgia? _____

_____

If by insurance policy, supply the following information for the last **three** years and send a copy of the declaration page of your current insurance policy.

Policy Year	_____	_____	_____
Insurance Carrier	_____	_____	_____
Policy Number	_____	_____	_____
Policy Period (From, To)	_____	_____	_____
Premium Amount	_____	_____	_____
Audited Payroll	_____	_____	_____
Experience Modification	_____	_____	_____

18. If the applicant's application for workers' compensation insurance has ever been rejected or policy of insurance cancelled, state why and by whom: _____

_____

19. Please supply the following information about each death, disability or occupational disease claim in Georgia in the past five (5) years with total costs incurred in excess of $25,000 (use separate page for full details if necessary). Please complete this item in its entirety. **DO NOT send printouts**.

Date of Loss	**Facts of Loss, Type of Injury or Disease**	**Indemnity Paid**	**Medical Paid**	**Outstanding Reserves**	**Total Incurred**

20. State the accident experience in Georgia for the last three years:

	1	**2**	**3**
Year			
Number of deaths			
Number of dismemberments			
Number of injuries causing disability of more than seven (7) days for which indemnity payments were made			
Number of medical only claims			
Total number of accidents of all kinds			

21. Total Medical Benefits Paid in Georgia in the last **THREE (3)** calendar years (regardless of the date of injury).

20____	20____	20____
$_____	$_____	$_____

22. Total Indemnity Benefits Paid in Georgia in the last **THREE (3)** calendar years (regardless of the date of injury).

20____	20____	20____
$_____	$_____	$_____

23. Total Current Outstanding Reserves in Georgia for **ALL CLAIMS** (regardless of date of injury).

20____	20____	20____
$_____	$_____	$_____

Who establishes reserve amount? _____

Who controls the reserve account? _____

24. Safety and environmental conditions:

Is your plant inspected, other than by a State Authority? _____

If so, by whom? _____

25. Do you have a safety committee whose duty it is to recommend safety devices and assure compliance with OSHA, the Georgia Department of Labor or general orders of the State Board of Workers' Compensation as to safety and environment? _____

26. Do you have a safety consultant? _____

If so, please identify the consultant: _____

27. Is there, in connection with your business or in the manufacturing or handling of products, any special or catastrophic hazard associated with your business or the products you manufacture?

_____

_____

If so, give a full description, stating the maximum number of employees at one time exposed to such hazard: _____

_____

28. a) Complete this question if a third-party administrator or servicing company will be managing claims if the applicant is approved for self-insurance. Attach a copy of the contract to your application.

Servicing Company in Georgia _____

Servicing Company's FEIN _____

Name/Title of Contact Person _____

Street Address _____

City/State/Zip Code _____

Telephone Number _____
(Toll-free number)

Email Address _____

b) State the details of the kinds of service that will be furnished by the service company or third-party administrator: _____

_____

_____

PLEASE NOTE: YOU MUST ATTACH A COPY OF THE GEORGIA THIRD-PARTY ADMINISTRATOR LICENSE. IF YOUR TPA IS EXEMPT FROM LICENSURE, PLEASE PROVIDE SIGNED FORMAL EXEMPTION LETTER. FOR EXAMPLE OF THE EXEMPTION LETTER, SEE OUR WEBSITE AT WWW.GAGUARANTY.COM.

29. Complete this question if the applicant will be managing its own claims if approved for self-insurance. Attach a description of the Managing Person's qualifications to handle your claims.

Name/Title of Contact Person _____

City/State/Zip Code _____

Telephone Number _____
(Toll-free number)

Primary Email Address _____

Secondary Email Address _____

Describe the applicant's facilities for handing claims: _____

_____

_____

_____

30. Does the applicant have a posted Panel of Physicians as required in O.C.G.A. 34-9-201? (yes or no) _____

31. Does the applicant have a posted Bill of Rights for The Injured Worker as described in O.C.G.A. 34-9-81? (yes or no) _____

32. State the payroll for the applicant's Georgia locations for the last three years:

Year	Payroll Amount
_____	$ _____
_____	$ _____
_____	$ _____

33. Describe the method by which applicant proposes to fund workers' compensation self-insured liability. State whether the applicant proposes:

(a) To set up a separate account or fund into which the projected cost of future benefits will be deposited annually _____

(b) To use a fixed percentage of the payroll _____

(c) To treat the liability as a current expense _____

(d) To transfer the incurred liability into a reserve account _____

(e) To establish liability as determined by the present value of incurred losses _____

(f) To use a captive insurance company _____

(g) To adopt some other procedure (describe) _____

_____

34. **IF A CAPTIVE INSURANCE COMPANY IS USED TO FUND ANY PART OF THE SELF-INSURANCE LIABILITY OF THE EMPLOYER, PLEASE PROVIDE A COPY OF THE MOST RECENT CERTIFIED FINANCIAL STATEMENT OF THE CAPTIVE AS WELL AS THE FOLLOWING INFORMATION REGARDING THE CAPTIVE MANAGER.**

NAME _____

ADDRESS _____

_____

TELEPHONE NO. _____

DOMICILE _____

35. APPLICANT **MUST** ENCLOSE COMPLETE ORIGINAL BOUND COPIES OF ITS FINANCIAL STATEMENTS, AUDITED BY AN INDEPENDENT CPA ACCORDING TO GENERALLY ACCEPTED ACCOUNTING PRINCIPLES FOR THE LAST **THREE** (3) YEARS.

Please note that the State Board of Workers' Compensation may rely on the information contained herein; therefore, the attached affidavit requires an officer of the applying company, preferably the President or the CFO, to certify that the most recent audited financials statements are attached, and that there are no material changes in the applying company's financial status between the previous and current year. If accepted into the program, you are required to notify the Georgia Self-Insurers Guaranty Trust Fund or the State Board of Workers' Compensation if any material changes do occur in said financial statements.

36. **This application is filed with the understanding and the agreement of the applicant herein that upon approval and in consideration thereof applicant hereby agrees as follows: (PLEASE READ CAREFULLY.)**

(a) That all reports required by the Workers' Compensation Act, State Board of Workers' Compensation or the Georgia Self-Insurers Guaranty Trust Fund will be promptly filed with the State Board of Workers' Compensation or the Georgia Self-Insurers Guaranty Trust Fund.

(b) The servicing organization handling claims for self-insurers must designate an office in the State of Georgia or if claims are handled out of state, shall designate an agent located in the State of Georgia who shall be authorized to execute instruments for the payment of compensation in an emergency (or, if necessary). The office handling claims shall be staffed during normal working hours and be available for immediate telephone contact with the Board and the public through a toll free telephone number.

(c) That applicant will file and maintain a proper surety bond (with an A.M. Best Company rating of "A" or better) or letter of credit and excess insurance as required by the State Board of Workers' Compensation and made payable to the Georgia Self-Insurers Guaranty Trust Fund. (LETTERS OF CREDIT MUST BE EITHER ISSUED OR CONFIRMED BY A GEORGIA DEPOSITORY.)

(d) That at the close of each fiscal year, after becoming self-insured and for so long as any claims remain open with accident dates during the self-insured period, a complete original bound copy of the audited financial statements will be filed with the Georgia Self-Insurers Guaranty Trust Fund as required by law. The full audit must be performed by an independent CPA firm according to generally accepted accounting principles.

(e) That no funds will be solicited, received, or collected from employees or deductions made from their wages for the purpose of discharging applicant's liability under the Workers' Compensation Act.

(f) **That applicant will pay annual prorated assessments made by the State Board of Workers' Compensation, Subsequent Injury Trust Fund and the Georgia Self-Insurers Guaranty Trust Fund in accordance with O.C.G.A. 34-9-63, O.C.G.A. 34-9-358, and O.C.G.A. 34-9-386.**

(g) **A claims audit may be required of any employer granted self-insured status while the employer remains self-insured or has any open claims with dates of accident or claims arising during the self-insured period.**

(h) **If an employer granted self-insured status is declared insolvent, the insolvent employer will provide to the State Board of Workers' Compensation or the Georgia Self-Insurers Guaranty Trust Fund immediately after being declared insolvent, the claims files and copies of medical records, personnel files, and supervisory contacts for all claimants whose workers' compensation claims remain open at the time of the insolvency.**

_____ initial here

37. Who should receive official notices from the State Board of Workers' Compensation and the Georgia Self-Insurers Guaranty Trust Fund.

Name _____

Street Address _____

City/State/Zip Code _____

Telephone Number _____
(Toll-free number)

Primary Email Address _____

Secondary Email Address _____

39. Date applicant wants to assume self-insured status: _____

40. If the applicant is incorporated, EITHER:

A. Attach a certified copy of the corporate minutes authorizing the application for certification as a self-insurer under the workers' compensation laws and the authorization for the individual named in Item 41 to execute this document and affidavit: OR

B. Complete the following:

RESOLVED: that _____, _____ of
(**Individual named in item 41**) **(Title of individual named in Item 41)**

_____ is hereby authorized to execute in the name and
(Applicant Company Name)

on behalf of the Company all instruments and documents which are deemed necessary or desirable in compliance with Workers' Compensation Laws, including, without limiting the generality of the foregoing, applications for the privilege of self-insurance, agreements, indemnity bonds, financial statements and other reports required in connection with the granting of such privilege and to order the corporate seal of the company affixed to any such instruments and documents.

* *

I, _____,
(Name of individual signing affidavit)

_____, of
(Title of individual signing affidavit)

_____
(Company name)

certify that the above resolution is true and correct copy of a resolution unanimously adopted by the Board of Directors of the above-named company at a meeting held on _____, at
(Date of meeting)

which meeting a quorum was present _____
and acting throughout, and said resolution is still in full force and effect.

IN WITNESS WHEREOF, I have hereunto affixed my signature and seal of the corporation this ___ _____ day of _____, 20_____.

Signature_____
Title_____
Company _____

(Corporate Seal Here)

41. I, _____, after being duly sworn do hereby depose and state under oath, and certify under penalty of law, that I am thoroughly familiar with the operation and affairs of the applicant to whom the responsibilities and statements set forth in the foregoing application, attachments *including financial statements*, and exhibits relate; that I have read and studied said application, attachments *including financial statements* ,and exhibits, and know the contents thereof; that I am authorized by the applicant to execute and submit this application with all attachments *including financial statements*, exhibits, and supporting documents, as well as to individually execute this affidavit; and that said application, representations, and statements therein contained, together with all supporting attachments *including financial statements*, exhibits, and documents are true and correct to the best of my knowledge, information and belief.

Subscribed and sealed this the _____ day of _____, 20_____.

_____
Signature of owner, partner, or corporate officer (President or CFO) as affiant

_____
Name (Typed or Printed)

_____
Title/Position with Applicant

Attest (If a Corporation)

_____
Signature of Corporate Secretary

_____
Name of Corporate Secretary (Typed or Printed)
PLACE CORPORATE SEAL HERE.

Sworn to and Subscribed before me by above affiant this date above shown:

_____
Signature of Notary Public

_____
Name of Notary (Typed or Printed)

My commission expires: _____

_____
Street Address

PLACE NOTARY SEAL HERE

_____
City, State, Zip Code

_____
Telephone Number

BEFORE YOU MAIL YOUR APPLICATION...

1. *DID YOU ENCLOSE COMPLETED ORIGINAL BOUND COPIES OF THE APPLICANT'S AUDITED FINANCIAL STATEMENTS FOR THE LAST THREE YEARS? THESE AUDITS MUST HAVE BEEN COMPLETED BY AN INDEPENDENT CPA. (SEE ITEM # 35)*

2. *IF YOU ARE INCORPORATED, DID YOU ATTACH A CERTIFIED COPY OF THE CORPORATE MINUTES AUTHORIZING THIS APPLICATION FOR SELF-INSURED STATUS? (SEE ITEM # 40)*

3. *HAS YOUR APPLICATION BEEN SIGNED, NOTARIZED, AND THE CORPORATE SEAL ATTACHED? (SEE ITEM # 41)*

4. *HAVE YOU ATTACHED A CHECK IN THE AMOUNT OF $500.00* ***MADE PAYABLE TO THE GEORGIA SELF-INSURERS GUARANTY TRUST FUND*** *FOR YOUR APPLICATION FEE?*

5. *HAVE YOU COMPLETED ALL QUESTIONS IN THEIR ENTIRETY?*

YOUR APPLICATION IN DUPLICATE IS TO BE SENT TO:

Mr. Tim Milsten
State Board of Workers' Compensation
270 Peachtree St. NW
Atlanta, GA 30303-1299