



# THE INDUSTRIAL COMMISSION OF ARIZONA

800 WEST WASHINGTON ST.  
P.O. BOX 19070  
PHOENIX, ARIZONA 85005-9070

## Commission Use Only

Date Division receives application \_\_\_\_\_

Date Division mails notice that application incomplete \_\_\_\_\_

Date Division mails notice that application complete \_\_\_\_\_

Date of order approving or denying authorization \_\_\_\_\_

\_\_\_\_\_ Application approved      \_\_\_\_\_ Application denied

Compliance with Time-frames

\_\_\_\_\_ A.C. Review      \_\_\_\_\_ Sub. Review      \_\_\_\_\_ Overall Review

## **INITIAL APPLICATION FOR AUTHORITY TO SELF-INSURE UNDER A.R.S. § 23-961.01**

1. State the name of the workers' compensation pool ("pool") applying for authority to self-insure.

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2. State the address of the pool's principal Arizona office.

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\_\_\_\_\_

3. State the telephone and fax numbers of the pool's principal office.

\_\_\_\_\_

4. State the effective date of the formation of the pool.

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5. State the name and address of industry or trade association, or professional organization to which member employers of the pool belong.

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**6.** State the effective date of formation of the industry or trade association, or professional organization to which member employers of the pool belong.

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**7.** State how the businesses of member employers are the same or similar.

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**8.** State the total amount of manual workers' compensation premiums paid by all member employers in the preceding calendar year.

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**9.** State the combined net worth of all member employers based on the members' financial statements for the last fiscal year.

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**10.** State the name and address of each person appointed to the pool's Board of Trustees.

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**11.** State the name, address, and telephone number of the administrator appointed by the Board of Trustees.

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**12.** State the name, address, telephone number, and contact person of the claims service company hired by the pool, if applicable.

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**13.** State the name, title, address, and telephone number of the person in charge of the pool's loss control program.

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14. State the name, title, address and telephone number of the person in charge of the pool's underwriting programs.

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15. Select a premium tax plan.

- Fixed Premium Plan
- Guaranteed Cost Plan
- Retrospective Rating Plan

16. Have you attached to the initial application the following documents in the order listed?

	<u>Yes</u>	<u>No</u>
a. Authorization (board resolution) for administrator to sign initial application, if applicable.	<input type="checkbox"/>	<input type="checkbox"/>
b. Copy of contract required under A.R.S. § 23-961.01.	<input type="checkbox"/>	<input type="checkbox"/>
c. Copy of articles of incorporation, if applicable.	<input type="checkbox"/>	<input type="checkbox"/>
	<u>Yes</u>	<u>No</u>
d. Copy of trust agreement, if applicable.	<input type="checkbox"/>	<input type="checkbox"/>
e. Copy of resolution from Board of Trustees approving each member employer for admission into the pool.	<input type="checkbox"/>	<input type="checkbox"/>
f. Copy of pool's bylaws.	<input type="checkbox"/>	<input type="checkbox"/>

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|----|---|--------------------------|--------------------------|
| g. | Description of loss control program required under R20-5-727.   | <input type="checkbox"/> | <input type="checkbox"/> |
| h. | Proof of coverage or confirmation from an authorized insurance carrier that the carrier will provide fidelity insurance.  | <input type="checkbox"/> | <input type="checkbox"/> |
| i. | Original, signed guaranty bond or confirmation from an authorized insurance carrier that the carrier will provide a guaranty bond to the pool, if applicable.                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| j. | In lieu of a guaranty bond, United States bonds or securities or confirmation from the pool that it will obtain United States bonds or securities.  | <input type="checkbox"/> | <input type="checkbox"/> |
| k. | In lieu of a guaranty bond, a letter of credit or confirmation from a financial institution that it will provide the pool a letter of credit.   | <input type="checkbox"/> | <input type="checkbox"/> |
| l. | Completed and signed Option/Election Form.  | <input type="checkbox"/> | <input type="checkbox"/> |
| m. | Proof of coverage or confirmation from an authorized insurance carrier that the carrier will provide excess insurance coverage.   | <input type="checkbox"/> | <input type="checkbox"/> |
| n. | Copy of signed agreement between pool administrator and Board of Trustees.  | <input type="checkbox"/> | <input type="checkbox"/> |
| o. | Copy of signed agreement between pool and claims service company, if applicable.  | <input type="checkbox"/> | <input type="checkbox"/> |
| p. | Written statement with supporting documentation requesting authorization to process claims in-house, if applicable.   | <input type="checkbox"/> | <input type="checkbox"/> |
| q. | List of workers' compensation class codes to be used by pool.   | <input type="checkbox"/> | <input type="checkbox"/> |
| r. | Statement showing how pool will determine premiums.   | <input type="checkbox"/> | <input type="checkbox"/> |
|    |   | <u>Yes</u>               | <u>No</u>                |
| s. | Detailed description of underwriting programs.  | <input type="checkbox"/> | <input type="checkbox"/> |
| t. | Actuarial feasibility study that documents rate structure needed to establish premiums to cover losses.   | <input type="checkbox"/> | <input type="checkbox"/> |
| u. | Original, signed application from each employer receiving approval by the Board of Trustees to join pool. (Use Commission form titled Application to Add Employer to a Workers' Compensation Pool). | <input type="checkbox"/> | <input type="checkbox"/> |

I, \_\_\_\_\_, certify under penalty of

perjury, that I have authority to sign this application, that I am \_\_\_\_\_ of the pool  
(title of person signing)  
and in that capacity have knowledge of the affairs of the pool to which the initial application and  
attachments relate, that I have read the initial application and all attachments to the initial  
application, and verify that the representations and statements contained in the initial application  
and accompanying attachments, are true to the best of my knowledge, information, and belief.

\_\_\_\_\_  
Signature of person signing application

\_\_\_\_\_  
Printed or typed name of person signing application

Subscribed and sworn to before me at \_\_\_\_\_

this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_.

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

My commission expires: \_\_\_\_\_



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## INFORMATION TO COMPLETE AN INITIAL APPLICATION FOR AUTHORITY TO SELF-INSURE UNDER A.R.S. § 23-961.01

### **A. Commission forms required to complete an initial application for authority to self-insure.**

1. Initial Application for Authorization to Self-insure as a Workers' Compensation Pool.
2. Application to Add Employer to a Workers' Compensation Pool.
3. Option/Election Form.

### **B. General instructions to complete an initial application to self-insure.**

1. Read and familiarize yourself with A.R.S. §§ 23-961, 23-961.01, and A.A.C. R20-5-701 et seq.
2. Answer all questions in the initial application. If a question asks for information that does not apply to you, then answer "not applicable".
3. Type or print all answers.
4. Be sure the application is signed by an individual authorized to sign on behalf of the pool.
5. Attach to the initial application the information required in A.A.C. R20-5-707 (the information required is also listed on the application). Please label (tab) and attach the information in the order listed on the initial application.
6. To facilitate processing of your application, please submit the initial application and attachments in a 3 ring binder. All attachments should be labeled (tabbed).
7. Applications to add employers to the pool (listed as attachment (u) to an initial application) should be placed in alphabetical order using the employers' names. The financial statements required to be submitted with an application to add a new employer should be placed in a separate folder labeled with the employer's name.
8. Use additional paper if necessary to answer a question.

*Please note additional information on reverse page*

### **C. Time-frames.**

1. Time-frames applicable to the processing of an initial application are found in A.A.C. R20-5-706.
2. The Division will review your application within 20 days of receipt to determine if your application is complete. The Division will mail you a letter notifying you whether your application is complete or incomplete.
3. If the Division determines that your application is incomplete, you have 45 days to submit the missing information. If you fail to submit the information required to make your application complete, the Division shall deem your application withdrawn. The Division will take no action on your application until you file a complete application.
4. If the Division determines that your application is complete, the Commission will process the application. Within 70 days of receipt of a complete application, the Commission will issue an order approving or denying authority to self-insure.
5. By mutual agreement of the Division and the applicant, the applicable time-frames may be extended.

For questions concerning the filing of an initial application, please contact Robert Harvey, Administrative Assistant, Group Self-Insurance, at 542-1839.

**REMEMBER: THE LAW REQUIRES THAT EVERY MEMBER OF A POOL MAINTAIN WORKERS' COMPENSATION INSURANCE UNTIL THE EFFECTIVE DATE OF A CERTIFICATE OF AUTHORITY TO SELF-INSURE.**