Official Form 223E

RENEWAL APPLICATION FOR SELF-INSURANCE

Rev 10/2019

Be sure this application is completed in full and all required enclosures are included or it may be returned with a $650.00 re-application fee.

Self-Insured Name:		FEIN:	Date of Filing:	
Principle Address:		City:	State:	Zip Code:
Email:		Website:		
Contact Responsible for Self-Insurance Program:				
Address:		City:	State:	Zip Code:
Phone:	Fax:		Email:	
Alternative Contact:				
Address:		City:	State:	Zip Code:
Phone	Fax:		Email:	
Utah Representative Contact:				
Address:		City:	State:	Zip Code:
Phone	Fax:		Email:	
Contact Responsible for Safety Program:				
Address:		City:	State:	Zip Code:
Phone:	Fax:		Email:	
Send Correspondence to:				
Address:		City:	State:	Zip Code:
Phone:	Fax:		Email	
Do you use a Third Party Administrator (TPA)?		Yes ☐ No ☐	If yes please complete the following section.	
Name of TPA:		Contact Name:		
TPA Address:		City:	State:	Zip Code:
Phone:	Fax:		Email:	
If the TPA and/or claims adjuster is not located in Utah, who is their Designated Agent?				
Agent Address:		City:	State:	Zip Code:
Phone:	Fax:		Email:	
FROI Contact:	Phone:		Email:	

This application must include:

a. Audited Financial Statement (if financial information cannot be obtained from Dunn & Bradstreet)

b. Renewal Fee of $650.00

c. Excess workers' compensation insurance certificate (if changed from previous year). Attach a copy of the insolvency endorsement as well. If we do not receive a cancellation notice, the excess insurance is still liable, even with an expiration date on the policy.

d. List of all locations, including any wholly owned subsidiaries, which were added or deleted within the last 12 months. If more space is needed attach a separate sheet.

160 East 300 South 3rd Floor P.O. Box 146610 Salt Lake City, Utah 84114-6610
Office: (801)-530-6800 Fax: (801)-530-6804 Toll Free: (800)-530-5090 www.laborcommission.utah.gov

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Locations Added			
Name	FEIN	Address	Date Added

Locations Deleted			
Name	FEIN	Address	Date Deleted

Provide the following information based on all open Utah workers' compensation claims, regardless of injury year.

The following information was provided as of ___________ (date).

Number of Outstanding Claims: $ ______________

Medical Reserve to be paid in the future: $ ______________

Indemnity Reserve to be paid in the future: $ ______________

Total Amount of Reserves: $ ______________

Previously Reported Amount: $ ______________

Total Adjustment: $ ______________

Where do you account for you reserves?

General Fund Account: ☐	Liability Fund Account: ☐	Other: ☐ Attach Explanation

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Use the data from the last three calendar years to complete the following section.

Losses are to be reported for the calendar year they were incurred, not when payment was made.

Actual Dollar Amounts are Shown ☐ 000's Omitted ☐ 000,000's Omitted ☐

FATALITIES			
Calendar Year			
Number of Accidents			
Medical Expenses	$___	$___	$___
Burial Benefits	$___	$___	$___
Dependent Benefits	$___	$___	$___
Total	$___	$___	$___
Reserves*	$___	$___	$___
Total Incurred Liability**	$___	$___	$___
Previously Reported	$___	$___	$___
Total Adjustment	$___	$___	$___

NON-FATAL			
Calendar Year			
Number of Accidents			
Medical Expenses	$___	$___	$___
Temporary Total Disability	$___	$___	$___
Temporary Partial Disability	$___	$___	$___
Permanent Partial Disability	$___	$___	$___
Permanent Total Disability	$___	$___	$___
Total	$___	$___	$___
Reserves*	$___	$___	$___
Total Incurred Liability**	$___	$___	$___
Previously Reported	$___	$___	$___
Total Adjustment	$___	$___	$___

*Future estimated amount to be paid on claims incurred during the calendar year that the injury/illness occurred. For example, you may have previously reported a $500,000.00 reserve for the injuries occurring during the calendar year for 2017. This year you now have set reserves at $400,000.00 for the 2017 losses. The adjusted amount would be $100,000.00.

**Total amount paid on the calendar year's claims + the estimated reserves set aside to be paid on the outstanding claims for the same year.

Have there been any changes within the last year pertaining to the following?

If yes, please provide additional information.

a. Loss Prevention Service? Yes ☐ No ☐

b. On-site Physician? Yes ☐ No ☐

c. Major changes to your employee handbook or procedures concerning workers' compensation? Yes ☐ No ☐

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d. Managed health care provider, or designated health care provider pertaining to workers' compensation? Yes ☐ No ☐

e. Gross payroll exceeding five (5) percent from previous year? Yes ☐ No ☐

f. Has the company formed, acquired, changed, divested of, merged, or started new business operations on their subsidiaries, companies, or divisions since the last application, or from the original application? Yes ☐ No ☐

If yes, please attach an explanation along with Name, Address, UI Number, Effective Date, Number of Employees, and Classification.

g. Number of Employees? ________________

Provide the company's NCCI Experience Modification (EMOD) reported to the Utah Tax Commission for the previous calendar year.

Has the company received any OSHA citations within the last year? Yes ☐ No ☐

If so, how many?
Attach an explanation of each citation. ________________

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The entire contents of this application, including enclosures, are certified to be correct to the best of my knowledge, information, and belief.

____
Name of Corporation or Public Entity

____
Signature of Official of Corporation or Public Entity with binding authority

The entire contents of this application, including enclosures, are certified to be correct to the best of my knowledge, information, and belief.

____
Name of Person Filing Form

____
Signature

Address: ______________________________

____

Phone: ______________ Fax: ______________

Subscribed and sworn to before me this
____________day of _______________, 20__.

____
(Notary Public Signature)

My commission expires___________________