Department of Business and Industry

Nevada Division of Insurance

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Application for Authority to Self Insure for Workers' Compensation

Nevada Industrial Insurance Act and Occupational Diseases Act Chapter 616A through 616D and 617, inclusive, of the Nevada Revised Statutes

PART A – EMPLOYER INFORMATION

Name of employer	FEIN	Proposed effective date
Mailing address	Physical address	
Contact person	Email address	
Title	Phone number / Fax number	
Contact address	City / State / Zip or postal code	

Principal activity of the business

Type of ownership of the Company	Are you registered with the Secretary of State?	If yes, what is the date of registration?
☐ Corporation ☐ Partnership ☐ Individually Owned	☐ Yes ☐ No	
This business was organized or incorporated (dd/mm/yy)	Under the laws of the state of	Date of commencement of business in Nevada
Do you have a parent company? ☐ Yes ☐ No	If yes, name of parent company	

Address of parent company

List the principals of your organization (corporate officers, partners or owners). (Attach a list, if necessary.)

NAME	TITLE	PERCENTAGE OF OWNERSHIP

List subsidiaries, divisions, and affiliates to be included in the Nevada self-insurance program. (Attach a list, if necessary.)

NAME	ADDRESS	FEIN

Provide the name and address for each operation to be covered under the Nevada self-insurance program. (Attach a list, if necessary.)

NAME	ADDRESS

PART B – ADMINISTRATOR INFORMATION

Do you plan to self-administer claims processing? ☐ Yes ☐ No If yes, please complete the information below.	Estimated cost of administration

Provide the name, title, address and telephone number of each person involved in the processing of workers' compensation claims. (Attach a list, if necessary.)

NAME	TITLE	ADDRESS	TELEPHONE

Do you plan to retain a third-party administrator to administer claims? ☐ Yes ☐ No If yes, please complete the information below.

NOTE: A third-party administrator must hold a certificate of registration with the Division of Insurance and have offices located within the State of Nevada.

Third-party administrator name	Address
Account manager(s)	
Telephone number	
Email address	Estimated cost of administration

PART C – SAFETY PROGRAM

Pursuant to NRS 616B.300 and 616B.424(4), explain what administrative resources are in place to enable you to promply report, administer, and settle all claims.

Upon approval for self-insurance, how do you plan to notify your employees of the change in coverage, administration of claims, and employee rights?

Do you have a formal safety program? ☐ Yes ☐ No

Provide the name of the person responsible for administration of your loss control program.

Name	Title	Telephone number

Give a brief description of your safety and loss control program. (Do not send manual.)

What medical facilities are available to your employees? ☐ First aid ☐ In-plant staff ☐ Local clinic ☐ Hospital

Do you have a light-duty program available for employees who, either temporarily or permanently, cannot return to their normal duties because of a workers' compensation injury or illness? ☐ Yes ☐ No

Explain:

PART D – FINANCIAL INFORMATION

Audited financial statements with the accompanying footnotes and the auditor's opinions for the three most recent years must be submitted with this application. If more current audited financial information is available, this must also accompany the application.

Please indicate the type of information supplied ☐ Annual report ☐ 10-K report ☐ Other

The current net worth of the applying business is $

Did the applicant have negative earnings in any of the last three years? ☐ Yes ☐ No

What is the fiscal year end of the business? (mm/dd)

PART E – WORKERS' COMPENSATION CLAIMS EXPERIENCE

Please submit complete loss runs that include number of medical claims, number of lost time claims, the payments made for medical and indemnity cost, the amounts reserved for claims payments, total incurred cost for medical, and indemnity payments for the last three years. This information should be provided by the present insurer.

Please supply the insurers' names, addresses, and policy numbers for all accounts that will be transferred to the self-insurance coverage.

NAME	ADDRESS	POLICY NUMBER

How many employees did your business have as of June 30 for the last three years?

Year 1	Year 2	Year 3

Have there been any fatalities in the last three years? If yes, attached a detailed statement for each incident. ☐ Yes ☐ No

PART F – NEVADA REQUIREMENTS FOR DEPOSITS, INSOLVENCY ASSESSMENT, AND EXCESS INSURANCE

The following do not have to be supplied to this office until approval has been granted but must be in place before the Certificate of Authority will be issued.

- Nevada requires a security deposit for all self-insured workers' compensation employers. This deposit is calculated by the Division, and successful applicants will be notified of the required amount.
- Nevada assesses an initial insolvency fee of 0.50% of the initial deposit. In subsequent years the annual assessment is 0.25% of the deposit amount as of June 30 of that year. This amount is calculated by the Division, and applicants will be notified of the required amount.
- Nevada requires a self-insured employer to provide a policy of excess insurance. This coverage must have a minimum self-insured retention of $100,000, a minimum of 60 days written notice of cancellation, and must be countersigned by a licensed Nevada agent.

Please identify the intended excess carrier and amount of self-insured retention.

Carrier	Self-insured retention

PART G – AGREEMENTS

In consideration of being certified for workers' compensation self-insurance in the state of Nevada, the applicant hereby agrees:

1. That the information in this application and the required attachments are true and correct.
2. That the liabilities for compensation to injured employees or their dependents will be promptly discharged in accordance with the requirements of the Nevada Industrial Insurance Act and Occupational Diseases Act, Chapters 616A through 616D and 617 inclusive, including any amendments.
3. That all reports of compensable or reportable injuries, diseases, and deaths will be promptly furnished to the Division of Industrial Relations or the Commissioner of Insurance as required by law.
4. That the Commissioner of Insurance will be promptly notified of any changes in financial condition which are material and affect the employer's ability to self insure claims.
5. That before any liquidation, sale, or transfer of ownership is made, the Commissioner of Insurance will be notified 60 days in advance and, subject to approval, arrangements for the payment of all existing liabilities will be made.
6. That the applicant will comply with any and all self-insurance workers' compensation statutes and regulations.

AFFIDAVIT

NOTE: If applicant is an individual, the sole proprietor shall sign; partnership, all partners shall sign; LLC, a member shall sign; corporation, an officer shall sign.

Being duly sworn on oath that I have read the above foregoing application, that I am acquainted with the affairs of the applicant employer and that the representations and statements set forth are true in substance and in fact.

Must be signed by an officer, director, principal or partner of the applicant:

_____
Month Day Year

_____
Signature

_____
Typed or printed name

_____
Title

_____
Address

_____
City State Zip