

Montana Department of Labor & Industry

Employment Relations Division, Workers' Compensation Regulation Bureau
P.O.Box 8011
Helena, Montana 59604
Phone: (406) 444-1555 Fax: (406) 444-7710 Email: amclean@mt.gov
Website: [Self-Insurance Plan 1](#)

Renewal Date:

Date Stamp - Office Use Only

Workers' Compensation Self-Insurance Application for 2017

Complete this form in its entirety. Unanswered questions may delay processing.
Refer to the related instruction sheet on the above web site for details.

Check One: New Renewal New member of existing group

Group Name: _____

If new, proposed effective date of self-insurance coverage: _____

GENERAL INFORMATION

Name of Company: _____ Date Established: _____

Date Company Started Business in Montana _____

Address: _____ Federal Employer Tax ID #: _____

Parent Company : _____ Date Established: _____

Address: _____

Montana Operations (continue on separate sheet if necessary):

Legal Name	Number of Employees	Location	Nature of Business
1 _____			_____
2 _____			_____
3 _____			_____
4 _____			_____
Total Number of Montana employees (Number of W-2's plus Volunteers) _____		0	Gross Montana Annual Payroll for CY 2016 \$ _____ -

Company Official(s) to Contact Regarding Self-Insurance:

Name	Title	Address	E-Mail	Phone No.
1 _____				
2 _____				

Company Official(s) to Contact Regarding Montana Operations:

Name	Title	Address	E-Mail	Phone No.
1 _____				
2 _____				
3 _____				

MONTANA WORKERS' COMPENSATION SELF-INSURANCE APPLICATION for 2017

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ACCIDENT AND CLAIM SUMMARY

Claims reported on: Policy Year Fiscal Year Calendar Year

Claim Year: beginning date _____ ending date _____

ACCIDENTS BY YEAR:	2016	2015	2014	2013	2012
# Medical Only					
# of Lost Time					
# of Fatal					
TOTAL Accidents	0	0	0	0	0

ALL CLAIMS BY YEAR:

<----- All Claims Open & Closed ----->

	2016	2015	2014	2013	2012	Open Claims Only for Years Prior to 2012
Total payments made: (line 1)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Unpaid reserves, without IBNR, as of end of most recent year: (line 2)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total incurred liability, without IBNR, updated as of most recent year-end: Sum of line 1 + line 2	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Expected recoveries from excess insurance carrier	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

When were Reserves last updated? _____ By Whom? _____

Three Year Average Incurred Liability (Use 2015, 2014, 2013): \$ -

Undiscounted Total Estimated UNPAID Liability On All Montana Claims:

For claims incurred before 7/1/89:
 For claims incurred on or after 7/1/89: _____
 Total Claims: \$ - (sum of line 2 above) \$ -

Total Cash Paid During the Last Calendar Year (1/1/2016 - 12/31/2016):
 Indemnity + Medical + Other = Total
\$ -

Medical payments in excess of \$200,000 per claim during last calendar year _____

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Are estimated unpaid compensation and medical liabilities included on company balance sheet?

Yes No

If yes, how are they classified? _____

If no, explain. _____

Do you have a formal safety program?

Yes No

Is there a Safety Engineer at Montana locations?

Yes No

CLAIMS EXAMINER INFORMATION

Name of Montana Examiner _____ Phone _____

Address _____

E-Mail address _____

Location of Montana Claim Files _____

Third-Party-Administrator _____

(if applicable)

SECURITY & EXCESS INSURANCE INFORMATION

Surety Bond:

Name of Surety Company _____ Phone _____

Address _____

Bond Amount \$ _____ Effective Date _____

Letter of Credit:

Name of Bank _____ Phone _____

Address _____

LOC Amount \$ _____ Effective Date _____

Government Bond/Security:

Type of Bond/Security _____ Cusip# _____

Interest _____ 0.00% Maturity Date _____

Bond Amount \$ _____ Effective Date _____

Certificate(s) of Deposit:

Name of Bank(s) _____

Certificate Number(s) _____

CD Amount(s) \$ _____ \$ _____ \$ _____

Specific Excess Insurance:

Name of Insurance Carrier _____

Effective Date _____

Expiration Date _____

Self-Insured Retention (SIR) \$ _____

Policy Limit \$ _____

Deductible \$ _____

Aggregate Excess Insurance:

Name of Insurance Carrier _____

Effective Date _____

Expiration Date _____

Self-Insured Retention (SIR) \$ _____

Policy Limit \$ _____

ELECTION AND CERTIFICATION

We hereby make application to be a self-insured employer in Montana and certify that all of the information provided is correct. Our firm is an employer in the State of Montana. If we are granted self-insured status by the Department, we agree to comply with and be bound by all of the applicable laws, rules, and regulations of Montana pertaining to workers' compensation and occupational disease.

We agree to notify the Department of Labor & Industry and the Montana Self-Insurers Guaranty Fund within 24 hours of the filing of any bankruptcy or determination of insolvency relating to this firm.

This election is made by the firm and authorized by the directors, officials, officers, by-laws, owner, or partners.

Typed Name	Title	Phone	Date
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Authorized Signature

Typed Name	Title	Phone	Date
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Authorized Signature

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