

**Montana Department of Labor & Industry  
Self-Insurance Workers' Compensation Application**

**GENERAL INSTRUCTIONS**

**COMPLETION OF FORM: Fill in all blanks and check appropriate boxes. All questions must be answered to avoid delay in processing.**

**\*\*\*Groups must contact the Department for additional application requirements\*\*\***

**ATTACHMENTS:** The following documents are to be sent with the application. **Initial**

**Applications:** (Allow 90 days for processing)

1. Two copies of the last two (2) years' audited financial statements. CPA Bound copies are preferred. Public groups need to submit only one copy. If you are submitting consolidated statements of parent company, a parental guaranty form must be completed.
2. Two copies of an actuarial analysis. One copy for public groups.
3. Claims summary loss run, a compilation of information relating to prior and existing claims made under the Workers' Compensation and Occupational Disease Acts of Montana, showing by policy year the total number of medical and indemnity claims, total compensation benefits paid, and the total amount reserved for future liabilities.
4. Copy of safety program or safety manual, proposed excess insurance carrier, proposed type of security deposit.
5. The Department may require additional information, documents or evidence.

**Renewal Applications:** (Must be received at least 60 days prior to your renewal date)

1. Two copies of the latest years audited financial statements. CPA Bound copies are preferred. Public groups need to submit only one copy.
2. Two copies of an actuarial analysis. One copy for public groups.
3. Copy of actuary report for most recently closed calendar year.
4. Certificate of Excess Insurance for the renewal period and the required Montana endorsements number 1 through number 4.
5. Any other information requested by the Department.

**MONTANA SELF-INSURERS GUARANTY FUND**

With the exception of public entities, participation in the Montana Self-Insurers Guaranty Fund is a condition of the authority to self-insure. The Department will notify the Fund of your application for self-insurance. The Department and the Fund will exchange information regarding financial statements, security deposits, excess insurance, etc. Please contact:

**Montana Self-Insurers Guaranty Fund**

Jeff Lapham, Executive Director  
5865 Rosendale Road  
East Helena, MT 59635-9727  
(406) 475-3766  
[mtguarantyfund@mt.net](mailto:mtguarantyfund@mt.net)

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### NAME OF COMPANY

Provide the name, address, and date established of the company applying for self-insurance privileges. If the applicant submits its parent's consolidated financial statements or its parent will guarantee Montana liabilities under the company's self-insurance program, provide the name, address, phone, and date established of the parent.

### MONTANA OPERATIONS

List the legal name, total number of employees, and nature of business for ***each location*** in Montana being included under the self-insurance program.

Self-Insured Groups – ***provide a list of your members*** being included under the self-insurance program.

***Total employees'*** means the total number of individuals employed by your business at any time during the last calendar year. This includes full time, part time, and volunteer employees, *not just FTE* positions.

### MONTANA PAYROLL SUMMARY

Provide the Gross Montana annual payroll figures and the ***actual employee count*** (including part-time employees) for the preceding calendar year. Wages are defined under 39-71-123, MCA.

### COMPANY OFFICIALS

List the company officials to contact regarding self-insurance privileges.

List the company officials to contact regarding Montana operations.

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### ACCIDENT AND CLAIM SUMMARY

#### CLAIMS REPORTING

Please indicate which 12-month period is being used to report the claim information on this page. Also indicate the beginning and ending dates of this year.

#### ACCIDENTS BY YEAR

Provide the number of accidents by benefit classification (i.e., medical only, lost time, or fatal) for the preceding five policy years. This information is used to calculate occupational injury rates for industry comparison purposes.

#### ALL CLAIMS BY YEAR (open & closed)

Provide the total benefits paid to date for claims incurred during each claim year shown on page 2 (line 1). All prior years include those open claims incurred prior to the last year reported on this form.

Provide the estimated amount of future liability based on lifetime of the claims, but not paid and without including IBNR (incurred but not reported), as of the end of the most recent claim year

(line 2). All prior years include those **open** claims incurred prior to the last year reported on this form.

Provide the **total** incurred liability, without including IBNR (incurred but not reported) for each of the past five policy years, updated as of the most recent year-end (line 1 plus line 2). (Total payments made + unpaid reserves = total incurred liability.)

#### THREE-YEAR AVERAGE

Calculate the average incurred liability for three claims years, **omitting the current year**.

#### TOTAL ESTIMATED UNPAID LIABILITY

Provide the estimated undiscounted total unpaid liability on all self-insured Montana workers' compensation and occupational disease claims. This figure includes those open claims incurred before 7/1/89 and claims incurred after 7/1/89, the inception date for the Montana Self-Insurers Guaranty Fund. "Total claims" should equal the total of all years reported under unpaid reserves without IBNR (line 2).

#### TOTAL CASH PAID

Provide the total gross payments made for all claims during the last calendar year broken down by indemnity, medical, and other. The total amount should equal all the checks written for workers' compensation in Montana in the last calendar year. **These figures should agree with amounts submitted on your quarterly expenditure reports.**

Provide the medical payments in excess of \$200,000 per claim.

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### **CLAIMS EXAMINER INFORMATION**

Montana is a resident claims examiner state. A self-insurer must designate at least one claims examiner maintaining an office in Montana. The claims examiner must have authority to accept and deny claims, issue compensation checks, and settle claims. Provide the name, address, phone number, and e-mail address of the designated Montana claims examiner.

### **SECURITY & EXCESS INSURANCE INFORMATION**

#### **Security Deposit:**

##### Initial Applicants:

Complete the section for the type of security deposit you will provide - Surety Bond, Letter of Credit, Government Bond, or Certificate(s) of Deposit.

A deposit is required for the first three years of operating as a self-insured employer. The minimum deposit will be the greater of \$250,000 or the average incurred liability for the past three years.

##### Renewal Applicants:

Complete the section for the type of security you have on deposit with the Department. Continue on separate sheet if necessary.

**Excess Insurance:**

Provide the carrier name, self-insured retention (SIR), policy period, and limits on your specific and aggregate excess insurance policies. The specific excess policy limit must be statutory.

**Change in excess insurance policy**

We operate on the assumption that when a self-insured employer changes insurance carriers, the self-insurer will retain the same or comparable insurance coverage. Whenever a self-insured employer changes insurance carriers, we need a copy of the entire new excess policy. Approval is needed in all cases since not all excess carriers are allowed. If any of the limits or SIR levels change, the Department must approve these changes ***prior to*** the effective date of the policy.

**Montana endorsements #1-4**

The required Montana endorsements #1 (insolvency), #2 (cancellation), #3 (commutation), and #4 (late claim reporting penalty waiver) must be added to the specific excess workers' compensation policy. The Montana endorsements are not part of a standard work comp policy, and the insurance carrier must manually add these endorsements to the policy. The endorsements are for self-insured policies only, and the endorsements may be found on our website.

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### **ELECTION AND CERTIFICATION**

Authorized directors, officials, officers, owners, or partners must sign and date the application. Include the telephone number(s) of the signatories.

Forward the application and supporting documents to:

Montana Department of Labor and Industry Employment  
Relations Division  
Workers' Compensation Regulation Bureau Self-Insurance  
Unit  
P.O Box 8011  
Helena, Montana 59604

To avoid a delay in processing, a new application must be received at least ninety (90) days prior to approval, and a renewal application must be received at least sixty (60) days prior to the renewal date. Please contact Adrienne McLean with questions at (406) 444-1555, fax (406) 444- 7710, [or amclean@mt.gov](mailto:amclean@mt.gov) -email.