

Montana Department of Labor & Industry

Employment Relations Division, Self-Insurance Program

P.O.Box 8011

Helena, Montana 59604

Phone: (406) 444-1555 Fax: (406) 444-4140

Website: Self-Insurance Plan 1

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Renewal Date:

Date Stamp - Office Use Only

Workers' Compensation Self-Insurance Application for 2021

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) _____ Gross Montana Annual Payroll for CY 2020 \$ _____

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 _____	_____	_____	_____	_____

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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:	2020	2019	2018	2017	2016
# Medical Only					
# of Lost Time					
# of Fatal					
TOTAL Accidents					

ALL CLAIMS BY YEAR:

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

	2020	2019	2018	2017	2016	Open Claims Only for Years Prior to 2016	
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 2019, 2018, 2017): \$ _____

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 (1/1/2020 - 12/31/2020):

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 _____

\$ _____

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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

**Workers' Compensation Self-Insurance Application for 2021
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