Renewal Date:

Date Stamp - Office Use Only

Montana Department of Labor & Industry
Employment Relations Division, Workers' Compensation Regulation Bureau
P.O.Box 8011
Helena, Montana 59604
Phone: (406) 444-7748 Fax: (406) 444-4140
Website: Self-Insurance Plan 1
Email: amber.weekes2@mt.gov

Workers' Compensation Self-Insurance Application for 2022

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 2021 $ -

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				-	

ACCIDENT AND CLAIM SUMMARY

Claims reported on: ☐ Policy Year ☐ Fiscal Year ☐ Calendar Year

Claim Year: beginning date ____________ ending date ____________

ACCIDENTS BY YEAR:	**2021**	**2020**	**2019**	**2018**	**2017**
# Medical Only					
# of Lost Time					
# of Fatal					
TOTAL Accidents					

ALL CLAIMS BY YEAR:	**<----- All Claims Open & Closed ----->**					**Open Claims Only for Years Prior to**
	2021	**2020**	**2019**	**2018**	**2017**	**2017**
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 2020, 2019, 2018): $ ____________

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* (1/1/2021 - 12/31/2021):

Indemnity + Medical + Other = Total $ ____________

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

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

____
Authorized Signature

____
Typed Name Title Phone Date

____
Authorized Signature

Workers' Compensation Self-Insurance Application for 2022
Supplemental Page