Montana Department of Labor & Industry
Employment Standards Division
PO Box 8011 | Helena, MT 59604
Email: WCRegBureauQER@mt.gov
Website: Self-insurance plan 1
Phone: (406) 444-7748 | Fax: (406) 444-4140

Renewal date:

Date stamp – office use only

Workers' Compensation Self-Insurance Application 2025

Complete the form in its entirety. Unanswered questions may delay processing.
Refer to the related instruction sheet on the above website 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: _____
City, State, Zip: _____

Parent company: _____ Date established: _____

Address: _____
City, State, Zip: _____

Montana Operations

(continue on separate sheet if necessary):

	Legal Name:	Federal employer tax ID:	Number of employees:	Location:	Nature of business:
1					
2					
3					
4					

Total number of Montana employees:
(Number of W-2s plus volunteers) _____ Gross annual payroll for CY 2024 _____

Company Official(s) To Contact Regarding Self-Insurance

	Name:	Title:	Address:	Email:	Phone:
1					
2					

Company Official(s) To Contact Regarding Montana Operations

	Name:	Title:	Address:	Email:	Phone:
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	2024	2023	2022	2021	2020
Medical only:					
Lost time:					
Fatal:					
TOTAL accidents:					

ALL CLAIMS BY YEAR:	ALL CLAIMS OPENED AND CLOSED					Open claims only for years prior to
	2024	2023	2022	2021	2020	2020
Total payments made (line 1):						
Unpaid reserves, without IBNR, as of most recent year (line 2):						
Total liability incurred, without IBNR as of most recent year-end (sum of line 1 and line 2):						
Expected recoveries from excess insurance carrier:						

When were the reserves last updated? _____ By whom? _____

Three-year average incurred liability (use 2024, 2023, 2022): _____

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 (1/1/2024 – 12/31/2024):

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 sheet? ☐ Yes ☐ No

If yes, how are they classified? _____

In 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: _____

Email address: _____

Location of MT claims files: _____

Third party administrator: _____
(if applicable)

Security and 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: _____ Maturity date: _____

LOC 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 this application to be a self-insured employer in Montana and certify that all 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, owners, or partners.

Printed Name	Title	Phone	Date

Authorized Signature

Printed Name	Title	Phone	Date

Authorized Signature

Supplemental Page