



APPLICATION FOR AUTHORITY TO SELF-INSURE

**(TO BE EXECUTED AND SWORN TO IN TRIPLICATE)
ALL INFORMATION CALLED FOR ON APPLICATION MUST BE IN TYPEWRITTEN FORM**

The undersigned (hereinafter referred to as the Applicant) hereby makes application to carry his/its own liability without insurance as provided in the Missouri Workers' Compensation Law. In connection with such application he/it makes the following declaration for the purpose of enabling the Division of Workers' Compensation to determine whether he/it possesses sufficient financial ability to render certain the payment of compensation which his/its employees and their dependents may be entitled to under the Missouri Workers' Compensation Law.

Applicant hereby agrees that if this application be approved, such approval shall be subject to his/its furnishing such security as may be required by the Division of Workers' Compensation. Applicant further agrees to abide by all of the provisions of the Missouri Workers' Compensation Law and by the rules governing self-insurers under said law.

1. NAME OF APPLICANT (IF A CORPORATION IS ORGANIZED UNDER THE LAWS OF A STATE OTHER THAN MISSOURI, A CERTIFIED COPY OF CERTIFICATE OF AUTHORITY TO DO BUSINESS IN MISSOURI SHOULD ACCOMPANY THE APPLICATION.)			3. NATURE OF BUSINESS A. DESCRIBE BRIEFLY THE GENERAL CHARACTER OF THE OPERATIONS PERFORMED AND THE ARTICLES MANUFACTURED OR COMPOUNDED AT THE PLANT OR ON THE PREMISES OF THE EMPLOYER.					
2. ADDRESS (PRINCIPLE OFFICE)			B. DESCRIBE BRIEFLY ALL CLASSES OF WORK PERFORMED AWAY FROM THE EMPLOYER'S PLANT OR PREMISES, INCLUDING THE DEMONSTRATION, IF ANY, OF THE EMPLOYER'S PRODUCT AND ALL GENERAL OPERATIONS OF CONSTRUCTION, INSTALLATION OR EXCAVATION.					
CITY	STATE	ZIP CODE						
PHONE NUMBER								
ADDRESS (MISSOURI OFFICE)								
CITY	STATE	ZIP CODE						
PHONE NUMBER								
4. PARENT COMPANY NAME								
5. PARENT COMPANY ADDRESS								
6. STATE WHERE INCORPORATED								
7. NAME AND ADDRESS OF EXCESS INSURANCE CARRIER								
8. WHAT COMPANY NOW IS CARRYING YOUR COMPENSATION INSURANCE?								
9. TOTAL WORKERS' COMPENSATION PAID IN PAST YEAR?			INSURANCE MODIFICATION FACTOR					
10. DESCRIBE FULLY IN AN ATTACHED STATEMENT THE SAFETY ORGANIZATION MAINTAINED WITHIN YOUR FIRM FOR THE PREVENTION OF ACCIDENTS AS WELL AS A DESCRIPTION OF THE ADMINISTRATIVE ORGANIZATION MAINTAINED TO HANDLE WORKERS' COMPENSATION MATTERS. INCLUDE THE REPORTING OF INJURIES, AUTHORIZATION OF MEDICAL CARE, PAYMENT OF COMPENSATION, AND THE HANDLING OF CLAIMS FOR COMPENSATION, TOGETHER WITH THE NAME AND ADDRESS OF EACH SUCH OFFICE AND THE QUALIFICATIONS OF THE PERSONNEL IN EACH OFFICE TO PERFORM THIS SERVICE.								
11. DATE YOU WISH AUTHORITY TO BECOME EFFECTIVE								

12. LOCATION OF FACTORIES, OFFICES, OR OTHER WORKPLACES IN STATE OF MISSOURI, AND NUMBER OF EMPLOYEES ENGAGED IN EACH PLACE.		13. CLASSIFICATIONS AND PAYROLL IN MISSOURI			
PLANT LOCATION	NO. OF EMPLOYEES	CLASSIFICATION CODE NUMBER - IF KNOWN, & DESCRIPTION OF JOB (EXAMPLE) CLERICAL DRIVERS OUTSIDE SALES	CLASS CODE 8810 7380 8742	AVERAGE NUMBER OF EMPLOYEES	ESTIMATED PAYROLL OF EMPLOYEES FOR ONE YEAR - THE TWELVE MONTHS PRECEDING DATE OF APPLICATION. THIS PAYROLL SHALL INCLUDE ALL EMPLOYEES.
TOTAL		TOTAL			

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APPLICATION GRANTED ON CONDITION THAT THE APPLICANT FILE ESCROW AGREEMENT AND DEPOSIT SECURITIES OR CASH IN THE AMOUNT OF \$ _____ OR PROVIDE SURETY BOND IN THE PRINCIPLE SUM OF \$ _____. SELF-INSURANCE AUTHORITY WILL BECOME EFFECTIVE AS OF DATE APPROVED SECURITY, IN THE AMOUNT REQUIRED, IS FILED AT THE OFFICE OF THE DIVISION IN JEFFERSON CITY.

ESCROW AGREEMENT FILED (DATE) _____, SHOWING SECURITIES OR CASH IN THE AMOUNT OF \$ _____ DEPOSITED IN ESCROW IN THE (NAME OF BANK) _____ OF (ADDRESS OF BANK) _____

SURETY BOND FOR \$	DATE EFFECTIVE	NAME OF SURETY COMPANY	SELF-INSURANCE AUTHORITY EFFECTIVE ON (DATE)
AUTHORITY APPROVED: SIGNATURE (DIVISION OF WORKERS' COMPENSATION)			DATE

FINANCIAL STATEMENT

NOTE THE DIVISION REQUIRES THAT ALL ITEMS LISTED BELOW BE COMPLETED.

CONFIDENTIAL REPORT MADE TO THE DIVISION OF WORKERS' COMPENSATION FOR THE PURPOSE OF SHOWING FINANCIAL ABILITY TO PAY COMPENSATION THIS _____ DAY OF _____, _____.
 DATE FISCAL YEAR ENDS:

1. NAME	2. ADDRESS
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ASSETS		
3. CURRENT ASSETS		
CASH ON HAND AND ON DEPOSIT		\$
NOTES RECEIVABLE	\$	
LESS NOTES RECEIVABLE DISCOUNTED	\$	\$
ACCOUNTS RECEIVABLE	\$	
LESS RESERVE FOR DOUBTFUL ACCOUNT	\$	\$
INVENTORIES (ITEMIZED)		
		\$
OTHER CURRENT ASSETS (ITEMIZED)		
TOTAL CURRENT ASSETS		\$
4. INVESTMENTS (DESCRIBE FULLY) (SECURITIES OF SUBSIDIARY OR AFFILIATED COMPANIES SHOULD BE LISTED SEPARATELY)		
		\$
5. SINKING FUNDS AND OTHER FUNDS		
		\$
6. FIXED ASSETS (DEPRECIATION RESERVES TO BE SHOWN SEPARATELY)		
TOTAL FIXED ASSETS		\$
7. DEFERRED CHANGES		
		\$
8. TOTAL ASSETS		\$

