DIVISION OF WORKERS' COMPENSATION

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

APPLICATION FOR GROUP SELF-INSURANCE

(To be executed and sworn to in triplicate)

P.O. Box 58
Jefferson City, MO 65102-0058

ALL INFORMATION CALLED FOR ON APPLICATION MUST BE IN TYPEWRITTEN FORM

The undersigned Group Fund hereby makes application to carry its own liability without insurance as provided in the Missouri Workers' Compensation Law. In connection with such application it makes the following declaration for the purpose of enabling the Division of Workers' Compensation (DWC) to determine whether it possesses sufficient financial ability to render certain the payment of compensation which 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 its furnishing such security as may be required by the DWC. 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.

_____ _____

Applicant Group Fund *(Official Name)* *(Effective Date)*

1. Address of Principal Office _____
(Number) *(Street)* *(City)* *(State)* *(ZIP Code)*

2. Trustees

Name	Business Address
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

3. Administrator _____
(Name) *(Address)* *(Phone Number)*

4. Claims Program _____
(Name of Service Company) *(Address)* *(Phone Number)*

5. Safety Program _____
(Name of Person Responsible) *(Phone Number)*

Missouri Division of Workers' Compensation is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. TDD/TTY: 800-735-2966 Relay Missouri: 711

6. Total Number of Employer Members _____
(Attach List of Members)

Total Estimated Premium _____

Group Experience Mod. _____

Excess Carrier _____

Standard Premium _____

Policy Number _____

Estimated Collectible
Premium After Discount _____

7. Applicant will Submit:

A. Specific Excess Insurance

Policy Limit $_____

Retention $_____

Term _____ to _____

B. Aggregate Excess Insurance

Policy Limit $_____

Term _____ to _____

Loss Fund _____% of collectible premium after any discount

Loss Fund $_____

Loss Limit $_____

Est. Min. Loss Fund $_____

C. Surety Bond

Amount $_____

Bond Number _____

Carrier _____

D. Fidelity Bond

Amount $_____

Bond Number _____

Carrier _____

In consideration of the privilege of being a self-insurer, we hereby agree:

a. That we will discharge our liability for compensation to injured employees or their dependents in accordance with the requirements of the Workers' Compensation Act of the State of Missouri.

b. That we will follow the Administrative Rules of the DWC and any additional conditions imposed by the Division as part of our approval.

c. That we will promptly furnish all reports to the DWC which it may lawfully require under the Workers' Compensation Act.

d. That we will notify the DWC promptly of any unfavorable turn in our financial condition which might reasonably reduce our ability to carry our own risk under the Workers' Compensation Act.

We affirm all information submitted as being true.

_____
(Group Fund)

by

_____
(Official Title)

Date _____

_____

Name of Group Fund

Effective _____ to _____

Amount of Payroll by Classification for Current Year of Group Fund

Code	Classification	Payroll	Manual Premium
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
	TOTALS	_____	_____
		Standard Premium	_____

Loss History Experience

Date	Gross Payroll	Total Losses
_____ year	_____	_____
_____ year	_____	_____
_____ year	_____	_____
_____ year	_____	_____
_____ year	_____	_____

Losses over $10,000 past five years:

Date	Total Amount
_____ year	_____
_____ year	_____
_____ year	_____
_____ year	_____
_____ year	_____