

# APPLICATION FOR SELF-INSURANCE

K-WC 120 (Rev. 11-15)

Applicant organization name

Date of application

Permit number  
(renewals only)

hereby applies for the privilege of being a self-insurer under the Kansas Workers Compensation Act and submits the following report in support of said application.

**All questions must be answered; if not applicable, put N/A.  
Attach additional sheets wherever needed.**

1. Address of principal office: \_\_\_\_\_

2. Applicant is:  Individual  Partnership  Corporation  Public Authority  LLC

3. Applicant's general officers, partners or public officials:

Name/Title

Business address

Name/Title	Business address
_____	_____
_____	_____
_____	_____
_____	_____

4. Date applicant's business/public authority commenced: \_\_\_\_\_

5. Person responsible for self-insurance program:

Name	Title	Phone
_____	_____	_____

Address of responsible person (if different from item 1 above)

6. Service company information

a. Loss prevention services:

(1) Name of service company \_\_\_\_\_

(2) Address of service company \_\_\_\_\_

(3) Phone \_\_\_\_\_

(4) Contact person \_\_\_\_\_

(5) Give details of services furnished by service company \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

b. Claims handling services:

- (1) Name of service company \_\_\_\_\_
- (2) Address of service company \_\_\_\_\_
- (3) Phone \_\_\_\_\_
- (4) Contact person \_\_\_\_\_
- (5) Give details of kinds of services that will be furnished by service company \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you DO NOT plan to use an adjusting company, please explain on a separate attachment the plan you have for adjusting claims for your company. Such explanation should include the name of the person directly in charge of the adjusting activity. Explain what procedure you plan to follow in regard to investigating and adjusting claims and whether those individuals adjusting claims will be exclusively engaged in that activity.

The Division of Workers Compensation may require the use of an adjusting company if we do not feel that your in-house adjusting procedure would be adequate to serve the injured workers.

DO THE ABOVE 5. AND 6. (a) AND (b) HAVE A WORKING KNOWLEDGE OF THE KANSAS WORKERS COMPENSATION ACT?  Yes  No

**7. Safety program**

- a. Person in charge \_\_\_\_\_
- b. Please furnish a copy of your safety manual. If previously filed, only changes need be submitted.
- c. When were premises last inspected? \_\_\_\_\_  
Inspecting agency \_\_\_\_\_

**8. Medical and hospital care**

- a. Do you employ a full or part-time doctor?  Yes  No  
Name \_\_\_\_\_
- b. Name of provider to whom injured are normally sent: ? \_\_\_\_\_  
\_\_\_\_\_
- c. Do you have a hospital in the plant?  Yes  No  
First aid room?  Yes  No  
Professional nurse on premises?  Yes  No

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**9. Loss history (5 years) in State of Kansas (NEW PERMIT APPLICATIONS ONLY)**

Liability Period		Gross Payroll	Total Losses	Paid Losses	Reserves	National Council on Compensation Insurance Experience Modification
From	To					

**10. Give the following information regarding the State of Kansas:**

W.C. Code No.*	Classification*	Number of Employees	Estimated Annual Gross Payroll	Current Manual Rates*	Manual Premium
<b>Totals</b>					

\* Generally available from your insurance agent or excess carrier. Use the current approved Assigned Risk Rates. These rates are measurable for manual premium determination.

Total estimated annual gross payroll: \$ \_\_\_\_\_

Total number of employees in Kansas: \_\_\_\_\_

Total estimated manual premium: \$ \_\_\_\_\_

**11. For the state of Kansas**, indicate the workers' estimated average weekly wage at your company (exclude clerical and executive wages): \$ \_\_\_\_\_





17. Do employees receive any supplemental benefits in addition to workers compensation benefits?  Yes  No

If yes, describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

18. Are there any actual or potential occupational disease exposures involved in applicant's operations?  Yes  No  
These may include dust, gases or fumes, chemicals and toxic substances, extreme changes of temperature, noises or pressure, physical vibrations, constant pressure and use, physical movement in constant repetition or radioactive rays, infections and organisms, bloodborne pathogens or radiation.

If yes, describe \_\_\_\_\_  
\_\_\_\_\_

19. Furnish information on any substantial or unusual changes (increase or decrease) in operations in Kansas that are planned or that have taken place in the last five (5) years.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

20. Does the applicant have any employees in Kansas who are subject to the:

Longshoremen and Harbor Workers' Act?  Yes  No

Jones Act?  Yes  No

Federal Employers' Liability Act?  Yes  No

If yes, explain \_\_\_\_\_

21. a. If the employer is rated by Standard & Poor or Dun & Bradstreet, show the latest ratings, INCLUDING the date of the rating: (Ultimate Parent rating if application is submitted by subsidiary).

Standard & Poor \_\_\_\_\_ Dated: \_\_\_\_\_

Dun & Bradstreet \_\_\_\_\_ Dated: \_\_\_\_\_

Other \_\_\_\_\_ Dated: \_\_\_\_\_

b. Give four-digit Standard Industrial Classification (SIC) Code that most clearly defines your operation as reflected in the financial statements submitted. (Ultimate Parent SIC if application is submitted by subsidiary.)

\_\_\_\_\_

The SIC Code is used to determine the appropriate Dun & Bradstreet reference for comparing financial condition to the industry norm. If verifiable information from an industry association would be more appropriate, please submit.

The Standard Industrial Classification (SIC) Code defines industries in accordance with the composition and structure of the economy. Each establishment is classified according to its primary activity; i.e., mining, construction, manufacturing, transportation, communications, utilities, wholesale trade, retail trade, services, etc. In Kansas, the SIC Code is assigned by Kansas Department of Labor (KDOL) Labor Market Information Services, under contract with the Federal Bureau of Labor Statistics.

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**22. Parent(s), affiliates and subsidiaries of applicant:**

- List parents of applicant in hierarchical order, beginning with ULTIMATE PARENT COMPANY regardless of Kansas operation.
- List all affiliates and subsidiaries of applicant that are operating WITHIN KANSAS.
- Place an arrow (→) in column (1) showing Applicant's direct parent company.
- List % of voting stock by each corporation's direct parent, and show whether corporation is a parent or subsidiary of the applicant.

Column 1	Legal Name of Corporation	Address(es) of all Kansas Locations	( % )	Parent or Sub.
<b>TOP PARENT</b>				

**23. Applicant divisions and operation:** Year \_\_\_\_\_

List each Kansas operation of the applicant. (*Do not list excess insurance on this chart.*)

Name of Operating Unit and Location (Include Street Address)	Operation Type Main Products, Services, Activities	Kansas Employees		No. Cases Entered on OSHA 300 log	To be Self-Ins.**	
		Average Number	Annual Gross Payroll		Yes	No
			\$			
			\$			
			\$			
			\$			
			\$			
			\$			
			\$			
			\$			
			\$			
			\$			
			\$			
			\$			
<b>TOTALS</b>						

\*\*If no: Full name of insurance company \_\_\_\_\_

Policy number \_\_\_\_\_ Policy ending date \_\_\_\_\_

Does this unit have separate employees and payrolls?  Yes  No

**24. EXCESS INSURANCE:**

List all excess policies that cover Kansas Workers Compensation Insurance (Check which type of excess in force).

Coverage Type: Specific  Aggregate  Other

Insurance Company (Full Name)	Retention	Upper Limit of Excess Policy	Policy No.	Policy Period	
				From	To
	\$	\$			
	\$	\$			

**25. All applications**

**A. Paid loss data for outstanding workers compensation claims**

*(Includes weekly compensation payments, travel and per diem for medical exams and/or treatment, lump-sum payments, compromise settlements, hospital, appliance and medical payments, rehabilitation, and death and funeral benefits.)*

**Amount paid for medical:** *(including payments made during the calendar year for any previous years accidents.)* ..... \$ \_\_\_\_\_

**Amount paid for indemnity:** *(including payments made during the calendar year for any previous years accidents.)* ..... \$ \_\_\_\_\_

**Total amount paid in recent calendar year:\*** ..... \$ \_\_\_\_\_

\* This figure must equal amount shown on Form K-WC 92, **Annual Loss Payment Report**, which is: \$ \_\_\_\_\_ *(Reflect Form 92 figure.)*

**B. Reserves for claims to be paid in the future**

(1) Reserve information for all Kansas claims including prior years, and current year to date through: \_\_\_\_\_

Total number of claims: \_\_\_\_\_

Amount reserved for known medical: ..... 1a \$ \_\_\_\_\_

Amount reserved for known indemnity: ..... 1b \$ \_\_\_\_\_

(2) Incurred but not reported (IBNR) claims:

Total number of claims: \_\_\_\_\_

Amount reserved for IBNR: ..... 2a \$ \_\_\_\_\_

(3) Reserved for future claims: ..... 3a \$ \_\_\_\_\_

**TOTAL AMOUNT RESERVED:** ..... \$ \_\_\_\_\_

**(1a + 1b + 2a + 3a)**

**C. Accident information**

During the most recent calendar year of \_\_\_\_\_ there were \_\_\_\_\_ accidents reported.  
(year) (number)

The accidents reported were \_\_\_\_\_ time lost and \_\_\_\_\_ no time lost.  
(number) (number)

**D. Name, qualifications and experience of person(s) evaluating loss reserves:**

*(Résumé or attachment is acceptable.)*

\_\_\_\_\_  
\_\_\_\_\_

**E. How are loss reserves for future liability expressed on your financial statement?**

\_\_\_\_\_

**26. Provide name of responsible individual as contact for the following areas:**

**a. Notice of Hearing:**

Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: (     ) \_\_\_\_\_ Email: \_\_\_\_\_

**b. Renewal Application:**

Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: (     ) \_\_\_\_\_ Email: \_\_\_\_\_

**c. Notice of Assessment:**

Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: (     ) \_\_\_\_\_ Email: \_\_\_\_\_

**d. Applicant's FEIN:** \_\_\_\_\_

## Settlement and Stipulations

Employer must agree to the conditions and stipulations below to qualify for self-insurer privileges. This statement must be signed by a corporate officer, city or county official, partner or individual; and have applicant's seal affixed before self-insurer privileges will be considered.

### **27. In consideration of the privilege of being a self-insurer in the State of Kansas, I hereby agree:**

- a. That I have filed all required reports and paid all fees necessary to remain a Corporation in Good Standing with the Office of the Kansas Secretary of State (785-296-4564).
- b. That I will discharge my liability for compensation to injured employees or their dependents in accordance with the requirements of the Workers Compensation Act of the state of Kansas.
- c. That I will not solicit, receive or collect any money from my employees or make any reduction from their wages and commissions for the purpose of discharging any part of my liability under the Act.
- d. That I will promptly furnish all reports to the Kansas Division of Workers Compensation which it may lawfully require under the Kansas Workers Compensation Act.
- e. To notify the Division of Workers Compensation in any case of contemplated liquidation, sale or transfer of ownership, or material reduction in Kansas operation. Subject to the Division of Workers Compensation approval, I will arrange for the payment of all existing liability and any liability arising thereafter for which I may become legally liable, by guaranty bond, deposit of securities or as otherwise required by the Division of Workers Compensation.
- f. That prior to any changes made to the excess insurance policy, I will request from the Division of Workers Compensation approval of the self-insured retention or policy limits, and I agree that any proposed changes will be justified in narrative form prior to the inception of the policy or date of renewal.
- g. That I will notify the Division of Workers Compensation at least 20 days in advance of any change in excess insurance carrier. I am familiar with the insurance laws in Kansas regarding the placement of excess insurance in the admitted and non-admitted excess insurance market. Also, I am aware of the hazards of having excess workers compensation coverage with a non-admitted insurance carrier.
- h. To let the Division of Workers Compensation know about any change in the kind or amount of services to be performed by the service company, if a company is used.
- i. That I will promptly notify the Division of Workers Compensation of any unfavorable turn in my financial condition which might reasonably reduce my ability to carry my own risk under the Kansas Workers Compensation Act.
- j. That the Form K-WC 40, *Posting Notice*, will be displayed in conspicuous places, such as employee bulletin boards as required by the Kansas Workers Compensation law. (The notices are available online at the Division of Workers Compensation's website: [www.dol.ks.gov/Files/PDF/KWC40-A.pdf](http://www.dol.ks.gov/Files/PDF/KWC40-A.pdf).)
- k. Immediately on receiving notice of injury to or death of an employee, the employer shall mail or deliver to the employee or legal beneficiary a clear and concise description of:
  - (1) the benefits available under the Workers Compensation Act;
  - (2) the process to be followed in making a claim for benefits;
  - (3) the identification of the person, firm or organization directly responsible for responding to and processing a claim for workers compensation benefits;
  - (4) the responsibilities of the self-insured employer, insurance company or group-funded self-insurance plan;
  - (5) the assistance available from the office of the Director of Workers Compensation; and
  - (6) the address and a toll-free phone number that will facilitate access to the assistance available from the director's office.

I. That in case of insolvency, I shall make our records available to the Division of Workers Compensation. I will also disclose our inability to pay the injured employee. I hereby agree to all other requirements contained in K.S.A. 44-532, 74-712 through 74-719 and K.A.R. 51-14-4.

m. **That I recognize that this self-insurer permit can be cancelled at anytime for failure to comply with the requirements set out herein.**

Employer: \_\_\_\_\_

Signature: \_\_\_\_\_

*(Corporate Officer, Official of City or County Government, Partner or Individual)*

APPLICANT'S  
OFFICIAL  
SEAL

Printed name: \_\_\_\_\_

Official position: \_\_\_\_\_

STATE OF \_\_\_\_\_ )  
 )  
\_\_\_\_\_ COUNTY )

*(The person signing the application above and subscribing the affidavit below must be the corporation President, Vice President, Secretary or Treasurer, or the corporation Assistant Secretary or Assistant Treasurer if authorized by articles of incorporation or bylaws to make this application.)  
(Authorized official if city or county government.)*

**AFFIDAVIT**

\_\_\_\_\_, First being duly sworn on oath, deposes and says that he/she is the person who signed the foregoing application, and that he/she is acquainted with the affairs of the said applicant employer, to which the representations and statements set forth in the foregoing application relate; that he/she has read said application, knows the contents thereof and that said representations and statements therein contained are true to the best of his/her knowledge, information and belief.

\_\_\_\_\_  
(Affiant's Signature)

\_\_\_\_\_  
(Official Position)

Subscribed and Sworn to before me at \_\_\_\_\_,  
this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
(Notary Public)

(SEAL)

MY COMMISSION EXPIRES \_\_\_\_\_