

Form SI-11 Rev. 2/20/2024	ARKANSAS WORKERS' COMPENSATION COMMISSION SELF-INSURANCE DIVISION 324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-2783 / 1-800-622-4472	SI-11
Ark. Code Ann. §11-9-404 & AWCC Rule 099.05		

APPLICATION FOR GROUP SELF-INSURANCE

To the Arkansas Workers' Compensation Commission:

The undersigned, a duly authorized representative of a group of employers subject to the provisions of the Arkansas workers' compensation laws and organized under the laws of the State of Arkansas for the purpose of qualifying as a group self-insurer, certifies that such employers have duly entered into agreements to pool their liabilities in accordance with Ark. Code Ann. §11-9-404(a)(3) and the applicable rules for group self-insurers and that such agreement is attached hereto and does make application for approval of the establishment of a group self-insurer to pay compensation benefits directly to the employees of the such employer members.

1. Name of the Group Self-Insurer: _____
2. Mailing address of the principal office: _____
3. Physical address of the principal office: _____
4. Telephone No.: _____ Fax No.: _____ Toll-free No. _____
5. Federal Employer Identification Number (FEIN): _____
6. Name and address of the individual who will serve as the Group Manager: _____

- Telephone No.: _____ Fax No.: _____ Toll-free No.: _____
- Email: _____
7. Desired effective date of the group: _____
8. Estimated number of first year members: _____
9. Estimated amount of first year premium: _____
10. Type of group self-insurer status desired: Homogeneous Common NAICS Code: _____

If the application is for homogeneous self-insurance, what is the *same type of business activity or pursuit*?

If the application is for common self-insurance, what is the trade or professional association of which the applying employers are members? _____

Give the organization date of the trade or professional association. _____

NOTICE: ITEMS 11-15 BELOW ARE CONFIDENTIAL INFORMATION

11. Name, address, and telephone numbers of the third party administrator with which the group members have contracted to service their workers' compensation program? (Note: This third party administrator must be a company approved by the Commission to handle self-insured clients):

Telephone No.: _____ Fax No.: _____ Toll-free No. _____

12. If no third party administrator is used, then proof of adequate servicing is to be attached in accordance with the rules.

13. Name, address, and telephone numbers for the company which will provide loss control services:

Telephone No.: _____ Fax No.: _____ Toll-free No. _____

14. Name, address, and telephone numbers of the managed care organization with which the group members have contracted (if any): _____

Telephone No.: _____ Fax No.: _____ Toll-free No.: _____

15. Do you plan to carry excess insurance? Yes No

If yes, between what limits? Retention \$ _____ to \$ _____

Aggregate? Yes No

In consideration of the approval of this application, the applicant hereby agrees to the following:

A. The applicant, on behalf of its members, will fully meet and comply with all obligations imposed by the provisions of the Arkansas Workers' Compensation Laws, Rules, and Regulations of the Commission.

B. The applicant will deposit with the Commission an acceptable security deposit in an amount prescribed by the Commission; will furnish excess insurance as prescribed; will pay tax assessments as prescribed; will comply with all reporting procedures as prescribed; will furnish necessary fiduciary bonds as prescribed; will accept as future members of the Group only financially sound employers, and employers who qualify in accordance with Ark. Code Ann. §11-9-404(3); and will submit an application remittance in the amount of \$100.00, payable to the Arkansas Workers' Compensation Commission.

Therefore, we respectfully request that authority be granted to our named Group for the privilege of receiving a Certificate of Authority to act as a Self-Insurer under the Arkansas workers' compensation laws.

(Name of group)

By _____
(Chairman, Board of Trustees)

State of Arkansas

County of _____ }

Subscribed and sworn to before me by _____

on this _____ day of _____, 2_____.

(Notary Public)

My Commission expires _____.