WORKER'S COMPENSATION BOARD OF INDIANA
402 WEST WASHINGTON STREET, ROOM W196
INDIANAPOLIS, IN 46204-2753
www.in.gov/wcb

STATE FORM 18488 9R13/3-990
FORM SI-1 (Revised 2018)
Approved by State Board of Accounts

WORKER'S COMPENSATION AND OCCUPATIONAL DISEASES ACTS
EMPLOYER'S APPLICATION FOR PERMISSION TO
CARRY RISK WITHOUT INSURANCE

This application is for employers subject to the provisions of the "Indiana Worker's Compensation and Occupational Diseases Acts", that wish to obtain a certificate to pay compensation directly, without insurance, to injured employees or to the dependents of employees who die as a consequence of illness or injury as a result of a workplace injury. This also covers payment of medical expenses incurred in the treatment of an injured worker.

This application will cover the period of September 1, 2022 to midnight, August 31, 2023. The information provided herein is for the purpose of enabling the Worker's Compensation Board of Indiana to determine whether the applicant possesses sufficient financial ability to render certain the payment of such compensation and medical expenses. Applicant Employer, through _____ (name of applicant), _____(title), who is qualified to speak on behalf of and bind the named applicant, under the penalties of perjury, hereby states the following facts:

1. EMPLOYER INFORMATION

_____ New Applicant _____ Renewal Applicant

Applicant Name: _____

Address: _____

_____

_____

Nature of Business: _____

_____

Website Address: _____

FEIN: _____

2. SUBSIDIARY INFORMATION

Indiana Location(s) Kind of Employment # of Employees

a. _____

b. _____

SUBSIDIARIES INCLUDED UNDER SELF-INSURANCE AUTHORITY

FEIN # TITLE NAME CONTACT INFORMATION

a. _____

b. _____

3. LOSS HISTORY

Please submit relevant Loss Run Reports **electronically** on a flash drive or a disc, with the information set out on the following chart.

Under Amount Paid, please provide the total paid for each calendar year, regardless of the date of injury. Under # of Injuries, please provide the number of injuries which occurred during the calendar year indicated.

	2019		2020		2021	
	Amount Pd	# Injuries	Amount Pd	# Injuries	Amount Pd	# Injuries
Medical						
TTD						
TPD						
PTD						
PPI						
Death Benefits						
Burial Expenses						
Settlements						
First Report of Injury						
Amputation						
Prosthetic Device						
TOTAL	$		$		$	

4. BOND CALCULATION

(a) Determine three-year average of total medical/compensation paid per "Loss History"

2019 Total Paid $_____
2020 Total Paid + $_____
2021 Total Paid + $_____
Three-Year Total Paid $_____ divided by 3 = $_____
3yr average

(b) Multiply 3 year average by 2 $_____

(c) Enter greater of $500,000 or line (b) $_____

(d) Increase/decrease in line (b) from prior year $_____
(Additional security required)

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5. SECURITY

a. SURETY BOND
Amount of Bond $ _____ ($500,000.00 Minimum) Cost of Bond $ _____ (Annual Premium) **(Required)**
Surety Name: _____
Bond # _____ (Application cannot be processed if blank)
Please provide a copy of the Bond herewith.

and/or LETTER OF CREDIT – please attach a copy

Amount of LOC $_____ Name of Financial Institution _____
Routing Number _____ Identification # of LOC _____

c. EXCESS COVERAGE:

Specific $_____ Self-Insured Retention $ _____
Aggregate $_____ Cost of Excess $_____(Required)
(Annual Premium)

d. Does the employer have a system to establish a reserve to pay claims for medical treatment or compensation? _____

e. List other states, if any, in which the employer is self-insured

_____

6. SELF-INSURANCE ADMINISTRATION

It is the obligation of the employer to timely advise the Board of any changes in the information provided below which occur during the self-insured period. Please note that the Board now sends all notices related to Self-Insurance via email and would prefer email notices from employers as well.

(a) Identify the person within the employer's organization who is primarily responsible for the self-insurance program. This person will receive all notices as it relates to the self-insurance program, please list an alternative if you would like two individuals to receive notices:

Name: _____

E-Mail: _____

Address: _____

Telephone: _____

(b) Identify the person(s) who is primarily responsible for the adjustment of Indiana employee claims made pursuant of the self-insurance program (within your company or at your third-party administrator):

Name: _____

E-Mail: _____

Address: _____

Telephone: _____

Number of years of experience in the adjustment of worker's compensation and occupational disease claims in Indiana: _____

Describe educational training in Indiana Worker's Compensation Law:
_____
_____

Has this individual attended at least one seminar on Indiana Worker's Compensation over the past year? _____

This is mandatory. Provide course _____, _____, _____
Name Location Date

(c) Identify the person who is primarily responsible to receive hearing notices and other official communications from the Worker's Compensation Board regarding Indiana disputed claims:

Name: _____

E-Mail: _____

Address: _____

Telephone: _____

(d) All companies who carry risk without insurance must file first reports of injury electronically according to standards prescribed by the Board. Please indicate whether the applicant is able to comply with this mandate.
_____ Yes _____ No _____ A copy of the approved plan is attached.

7. ATTACHMENTS

All applicants must attach the following items to this application:

_____ (a) An audited financial statement signed by an officer of the employer. A copy of the employer's last annual report to its stockholders may be accepted in lieu of a financial statement, if prepared within the last six (6) months. This information shall be treated as confidential by the Board and used only in evaluating this application. It will not be provided to any other entity.

_____ (b) Loss runs from the prior 3 years to verify the information provided in the Loss History and Bond Calculation sections of the application. Detailed loss information is included, specifically claimants name and total payment amounts. **Please submit electronically or on a disc/flash drive.**

_____ (c) Additional information concerning the knowledge of the Act, education and claims experience of the person responsible for receiving notices from injured employees, and the amount of time this person devotes to the workers compensation process (if self-administered).

_____ (d) Please provide information regarding training that those individuals responsible for the administration of self-insurance, have received in the past year regarding Indiana worker's compensation administration, laws, regulations, or other.

_____ (e) Copy of bond, LOC or other form of security approved by the Board.

Additionally, new applicants must attach the following information:

_____ (f) Premium payments made the last three years and to which carrier(s).

_____ (g) NCCI experience modification for the last three years.

_____ (h) Audited financial statements, as described above, for the past three years.

_____ (i) Administrative costs anticipated in association with self-insuring, particularly if the applicant intends to utilize a third-party administrator.

8. CONDITIONS

The applicant hereby expressly understands and agrees as follows:

a. This privilege may be revoked at any time at the discretion of the Worker's Compensation Board of Indiana ("Board").

b. Applicant shall fully discharge, by immediately negotiable instrument or approved debit card, payment of all installments of compensation for disability or impairment promptly when due, as well as liability for physician's fees, hospital services, hospital supplies, and/or burial.

c. If the Board so requires, following a determination of Permanent Total Disability by agreement or award, the applicant shall demonstrate within thirty (30) days after this determination continuing liability to pay compensation to an injured employee for a definite period for a permanent injury (or to the dependents of a deceased employee) by making a special deposit, with a bank or trust company within the State of Indiana approved by the Board, in an amount set by the Board. Such special deposit to be made upon such terms as are prescribed by the Board.

d. Applicant shall promptly notify the Board of any change in condition which could ultimately affect its ability to pay medical expenses or compensation or administer its self-insurance program.

e. Applicant shall discharge all amounts due for statutory assessments under the Acts.

f. Applicant shall furnish and file with the Board any security agreement, surety bond, indemnity agreement, Letter of Credit, and/or excess insurance coverage, which may be required as a condition for approval of this application. Applicant acknowledges this security, whether in bond or LOC form, shall not be considered an asset of Applicant’s estate for bankruptcy purposes and agrees to assist the Board, if necessary, in obtaining the funds necessary to pay Applicant’s worker’s compensation obligations should Applicant be financially unable to otherwise satisfy those obligations.

g. Applicant, upon approval by the Board, recognizes, understands and agrees that in all cases the total assets of the applicant and its subsidiaries, if any, are pledged and available for the payment of any valid compensation or occupational disease claims made pursuant to Indiana law.

h. Applicant understands that if its surety bond is canceled and no replacement bond is simultaneously filed with the Board, its self-insured status shall terminate upon the effective date of the bond cancellation without further notice from the Board and Applicant shall immediately purchase a Worker’s Compensation insurance policy.

i. Applicant understands and agrees that the surety posted will not be released until all possibility of additional losses has terminated and the Worker’s Compensation Board has approved the bond’s release, but in no event will the bond’s release be granted prior to three years from the last date of self-insurance.

j. Applicant understands and agrees that the surety bond posted will not be reduced until a minimum of two years from the last date of self-insurance and that the decision to reduce the bond is in the sole discretion of the Board and will be based upon currently active claims and claims that have been closed within the two years prior to the date of the request for reduction of the bond.

The statements made herein are true and accurate to the best information and knowledge of the undersigned and are made for the express purpose of inducing the Worker's Compensation Board of Indiana to grant the Applicant self-insured status as allowed by IC 22-3-5-1.

This application is executed at_____ this _____day of

_____,_____.

_____
(Company Name)

BY: _____
(Signature)

TITLE: _____ **EMAIL:** _____
(Must be an Officer of Applicant)

FOR BOARD USE ONLY:

_____ APPROVED _____ DENIED

DATED: _____

WORKERS COMPENSATION BOARD OF INDIANA

_____
BY: Linda Peterson Hamilton, Chairman

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