

Self-Insurer Applicant:

Application for workers' disability compensation self-insured authority is made on Form WC-402. Questions 1 through 10 must be completed. Requests for attached information as stated in questions 11 through 14 (on the back of the application) must be submitted with the application. Completed applications should be mailed to: Michigan Department of Labor and Economic Opportunity, Workers' Disability Compensation Agency, Self-Insured Programs, P. O. Box 30016, Lansing, Michigan 48909. If you are using a courier service that requires a street address instead of a post office box number, please mail to: Michigan Department of Labor and Economic Opportunity, Workers' Disability Compensation Agency, Self-Insured Programs, 2501 Woodlake Circle, Okemos, MI 48864. Failure to complete, sign and notarize the application, or applications received without requested attachments, will result in the application being returned.

Under normal circumstances, our review and decision process will take about 30 days from the date a completed application is received with all requested attachments.

An applicant must demonstrate a reasonable financial position that will ensure all liabilities incurred under the Michigan Workers' Disability Compensation Act will be satisfied as prescribed in the Act. The applicant must have been "in business" five years. Multiple entities under one authority must be combinable pursuant to administrative rule 408.43.

Generally, specific and aggregate excess insurance is required. Applicants, except governmental entities, will be required to post a bond or letter of credit. The minimum amount is \$100,000. If the employer elects a letter of credit and it is subsequently not renewed or the proceeds from a draw are needed to pay any Michigan workers' disability compensation liability that is the employer's responsibility, the Agency will deposit all letter of credit proceeds with the State Treasurer and establish a trust. Upon termination of the trust, all remaining proceeds of a letter of credit plus any interest will be deposited in the Self-Insurers' Security Fund. In the event claims are filed against the employer with dates of injury within the self-insured period after termination of the trust, the Self-Insurers' Security Fund shall reopen the trust with funds not to exceed the letter of credit proceeds received from the trust upon termination.

If the applicant requests combinable entities to be included under one self-insured authority, corporate guaranties for the compensation liability will be required. An approved service company for claims handling will be required unless the applicant can demonstrate it has competent staff and reporting capabilities to administer claims in-house.

If the application is approved, it is approved contingent upon obtaining the requirements contained in the approval letter. The program must be initiated within 30 days from the date of the contingent approval letter or the approval expires. All requirements must be furnished before an effective date will be granted.

Self-insured authority is evaluated annually. There is no substitute for a demonstration of reasonable solvency and ability to pay claims as required in the Act. A renewal application, WC-402R, must be filed 30 days prior to the renewal date.

Copies of documents required to be filed by approved applicants are attached. If we can be of assistance in the completion of forms or answer any questions about the approval process, please contact our office at 517-284-8939.

Attachments

**WORKERS' DISABILITY COMPENSATION
SELF-INSURER APPLICATION**

Michigan Department of Labor and Economic Opportunity
 Workers' Disability Compensation Agency
 Self-Insured Programs
 PO Box 30016
 Lansing, MI 48909

AGENCY USE ONLY
APPROVED _____
DENIED _____
DATE _____
DIRECTOR, WDCA _____
LOGGED _____

Authority: Workers' Disability Compensation Act of 1969, as amended
 Completion: Mandatory
 Penalty: Denial

LEO is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.

- Employer (legal name) _____
- Employer's address _____
Street

City State Zip
- Employer's legal structure _____ Corporation _____ Partnership _____ LTD Liability Co.
 _____ Governmental Entity _____ Other
- Employer's federal identification number _____
- Employer's business was chartered under the laws of the state of _____ on _____
State Date
- Employer has _____ total employees. Number of Michigan employees _____
Number
- Employer representative responsible for the self-insured program
 Name _____
 Title _____
 Mailing Address _____
Street

City State Zip
 Telephone (_____) _____ Fax (_____) _____
- Designated service company _____
- Requested effective date for program, if approved _____
- Loss history (Michigan only)

Liability Period From	To	Total Michigan Payroll	Total Incurred	Paid	Reserve

Losses evaluated at _____

11. Attach a list of all subsidiaries/affiliates you are requesting to be self-insurers under the applicant's approval. The name, address, FEIN, number of employees and relationship to the applicant pursuant to R408.43(3) must be furnished for each employer to be self-insured in this program. If the applicant and other employers operate at more than one location, all addresses must be furnished.
12. Attach a current compensation loss summary, by year, that supports at least the three previous years' loss experience as reported in number 10 on the front of this form. Loss summaries must clearly show paid, reserves and total incurred by year.
13. Attach the quote for excess insurance you propose to purchase.
14. Attach applicant's most recent annual financial statements. If statements are more than six months old, include an interim statement, if available. A five-year summary showing sales, operating income, net income, working capital and equity is required if it is not included in the current financial statements.
15. Applicant may attach any information in addition to the above requested documents that explains or supports the financial position demonstrated, the ability to pay claims as a self-insurer, the loss experience, or the relationship of the applicants.
16. Applicant must contract with an agency-approved service company or provide documentation that demonstrates it has within its own organization ample facilities and competent personnel to service its own program with respect to claims administration.

All employers granted self-insured authority as a result of this application hereby agree:

- (a) To pay all benefits incurred as a self-insurer to employees or their dependents in accordance with the Michigan Workers' Disability Compensation Act of 1969, as amended.
- (b) In case of insolvency, as defined in 418.502, the undersigned employer/applicant agrees to make all personnel, wage and hour, medical records and employment contract records available to an agent of the Michigan Self-Insurers' Security Fund. A copy of this provision will be provided to the person in charge of the above records and counsel for applicant/employer for future reference and implementation.
- (c) In the event of a sale of all assets and cessation of all operations, self-insurer authority will be surrendered coinciding with such action. If operations of the self-insured are continued by a successor employer who hires any or all of the self-insurer's employees, the sale agreement will include a provision that gives access to personnel, wage and hour, medical records and employment contract records to the SISF if and when the SISF becomes liable for payment of benefits of the self-insured employer.
- (d) To promptly notify the Workers' Disability Compensation Agency of any unfavorable change in financial position that may impair the self-insurer's ability to meet all obligations incurred as a self-insurer under the Michigan Workers' Disability Compensation Act of 1969, as amended.
- (e) That this approval is granted to the applicant and combinable entities identified in this application and further acknowledge changes in the legal status (merger, spin-off, consolidation, sale, etc.) of any approved entity may terminate the self-insured authority effective on the date of change in status.

I affirm all information submitted as being true.

NOTARY SIGNATURE: _____

BY: _____
Type Name of Person Signing

COUNTY OF: _____

TITLE: _____
Title of Person Signing

MY COMMISSION EXPIRES: _____

SIGNATURE: _____

DATE: _____

AFFIX STAMP:

**MICHIGAN CERTIFICATE OF
SPECIFIC/AGGREGATE EXCESS LIABILITY INSURANCE**

TO: Michigan Department of Labor and Economic Opportunity
Workers' Disability Compensation Agency
Self-Insured Programs
P.O. Box 30016
Lansing, Michigan 48909

This certifies that a workers' compensation excess liability insurance policy has been issued to the employers named below and the filing of this certificate is confirmation that the excess liability insurance policy identified below is effective on the date stated, that the policy form is approved for use in Michigan by the Insurance Commissioner and complies with all requirements in the Michigan Workers' Disability Compensation Act of 1969 and Administrative Rule 408.43k. Cancellation or intent to not renew the policy by the insurer or insured must be by courier, certified, or registered mail and sent to the Workers' Disability Compensation Agency not less than 60 days prior to the cancellation or nonrenewal.

Name of Insured Employers _____
(List all self-insured employers, attach additional page if necessary)

Name of Insurer _____

Address _____

Policy Number _____ Effective Date _____

TERMS OF COVERAGE

Specific
Policy Limit \$ _____
Retention \$ _____
Policy Term _____
(Years)

Aggregate
Policy Limit \$ _____
Retention Percentage _____
Minimum Retention \$ _____
Estimated Retention \$ _____
Policy Term _____
(Years)

(Insurer)

(Authorized Signature)

MICHIGAN CONTINUOUS SURETY BOND

Bond No. _____

We, _____,
List all Self-Insured Employers as Principals

of _____,

as principal, and _____,

of _____,

a corporation duly incorporated under the laws of the state of _____ and authorized to do business in Michigan, as surety, establish this surety bond in the sum of \$ _____ for payment to the Michigan Department of Labor and Economic Opportunity, Workers' Disability Compensation Agency (Agency).

The Agency grants the principal the privilege of self-insuring its workers' compensation liabilities under the Michigan Workers' Disability Compensation Act (Act), MCL 418.611, effective 12:01 a.m., _____, 20____, by the Department.

As a self-insured employer, the principal shall pay its employees all workers' compensation benefits that are due, or which may become due, under the Act, MCL 418.101 *et seq*, as a result of a work-related disease, injury or death, with a personal injury date that occurs while it is self-insured.

If the principal, its heirs, executors, administrators (or its successors and assigns in case of a corporation), discharges and pays all workers' compensation benefits with a personal injury date that occurs during the effective period of this bond, then, this bond shall be void. Otherwise this surety bond shall remain in full force and effect. Notwithstanding the number of claimants or the length of time this bond is in effect, there shall be only one surety bond amount and the aggregate liability of the surety shall not exceed the surety bond amount shown above.

This bond may be cancelled at any time by the surety upon giving 60 days notice to the principal and the Agency. The liability of the surety shall terminate at the expiration of the 60 days except that the surety shall be liable for workers' compensation benefits with a personal injury date that occurs during the effective period of this surety bond, and before the 60 day expiration date.

This surety bond shall be effective _____, 20 _____, until canceled.

Surety

Witness: _____

Print Name: _____

Title: _____

(Print name and address of Surety)

Signature: _____

Print Name: _____

Title: _____

Principal

Witness: _____

Print Name: _____

Title: _____

(Print name and address of Principal)

Signature: _____

Print Name: _____

Title: _____

Date: _____

AFFIDAVIT AND ACKNOWLEDGMENT OF SURETY

STATE OF _____)

COUNTY OF _____)

As a Notary Public, I certify that _____,
acting on behalf of the surety, personally appeared before me and that he or she is _____
of the _____ and that he or she is authorized to execute this surety bond pursuant to a power of
attorney of the company that is dated _____, a copy of which is attached; that the power of
attorney has not been revoked; that the company has complied with all the requirements of law
regulating the admission of such companies to transact business in the State of Michigan; and that
the company is solvent and fully able to meet promptly all of its surety obligations.

Subscribed and sworn to before me
this _____ day of _____, 20____

(Notary Public)

_____ County, Michigan

My commission expires _____.

ACKNOWLEDGMENT OF PRINCIPAL

STATE OF MICHIGAN)

COUNTY OF _____)

Subscribed and sworn to before me
this _____ day of _____, 20____

(Notary Public)

_____ County, Michigan

My commission expires _____.

WORKERS' DISABILITY COMPENSATION SELF-INSURER LETTER OF CREDIT INFORMATION

Pursuant to the Michigan Workers' Disability Compensation Act, Sec. 418.611 (1) (a), the director may require and accept a Letter of Credit as one condition for granting self-insured authority.

1. **Letter of Credit Required Language**

Specific language is required and any deviations will not be accepted. See attached sample.

2. **Acceptable Banks**

Irrevocable letters of credit shall be issued by a state-chartered bank, a federally chartered bank or foreign bank. Funds shall be immediately payable on demand. The director may require confirmation of acceptable letters of credit from any state, federally or foreign chartered bank without state operations or branch services within this state. If a confirmation is required, it shall be by a State of Michigan chartered bank or federally chartered bank with Michigan branch operations and state that the confirmation bank is primarily obligated on the letter of credit.

3. **Memorandum of Understanding**

The employer must furnish a Memorandum of Understanding with the Letter of Credit on a form provided by the Workers' Disability Compensation Agency (Agency). See attached form.

In summary, the Memorandum of Understanding confirms the following:

- a. The Letter of Credit is in lieu of a surety bond and is a requirement to obtaining self-insured authority.
- b. The Letter of Credit is automatically extended every year.
- c. A policy of insurance or a surety bond of equal amount may be substituted for a Letter of Credit subject to prior approval by the Agency.
- d. The employer affirms that the Letter of Credit can be called if in the judgment of the Agency it is needed to cover any workers' disability claims or if the Agency receives notice of termination of the Letter of Credit. If drawn, all monies from the Letter of Credit shall be paid and used in accordance with paragraph 4, number 5 of the Memorandum of Understanding, which is attached.
- e. Legal proceedings shall be subject to Michigan courts and law.

Review the Memorandum of Understanding and Rule R408.43q for complete terms and conditions.

The Letter of Credit together with the Memorandum of Understanding must be furnished to and accepted by the Agency before an effective date will be granted for self-insured authority.

MAIL COMPLETED DOCUMENTS TO:

Department of Labor and Economic Opportunity
Workers' Disability Compensation Agency
Self-Insured Programs
2501 Woodlake Circle
Okemos, MI 48864

If you have any questions, please contact us at (517) 284-8939

Required Language:

For Reference Only
Entity

IRREVOCABLE LETTER OF CREDIT No. _____

Department of Labor and Economic Opportunity
Workers' Disability Compensation Agency
Self-Insured Programs
2501 Woodlake Circle
Okemos, MI 48864

Dear Madam or Sir:

We have established this Irrevocable Letter of Credit solely in your favor for drawing up to U.S. \$ _____ (_____) effective immediately and expiring at (bank address) with our close of business on _____.

We hereby undertake to promptly honor your sight draft(s) drawn on us, indicating our Letter of Credit No. _____, for all or any part of this Letter of Credit if presented at (bank address) on or before the expiry date or any automatically extended date.

Except as stated herein, this undertaking is not subject to any condition or qualification. The obligation of the Bank under this Letter of Credit shall be the individual obligation of the Bank, in no way contingent upon reimbursement with respect thereto.

It is a condition of this Letter of Credit that it shall be deemed automatically extended without amendment for one year from the expiry date hereof, or any future expiry date, unless at least sixty (60) days prior to any expiry date we shall notify you by Registered Mail or Overnight Mail Service that we elect not to consider this Letter of Credit renewed for any such additional period.

It is a further condition of this Letter of Credit that any interruptions of the Bank's conduct of business, on the date of expiration, caused by an Act of God, riot, civil commotion, insurrection, war or other cause beyond the Bank's control, or by any strike or lockout, will automatically extend the expiry date hereof, as well as future expiry dates, by a period of 30 days after the resumption of business for you to draw against this Letter of Credit.

Should you have occasion to communicate with us regarding this Letter of Credit, kindly direct your communication to the attention of our Letter of Credit Department, making specific reference to our Letter of Credit No. _____.

This Letter of Credit is subject to and governed by the International Chamber of Commerce Publication No. 590 ("ISP 98") to the extent not inconsistent with Michigan Law. If any legal proceedings are initiated with respect to payment of this Letter of Credit it is agreed that such proceedings shall be subject to Michigan courts and law.

Sincerely,

MEMORANDUM OF UNDERSTANDING

This is a Memorandum of Understanding between _____ (Employer) and the Workers' Disability Compensation Agency (Agency). As used in the Memorandum of Understanding, "Employer" means _____ and all its subsidiaries and affiliated entities that have been approved as self-insurers and any new entities approved as self-insurers as a result of future amendments to the application.

Employer has applied for the privilege of self-insuring its obligations under the Workers' Disability Compensation Act; and

The Agency has approved that application contingent upon Employer posting security in the initial amount of \$_____, with said amount subject to change as directed by the Agency; and

Employer wishes to meet this security requirement by posting a Letter of Credit issued by a Michigan state chartered bank, federally chartered bank, or a foreign bank. If a confirmation is required, it shall be by a State of Michigan chartered bank or a federally chartered bank with Michigan branch operations.

Pursuant to administrative rule 408.43q, the Employer agrees:

1. The Letter of Credit is being furnished to the Agency in order to meet the condition established by the agency for approval of self-insured status.
2. Unless the Agency is notified otherwise by registered mail, at least 60 days before the expiration date, the Letter of Credit will be automatically extended without amendment for an additional one year period.
3. If the Agency is notified that the Letter of Credit will not be renewed the Agency may, at its discretion and after 30 days from the date of receipt of the nonrenewal notice, draw on the Letter of Credit.
4. The Agency may, at its discretion, draw on the Letter of Credit at any time if needed to pay any Michigan workers' disability compensation liability which is the Employer's responsibility.
5. All proceeds resulting from the Agency drawing on the Letter of Credit shall be deposited with the State Treasurer and a trust shall be established to pay the obligations of the Employer under the Michigan Workers' Disability Compensation Act. The Director of the Agency shall be the grantor of the trust. In the event that monies remain in the trust after all current claims have been paid the remaining funds will be paid to the Self Insurers' Security Fund.
6. The Letter of Credit and this Memorandum of Understanding shall be governed and interpreted under the laws of Michigan. Any legal action with respect to the Letter of Credit shall be subject to Michigan courts and law.

EMPLOYER

BY: _____
Type Name of Officer

SIGNATURE: _____

TITLE: _____
Type Title of Officer Signing

DATE: _____

WORKERS' DISABILITY COMPENSATION AGENCY

R408.43q - EFFECTIVE MARCH 1, 2007

R 408.43q Irrevocable letter of credit; acceptance; requirements; payment of surety bond or letter of credit.

Rule 13q. (1) An irrevocable letter of credit may be accepted by the bureau as other security for a Self-insured program as provided by section 611(1)(a) of the act. The bureau will retain discretion in each particular case to determine if the letter of credit is acceptable and if its language and format are satisfactory.

(2) Irrevocable letters of credit shall be issued by a state-chartered bank, a federally chartered bank or foreign bank. Funds shall be immediately payable on demand. The director may require confirmation of acceptable letters of credit from any state, federally or foreign chartered bank without state operations or branch services within this state. If a confirmation is required, it shall be by a State of Michigan chartered bank or federally chartered bank with Michigan branch operations and state that the confirming bank is primarily obligated on the letter of credit.

(3) An employer who elects an irrevocable letter of credit as other security for a self-insured program shall furnish a memorandum of understanding with the letter of credit, on a form provided by the bureau, which affirms the employer's acceptance of all of the following requirements:

(a) A letter of credit is furnished to the bureau instead of a surety bond as one of the requirements for approval of a self-insured program.

(b) The employer understands that the letter of credit shall be deemed automatically extended without amendment for 1 year from the expiry date or any future expiry date unless, 60 days before any expiry date, the bureau is notified, by courier, certified or registered mail, that the letter of credit shall not be renewed for any additional period.

(c) A policy of insurance or a surety bond of equal amount may be furnished at a later date as a substitute for the letter of credit if the policy of insurance or surety bond covers all claims that would have been covered by the letter of credit. All policies of insurance and surety bonds furnished as substitutes for letters of credit are subject to prior bureau approval.

(d) The employer shall affirm that the irrevocable letter of credit in the amount requested by the bureau is being offered with the understanding that if the bureau receives notice that the letter of credit will not be renewed, then the bureau, in its discretion, may, after 30 days from the date of receipt of the notice, call the proceeds of the letter of credit and deposit the proceeds in the state treasury. And further, if, in the judgment of the bureau, the letter of credit is needed to cover any worker's disability compensation claims, then the proceeds of the letter of credit shall be called immediately and deposited in the state treasury for such purpose.

(e) If legal proceedings are initiated by any party with respect to payment of any letter of credit, then the proceedings shall be subject to Michigan courts and law.

(4) The bureau shall not grant an effective date for a self-insured program until a completed letter of credit and the memorandum of understanding have been reviewed and accepted by the bureau.

(5) If it is necessary for the director, under statute and bureau rules, to call the bond or other security, then a trust shall be established with the funds, unless the provider of the bond or other security elects to handle the claims directly and the bureau approves. If a trust is established, the funds shall be deposited in the state treasury and the state treasurer, as provided by section 551(7) of the act, shall be the custodian of the trust. The trustees of the trust shall be the trustees of the funds denominated in chapter 5 of the act and also those who are appointed as trustees under section 511 of the act. The service company of the self-insured employer, if any, shall continue to perform in accordance with the terms of the employer's contract with the service company.

REQUIRED APPLICATION FOR CERTIFICATION OF A CARRIER'S PROFESSIONAL HEALTH CARE REVIEW PROGRAM

A carrier's WC-590 (Certification of a Carriers' Professional Health Care Review Program) is a form which is required to be completed by a carrier or self-insurer or their service company. The Workers' Disability Compensation Health Care Services Rules require that the Health Care Services Division of the Workers' Disability Compensation Agency certify a carrier or self-insurer's professional review program. This certification is renewable every 3 years or whenever a change in the review process occurs. The purpose of professional review is to ensure that services are related to the covered work injury and that the carrier is reimbursing for medically necessary and appropriate medical care in accordance with MCL 418.315 of the Workers' Disability Compensation Act as well as the Health Care Services (HCS) Rules. As outlined in R418.10101 of the HCS rules, carriers are to review the quality and quantity of medical services, based on accepted medical standards. This rule also allows carriers to dispute services that are not medically appropriate or related to the covered work injury.

The certification process requires that the carrier/self-insurer submit their review methodology to the Agency's Health Care Services Division every three years. **If in a three-year period there is a change in service company, review company or review process, a new WC-590 application is necessary in order to remain in compliance.** The review methodology need not be included with the application if it is already on file and current with the Health Care Services division.

If any questions when filling out the WC-590 form, please contact the Health Care Services division at 517-284-8898.

APPLICATION FOR CERTIFICATION OF A CARRIER'S PROFESSIONAL HEALTH CARE REVIEW PROGRAM

Michigan Department of Labor and Economic Opportunity
Workers' Disability Compensation Agency
Health Care Services Division
PO Box 30016, Lansing, Michigan 48909

Date of Application	Initial <input type="checkbox"/>	Renewal <input type="checkbox"/>
Note: A new application must be submitted whenever there is a change in carrier, service company, or review company.		

This form is required in accordance with Part 12, R 418.101206 of the Workers' Compensation Health Care Services Rules to receive certification of a carrier's professional review program.

I. CARRIER

Carrier	Service Company	Review Company
NAIC No., Self-Insured No., or FEIN	Agency Assigned Number	Employer Identification
Name	Name	Name
Address (Street)	Address (Street)	Address (Street)
City, State, Zip Code	City, State, Zip Code	City, State, Zip Code
Telephone No. (Include area code)	Telephone No. (Include area code)	Telephone No. (Include area code)
Contact Person and Email Address	Contact Person and Email Address	Contact Person and Email Address

II. METHODOLOGY/REVIEW STAFF AND CREDENTIALS

Attach methodology, according to the Workers' Disability Compensation Agency procedure, used to perform a carrier's professional review.

R 418.101204(5)(a)-(c) requires that medical appropriateness of services shall be determined through one of the following approaches:

- 1) Review by licensed, registered, or certified health care professionals.
- 2) The application by others of criteria developed by licensed, registered, or certified health care professionals.
- 3) A combination of (1) and (2) according to the type of covered injury or illness.

The methodology should include a list of all licensed, registered, or certified health care professionals reviewing case records and medical bills for the above carrier. Provide current licensure information (license #, state of issue, date of expiration and restrictions) and qualifications for medical bill review. In addition, include a list of all peer reviewers with current license information and specialty.

*When a service company submits applications for numerous self-insured employers, and the methodology is identical, it is not necessary to submit the professional review methodology more than once. The Workers' Disability Compensation Agency will maintain on file, the review methodology for each service company.

~~**Methodology for professional certification must be submitted once every three years or whenever changes occur.~~

III. AUTHORIZED SIGNATURE

By signing this form, I certify that the information included on this form is correct and complete to the best of my knowledge and that the professional review methodology is attached or has already been submitted by the service company and/or their designated agent. I understand that submitting false information is cause for denial of the application or will subject me to penalties as provided by law.

Authorized Signature (In Ink)	Authorized Name and Email Address (Typed)	Date
Alternate Person Name	Alternate Email Address	Alternate Telephone Number

LEO is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.	<table style="width: 100%; border: none;"> <tr> <td style="border: none;">Authority:</td> <td style="border: none;">R418.101206 (Part 12)</td> </tr> <tr> <td style="border: none;">Completion:</td> <td style="border: none;">Required</td> </tr> <tr> <td style="border: none;">Penalty:</td> <td style="border: none;">None</td> </tr> </table>	Authority:	R418.101206 (Part 12)	Completion:	Required	Penalty:	None
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