

FORM-SI-EMPLOYER

OKLAHOMA WORKERS' COMPENSATION COMMISSION

1915 NORTH STILES AVENUE
OKLAHOMA CITY, OKLAHOMA 73105
(405) 522-3222 or In-State Toll Free (855) 291-3612

APPLICATION FOR INDIVIDUAL OWN RISK EMPLOYER PERMIT

Date August 26, 2015

The undersigned, an employer subject to the provisions of the Administrative Workers' Compensation Act, hereby applies for permission to carry its own risk without insurance. To enable the Workers' Compensation Commission to determine whether or not the applicant possesses sufficient financial ability to render certain the payment of any award made by the Commission, said applicant hereby states the following:

1. Employer's Name City of Norman Own Risk # 10970
2. Employer's Federal Identification Number 73-6005350
3. Home Office Address P.O. Box 370, Norman OK 73070
4. Oklahoma principal office address N/A
5. Incorporated or organized under the laws of the State of Oklahoma
6. If foreign corporation, give date licensed to do business in Oklahoma N/A
7. Nature of business Municipal Government
8. General Information on Company:
 - a. Years engaged in continuous business 120, In Oklahoma Since 1895
 - b. Payroll in each of the preceding three (3) years:
Year: 15, \$ 71,173,376; Year: 14, \$ 69,157,539;
Year: 13, \$ 67,716,318

Payroll in Oklahoma in each of the preceding three (3) years:
Year: 15, \$ 71,173,376; Year: 14, \$ 69,157,539;
Year: 13, \$ 67,716,318
 - c. Number of employees presently employed 932
In Oklahoma 932
 - d. Estimated payroll in Oklahoma for the next twelve (12) months 73,033,462

9. Excess Insurance Information, if any at the time of this application:

- a. Name of carrier _____ Policy # _____
- b. Policy dates: Effective _____ Expiration _____
- c. Under this policy: Self Insured Retention _____ Limits of Liability _____

NOTE: The Commission may require an individual own risk employer to provide proof of excess coverage with such terms and conditions as are commensurate with the employer's ability to pay the benefits required by the Administrative Workers' Compensation Act.

10. Estimated manual premium for your company \$2,218,500 _____

11. a. In the section below, state the loss history for the past five (5) calendar years. Copy the requested information from your loss runs (if the hard copy of your loss runs are required you will be notified). **Also include the current year's history, indicating how many months of the current year are included:**

Total incurred losses in Oklahoma (include for all injuries, both open and closed claims)

CY or FY	\$ Medical Paid	\$ Indemnity Paid	\$ Total Paid	\$ Total Reserves Outstanding
2015 mo July	\$237,092	\$28,293	\$265,385	\$230,209
2014	500,719	307,154	807,873	265,405
2013	619,656	611,640	1,231,296	178,142
2012	882,512	916,390	1,798,902	88,980
2011	471,996	693,212	1,165,208	30,385
2010	980,454	1,213,669	2,194,123	53,850

CY or FY	Cases Opened	Cases Reopened	Cases Closed	Death Cases
2015 mo July	122	0	89	0
2014	115	0	110	0
2013	142	0	140	0
2012	139	0	137	0
2011	148	0	146	0
2010	209	0	208	0

- b. List of Death and Permanent Total Disability (PTD) Claims for all years of self insurance (use separate sheet if necessary): _____

- c. Total Self Insurance Reserves Outstanding: \$ 1,197,305 _____
(for all years of self insurance)

Total Self Insured Open Cases: 33 _____
(for all years of self insurance)

12. a. Enclose current audited financial report or financial statement signed by two authorized company executives, including balance sheets, income statements and notes.
- b. A governmental entity must provide a definite statement of the amount it has specifically appropriated for workers' compensation claims for the latest and the next fiscal year.

Amount appropriated for current fiscal year	<u>2,218,500</u>
Next fiscal year (if available)	<u>N/A</u>

13. a. Is the applicant a subsidiary of another employer? No If yes, submit the parent company's financial statements in accordance with Paragraph 12(a) above.

- b. Does the applicant have subsidiary companies that it wants to include under this permit? No

(Attach a list of the names and addresses of ALL entities to be included under this permit, including subdivisions.)

- c. If you answered yes to either question 13a or 13b, attach a copy of a written agreement whereby the ultimate parent employer guarantees that it will be fully responsible for any liabilities that its subsidiaries may incur under the Administrative Workers' Compensation Act.

14. a. Name, address and email address of the company's Third-Party Administrator for the servicing of the self insurance claims.

N/A

- b. If an approved Third-Party Administrator is not employed, please submit qualifications of benefits administrator.

15. In consideration of the approval of this application, the applicant hereby expressly agrees as follows:

- a. The applicant's privilege to carry its own risk without insurance may be revoked at any time for good cause by the Workers' Compensation Commission.
- b. The applicant agrees to comply with all applicable statutes and the rules of the Workers' Compensation Commission.

Include an annual, nonrefundable, application fee of \$1,000, made payable to the Oklahoma Workers' Compensation Commission.

I declare under penalty of perjury that I have examined this application and all statements contained herein, and to the best of my knowledge and belief, they are true, correct and complete.

Signed this 26 day of August, 20 15.

Cindy S. Rosenthal, Mayor

Print Name and Title (note: person signing should be authorized to bind the applicant to the agreements contained herein)

Signature

P.O. Box 370

Mailing Address

201 West Gray Street, Building C

Street Address, if different from Mailing Address

Norman OK 73069

City State Zip Code

(405) 217-7720

Telephone Number

clint.mercer@normanok.gov

E-mail Address

Administrative Workers' Compensation Act, 85A O.S., §6(A)(1)(a): "Any person or entity who makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who employs any device, scheme, or artifice, or who aids and abets any person for the purpose of: (1) obtaining any benefit or payment ... shall be guilty of a felony."

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony punishable by imprisonment, a fine or both.

Send application to:

Insurance Division
Oklahoma Workers' Compensation Commission
1915 North Stiles Avenue
Oklahoma City, OK 73105-4918

CC-FORM-7

Send original to:
Workers' Compensation Commission

WORKERS' COMPENSATION COMMISSION
1915 NORTH STILES AVENUE
OKLAHOMA CITY, OK 73105

This space for Commission Use only

DESIGNATION OF SERVICE AGENT

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony punishable by imprisonment, a fine or both.

Consistent with Workers' Compensation Commission Rule 810:10-1-11, once a claim for compensation (CC-Form-3, CC-Form-3A or CC-Form-3B) is filed, the Commission shall send all notices and correspondence to the designated agent of the insurance carrier, individual own risk employer or group self-insurance association, until an entry of appearance is filed as provided by Commission Rule 810:10-1-10. When the claimant files a claim for compensation (CC-Form-3, CC-Form-3A or CC-Form-3B), the Commission shall email a file-stamped copy of the claim form bearing the assigned file number to a single service agent of the self-insured employer, group self-insurance association, insurance carrier or CompSource Oklahoma which shall be designated on a CC-Form-7 and filed with the Commission. The Commission shall send all notices and correspondence to the service agent until an entry of appearance or notice of substitution of attorney is filed pursuant to Rule 810:10-1-11. If no service agent is designated on the CC-Form-7, notices and correspondence shall be sent to the:

1. Signatory on the self-insurance application, if the insurer is an individual own risk employer;
2. Administrator of the group self-insurance association, if the insurer is a group self-insurance association;
3. Person designated to receive notice of service of process for an insurer as provided in 36 O.S., § 621, if the insurer is a foreign or alien insurance carrier; or
4. Service agent on file with the Oklahoma Secretary of State, if the insurer is a domestic insurance carrier.

If the employer is uninsured or the Commission cannot determine insurance coverage, notices and correspondence shall be sent to the employer at the address supplied by the claimant on the claim for compensation form. If the notice is returned to the Commission because the claimant supplied the wrong address for the employer, the Commission shall so inform the claimant. The claimant has the obligation of providing the Commission with the proper address so notices and correspondence can be sent to the employer.

The following information is required and must be amended whenever a change of service agent is made.

Please check (☒) the appropriate box below

Name of:	<input type="checkbox"/> Carrier	<input checked="" type="checkbox"/> Individual Own Risk Employer	<input type="checkbox"/> Group Self-Insurance Association	<input type="checkbox"/> Qualified Employer
City of Norman		Norman	OK	73070-0370
Home office mailing address:		City	State	Zip
P.O. Box 370			(405) 217-7720	
Street Address, if different from mailing address:			Phone Number	

Designated Service Agent

Name of Individual or Business:

City of Norman

Name of contact person, if the service agent is a business:

E-mail:

Jeff Bryant, City Attorney

jeff.bryant@normanok.gov

Mailing address:

City

State

Zip

P.O. Box 370

Norman

OK

73070-0370

Street Address, if different from mailing address:

Phone Number

201 West Gray Street, Building C

(405) 217-7720

Signed this 26 day of August, 2015

Signature

I HEREBY CERTIFY THAT THIS DOCUMENT WAS MAILED TO
THE WORKERS' COMPENSATION COMMISSION ON:

Prepared by Clint Mercer, CPA

August 26

2015

Title Chief Accountant



The City of **NORMAN**

201 West Gray, Bldg. C • P.O. Box 370
Norman, Oklahoma 73069 • 73070

OFFICE OF THE FINANCE DIRECTOR
Phone 405-366-5413
FAX: 405-366-5417

August 26, 2015

Andrea Bair
Worker's Compensation Commission
Insurance Services Division
1915 North Stiles
Oklahoma City, OK 73105

Dear Ms. Bair:

Please see the enclosed own risk application for the City of Norman ("City"). The City has budgeted \$2,218,500 for Worker's Compensation for fiscal year ending June 30, 2016. Below is a breakdown of some of these accounts:

Worker's Compensation Claim Settlements	\$510,000
Worker's Compensation Medical Costs	1,159,000
Worker's Compensation Weekly Payments	400,000
Administrative Fees for W/C	141,500
Worker's Compensation Patient Mileage	8,000

Please find the Comprehensive Annual Financial Report (CAFR) for the fiscal year ended June 30, 2014 and the application check for \$1,000 as requested. The CAFR report represents our most current audited financial statements. The CAFR for fiscal year ended June 30, 2015 will not be available until December 31, 2015. Please find our June 30, 2015 preliminary general ledger account information. These figures are preliminary and will change during the audit due to adjustments.

Workers' compensation claims are funded via appropriations as noted above. Awarded settlements are placed on the Cleveland County property tax rolls and collected over three years.

The City's Medicare Reporting contact is Mr. Charles Coyne.

If you have any further questions, please contact me at (405) 217-7720. My e-mail address is clint.mercer@normanok.gov.

Sincerely,

Clint Mercer, CPA
Chief Accountant

Encl:



The City of **NORMAN**

201 West Gray, Bldg. C • P.O. Box 370
Norman, Oklahoma 73069 • 73070

OFFICE OF THE FINANCE DIRECTOR
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August 26, 2015

Andrea Bair
Worker's Compensation Commission
Insurance Services Division
1915 North Stiles
Oklahoma City, OK 73105

RE: Workplace Safety Plan

Dear Ms. Bair:

Pursuant to your request, the City of Norman's Workplace Safety Plan is as follows:

1. Monthly Safety Meetings

We conduct monthly safety meetings at each division. The meetings take place within each division's break room and cover topics such as the following:

Lock-Out-Tag Out	Personal Protective Equipment
Safe Driving Procedures	Heat Stress Safety
Blood Borne Pathogen Safety	Safe Lifting Procedures
Electrical Safety	Slips, Trips & Falls
Fire Extinguisher Safety	Hazard Communication (SDS – Right to Know)
Tornado Safety	

2. Orientation Safety Training

Orientation Safety Training consists of training on preventing injuries and vehicular accidents. All new employees go through this training before reporting to their Departments for work. Subjects include:

Back Injury Prevention	OJI Reporting
NFPA Rating Diagram	Driving Safety
Personal Protective Equipment	Preventing Slips, Trips & Falls
Blood Borne Pathogen Safety	Hazard Communication (SDS – Right to Know)
General Office Safety	

Vehicle collisions are classified by the Safety Manager as either chargeable (our fault) or non-chargeable. The driver may challenge this finding, and request an Accident Review Committee be convened. At this meeting the driver states his case to his Department Head, and the Department Head determines whether it is chargeable or not.

Currently the City has two Safety Committees who meet regularly. One is a committee comprised of solely Division Heads who meet monthly to "ensure safe work practices, so that we can prevent accidents, injuries and property damage; in order to save money needlessly spend on repairing our

people, vehicles and property." The other committee meets quarterly and is comprised from the safety coordinators from each Division. Supervisors, workers, union representatives and other key management personnel participate in the committee. The City also maintains a comprehensive safety manual.

The City has an Employee Assistance Program, which helps employees overcome personal conflicts, drug, or alcohol abuse. The City's Police Department conducts high-speed pursuit driver's training at the Lloyd Noble parking lot as well as the Burns Flat Course on an annual basis. The following is the sequence in which worker's compensation claims originate and are processed:

1. Receive phone call of injury
2. Authorize treatment at the appropriate medical facility (i.e., Norman Regional Hospital for serious injuries or Norman Regional Occupational Health Medicine and Concentra, for routine injuries).
3. Receive a written on-the-job (OJI) report of circumstances from supervisor.
4. Generate Form 2 and send to the Worker's Compensation Commission.
5. Open and maintain a file for the injury.
6. Log all medical expenses within Micro Niche database software.
7. Request purchase orders for expenses using purchase requisitions.
8. Transition of the entire file is handed off to the City Attorney's Office once the OJI becomes a Worker's Compensation claim.

The primary City staff responsible for worker's compensation cases is Jeanne Snider, Assistant City Attorney. The primary safety staff member responsible for the safety plan is Gala Hicks. I am responsible for the OJI duties of the City.

If you have any further questions, please contact me at (405) 217-7720.

Sincerely,

A handwritten signature in black ink, appearing to read 'Clint Mercer', with a long horizontal line extending to the right.

Clint Mercer, CPA
Chief Accountant