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

APPLICATION FOR INDIVIDUAL OWN RISK EMPLOYER PERMIT

Date September 25, 2018

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 Legal Business Name City of Norman
2. If the Employer does business, or has done business under another name in Oklahoma , including any trade name, list those other names _____
3. Own Risk # (if a renewal applicant) 10970
4. Employer's Federal Identification Number (FEIN) 73-6005350
5. Home Office Mailing Address P.O. Box 370, Norman OK 73070
   (Please include City, State, Zip)
6. Home Office Physical Address (if different) 201-C West Gray Street, Norman OK 73069
   (Please include City, State, Zip)
7. Oklahoma Principal Office Address (if different) N/A
   (Please include City, State, Zip)
8. If the Employer is an out-of-state company, give year licensed to do business in Oklahoma N/A
9. Nature of business Municipal Government
10. Name of the Employer's Medicare Reporting contact *(If managed through a third party vendor, list company's name and contact)* Tom Szold
11. Primary contact for Employer *(Whom we should contact for additional information about this application)*

Clint Mercer — Chief Accountant

Name — Title

clint.mercer@normanok.gov (405) 217-7720

Email address Telephone Number

12. Secondary contact for Employer *(Whom we should contact if the primary contact is not available)*

Jeff Bryant City Attorney

Name Title

jeff.bryant@normanok.gov (405) 366-5428

Email address Telephone Number

13. General Company Information:

a. Years engaged in continuous business 123 In Oklahoma Since 1895

b. Number of employees presently employed 1,030 In Oklahoma 1,030

c. Estimated payroll in Oklahoma for the next twelve (12) months 77,590,235

d. Payroll in each of the preceding three (3) years:

	Overall	In Oklahoma
Year: 18	$77,590,235	$77,590,235
Year: 17	$78,011,297	$78,011,297
Year: 16	$73,763,930	$73,763,930

14. a. Is the Employer applying for an Oklahoma Own Risk License owned by another employer or parent company? (Check appropriate answer) ☐ Yes ☑ No
If yes, list owner name: _____

b. Does the Employer want to cover other employers/companies under the permit? (Check appropriate answer) ☐
Yes ☐ No ☑
If yes, list other employers/companies; _____
Attach a list of other employers/companies, with the employer/company FEIN, address, and covered locations.

c. Does the Employer own other employers/companies that it does not want to cover under the permit? (Check appropriate answer) ☐ Yes ☑ No
If yes, list other employers/companies; _____
Attach a list of other employers/companies, with the employer/company FEIN, address, and covered locations.

15. a. Does the Employer use a Third-party Administrator (TPA) or an In-house Benefit Administrator to service self insurance claims? (Check appropriate answer) ☐ TPA ☑ In-house Benefit Administrator

b. If the Employer uses a TPA, provide the name and address (including City, State, and Zip) of the TPA, contact name, contact phone number, and contact email address: _____

c. If the Employer uses an In-house Benefit Administrator, provide the name and Oklahoma adjuster's license number: Jeanne Snider, JD

16. In the section below, state the loss history for the past five (5) years. Copy the requested information from your loss runs. **Also include the current year's history, indicating how many months of the current year are included.**
Note: An actuarial report may be requested by the Commission.

a. Total incurred losses in Oklahoma (include for all injuries, both open and closed claims):
(Please report by date of injury, not date reported or date paid)

Calendar Yr or Fiscal Yr Ending	Medical $ Paid	Indemnity $ Paid	Total $ Paid (including any expenses)	$ Total Reserves Outstanding
2017 1 # mos.	278,403	34,041	312,444	272,982
2016	298,683	133,889	432,572	99,592
2015	405,733	119,145	524,878	207,252
2014	399,247	185,700	584,947	47,966
2013	533,843	593,329	1,127,172	22,453
2012	635,220	774,726	1,409,946	0

Calendar Yr or Fiscal Yr Ending	# of Cases Opened	# of Cases Reopened	# of Cases Closed	# of Cases Currently Open
2017 1 # mos.	115	0	103	12
2016	113	0	106	7
2015	98	0	88	10
2014	110	0	107	3
2013	115	0	113	2
2012	142	0	142	0

b. Total Self Insurance Net Reserves Outstanding for All Years of Self Insurance: 697,637
(Net Reserves Outstanding = Current Reserves Minus Any Expected Excess Carrier Reimbursements)

c. Total Self Insured Open Cases for All Years of Self Insurance: 37

d. Estimated manual premium: 2,218,500
(This information may be available from the Employer's excess insurance carrier, agent or broker)

17. Excess Insurance Information:

a. Name of Carrier _____ Policy # _____

b. Policy dates: Effective _____ Expiration _____

c. Self Insured Retention _____

d. Does the Employer carry Aggregate Excess Insurance? (Check appropriate answer) ☐ Yes ☑ No

If yes: Aggregate Retention _____ Aggregate Limits _____

Note: A certificate of excess insurance or a valid binder issued by said carrier must be attached to this application. If coverage renews during the permit year, please send a copy of the certificate for the renewed coverage.

18. For governmental entities:
a. Amount appropriated for the current fiscal year 2,218,500

b. Amount appropriated for the next fiscal year (if available) N/A

c. Amount any other reserved funds allocated for payment of prior years' open claims: N/A

19. Include the **nonrefundable annual application fee of $1,000**, made payable to the **OK Workers' Compensation Commission**, and any required attachments indicated below with this application. All items may be emailed to InsuranceDepartment@wcc.ok.gov. However, we **must** receive the original parental guaranty via mail or courier.

☐ Signed Application

☐ Nonrefundable annual application fee **$1000** made payable to: **Oklahoma Workers' Compensation Commission**

☐ Proof of Excess Insurance (the most current certificate; a current certificate is required for final approval) **The Workers' Compensation Commission should be listed as the Certificate Holder or Regulatory Authority.**

☐ A completed **Designation of Service Agent** CC-Form 7 (even if there are no changes from last year)

☐ The Employer's most recent audited financial statements, including balance sheet, income statement, statement of cash flows, and notes (If the company does not have audited financial statements, unaudited financial statements signed by two company executives may be submitted)

☐ ***If*** the Employer is owned by another company, the audited financial statements for the parent company

☐ The most recent interim financial statements available for the Employer and any parent company, including balance sheet, income statement, and statement of cash flows.

☐ ***If*** the Employer has employees at multiple Oklahoma locations, a list of all locations, with the full address for each location.

☐ A list of any additional employers/companies to be included under the permit, including their Federal Identification Number (FEIN) and list of covered Oklahoma locations.

☐ If the Employer owns other employers/companies that should **not** be included on the permit, a list of the names, addresses, and federal employer identification numbers (FEIN) of ALL employers/companies to be excluded from the permit, including subdivisions. Advise whether those employers/companies are included under another Own Risk License, or if workers' compensation obligations are Insured and by what Insurance Carrier Name.

☐ Loss runs for the past five years. **Loss runs should contain a summary for each year, containing total $ paid (including any expenses) and total reserve $ outstanding. Data that identifies individual employees may be redacted.** Actuarial reports are not required but are helpful if available.

☐ ***If*** the renewing Employer has a parental guaranty of funds and there are ***any changes to the named insureds*** on the permit applicant/renewal; then **you must provide a new, notarized original parental guaranty** from the parent or principal employer.

☐ ***For Governmental Entities*** A copy of the minutes from the board meeting where the budgeted amount was approved.

☐ ***For Governmental Entities*** If the financial statement or CAFRA does not indicate that the appropriated funds are placed into a segregated fund, in compliance with Commission Rule 810:25-9-11, please provide documentation that the funds are placed in a segregated fund.

20. **PLEASE READ CAREFULLY –**

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 notify the Commission of any change in its financial condition or ownership in the interim period between applications, such as a net financial loss, which may impact the applicant's financial ability to pay its workers' compensation obligations.

c. The applicant agrees to comply with all applicable statutes and the rules of the Workers' Compensation Commission.

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.

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 _____ day of September, 20 18.

Signature
(NOTE: the person signing MUST be authorized to bind the Own Risk Employer to the agreements contained herein)

Lynne Miller	Mayor
Print Name of Person Signing Above	Title of Person Signing Above

P.O. Box 370	Norman	OK	73070
Mailing Address	City	State	Zip Code

201 West Gray, Bldg C	Norman	OK	73069
Street Address, if different from Mailing Address	City	State	Zip Code

clint.mercer@normanok.gov	(405) 217-7720
E-mail Address of Person Signing Above	Telephone Number of Person Signing Above

Send application to:
OKLAHOMA WORKERS' COMPENSATION COMMISSION
INSURANCE SERVICES DIVISION
1915 NORTH STILES AVENUE, SUITE 231
OKLAHOMA CITY, OK 73105

WORKERS' COMPENSATION COMMISSION
1915 NORTH STILES AVE
OKLAHOMA CITY, OK 73105
405-522-3222

This space for Commission Use only

CC-FORM-7
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.

The following entities must designate a single agent for service of notice by filing this Designation of Service Agent form with the Commission: insurance carriers; individual own-risk employers; group self-insurance associations; and qualified employers.

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 will send all notices and correspondence to the designated agent, until an entry of appearance or a notice of substitution of attorney is filed as provided in Commission Rules 810:10-1-10 or -11.

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

Please check (☑) the appropriate box below:

■ Carrier ■ Individual Own Risk Employer ☐ Group Self-Insurance Association ☐ Qualified Employer

(If this service agent designation applies to the entity's subsidiaries, attach a list of the applicable subsidiaries and/or affiliates, including addresses.)

City of Norman	(405) 366-5428
Entity Name	Entity Phone Number
Jeff Bryant, City Attorney	jeff.bryant@normanok.gov
Name of contact person	Contact Email

P.O. Box 370	Norman	OK	73070
Home Office Mailing Address	City	State	Zip
201-C West Gray	Norman	OK	73069
Street Address (if different):	City	State	Zip

Designated Service Agent Information:

City of Norman	(405) 366-5428
Agent Name	Agent Phone Number
Jeff Bryant, City Attorney	jeff.bryant@normanok.gov
Name of contact person if the service agent is a business	Agent Email

P.O. Box 370	Norman	OK	73070
Home Office Mailing Address	City	State	Zip
201-C West Gray	Norman	OK	73069
Street Address (if different):	City	State	Zip

Signature of Entity Representative	Printed Name of Entity Representative
September____, 2018	City Attorney
Date Signed	Title of Entity Representative

Revised 09/15