

APPLICATION FOR GOVERNMENTAL SELF-INSURANCE

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

200 East Gaines Street
Tallahassee, Florida 32399-4224

COMPLETE ALL APPLICABLE SECTIONS BEFORE FILING WITH THE DIVISION

DIVISION RECEIVED DATE
DRAFT

PLEASE PRINT OR TYPE

Applicant Name: _____ D. B. A.: _____	Federal I.D. Number (FEIN): _____	NAICS Code: _____
Physical Address: _____ City: _____ State: _____ Zip: _____	Nature of Business: _____	
Mailing Address: _____ City: _____ State: _____ Zip: _____	<u>Name of Self-Insurance Program Coordinator:</u> Name: _____ Title: _____	
Telephone Number: _____ Fax Number: _____	Address if different: _____ City: _____ State: _____ Zip: _____	
Name of Workers' Compensation Carrier at Time of Application: _____	Telephone Number: _____ Fax: _____ E-Mail Address: _____	
Renewal Date for Current Coverage: _____	Desired Effective Date: _____	

Briefly Describe the General Nature of the Operations of the Applicant:

Required Attachments:

- Completed Certification of Servicing (Form SI-19)
- Copy of Current Experience Modification Rating
- Completed Application for Self-Insurance Estimated Payroll (Form DFS-F2-SI-EP)
- Legal memorandum presenting evidence that the Applicant meets the Scope of Section 440.38(6), F.S.
- Documentation through which Applicant is organized and/or authorized to operate as a Governmental Entity.

Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in s. 817.234. Section 440.105(7), F.S.

I, _____, certify that all information contained in this application is true and correct to the best of my knowledge.
(Print Name)

(Signature)

(Title)

(Date)

INSTRUCTIONS FOR COMPLETION

All information entered on this application must be typed or printed and the application and all accompanying documents must be filed with the:

Florida Department of Financial Services
Division of Workers' Compensation
Bureau of Monitoring and Audit, Self-Insurance Section
200 East Gaines Street
Tallahassee, Florida 32399-4224.

DRAFT

The undersigned employer (hereinafter referred to as the applicant), an employer subject to the provisions of the Florida Workers' Compensation Law, hereby makes application for the status of a self-insurer in order to pay compensation directly. In connection with such application, the applicant makes the following declarations for the purpose of enabling the Division of Workers' Compensation (hereinafter referred to as the Division) to make a finding of facts as to whether the applicant meets the qualifications for self-insurance established in Section 440.38(6), F.S.

The Division will review this application and accompanying documents and will advise the applicant in writing of any additional requirements imposed by Chapter 69L-5, F.A.C. All requirements shall be fulfilled prior to the Division's approval of this application. Sections 120.57 and 120.60, F.S., and the applicable rules of procedure, govern the approval or denial of this application. In the event this application is denied, the applicant shall have the right to request an administrative hearing on the denial of the application in accordance with Sections 120.57 and 120.60, F.S.

If all requirements to self-insure are not met within 90 days of the date of application, the Division reserves the right to deny this application without prejudice.

A Governmental entity authorized to self-insure pursuant to Chapter 440.38(6), F.S., is required to comply with all provisions of Chapter 440, F.S. including but not limited to timely and accurate payment of benefits and reporting of data.