Department of Labor & Industries
Self-Insurance Section
PO Box 44891
Olympia WA 98504-4891

APPLICATION FOR SELF-INSURANCE CERTIFICATION

	UBI	Date certification requested
Name of applicant	Type of business	Corporation ☐ Partnership ☐ Sole prop ☐ LLC ☐
Business address	City	State ZIP+4
Name of self-insured representative	Title	Phone
Mailing address	City	State ZIP+4
Name of safety representative	Title	Phone
Mailing address	City	State ZIP+4
Name of claims administrator	Title	Phone
Mailing address	City	State ZIP+4

Will administrator have authority to promptly provide all benefits? Yes ☐ No ☐	Will administrator have authority to handle appeal cases? Yes ☐ No ☐	Will self-insured program be administered within the state of Washington? Yes ☐ No ☐

Name and address of applicant and subsidiaries located within the state of Washington (please attach sheet for additional subsidiaries)

Name	Address	UBI	No. of employees

Name of state corporation is chartered	Date of charter

IT IS UNDERSTOOD AND AGREED that, in consideration of becoming self-insured in the state of Washington, the applicant consents to be sued in the Courts of the state of Washington in regard to any obligations as a self-insurer, and fourth consents to the service of process upon its registered agent in the state.

Registered Agent	Address

Date	Company official (type or print)	Title	Signature

I, the undersigned, declare under the penalties of perjury and/or the revocation of any certification granted, that I am the applicant or authorized representative of the firm or corporation making this application and that the answers contained, in including any accompanying information, have been examined by me and that the matters and things set forth are true, correct and complete.

Date	Company official (type or print)	Title	Signature

RESET

INSTRUCTIONS TO COMPLETE

APPLICATION FOR SELF-INSURANCE CERTIFICATION

The following information must accompany your application for self-insurance certification.

1] UBI

UBI is the Uniform Business Identifier used in reporting to state agencies. For information, contact the Self-Indurance Senior Surety Analyst or the Department of Revenue.

2] NAME OF SELF-INSURED REPRESENTATIVE

This individual, an employee of your business, will be your company's representative with our Department to whom all departmental correspondence, reports and information will be sent. It is the applicant' responsibility to inform our offices of any changes in representation within 30 days.

3] NAME OF SAFETY REPRESENTATIVE

This individual should be located within the state of Washington. A representative of our Division of Occupational Safety and Health will contact t his person to review y your business's safety programs to ensure compliance with the appropriate rules and regulations. If a safety representative is available at each Washington location, please include this information on a separate sheet

4] NAME OF CLAIMS ADMINISTRATOR

It will be the responsibility of the individual to ensure that any and all benefits are provided in compliance with the Industrial Insurance laws. If this person has not been previously approved to administer claims in the state of Washington, please contact our trainer at (360) 902-6904.

5] NAME AND ADDRESS OF APPLICANT AND SUBSIDIARIES

Please list all subsidiaries or divisions operating within the state of Washington. All subsidiaries in which the applicant has at least 50% ownership must be included with its certification. This list should include the physical location and the number of employees at each location.

6] PARENT GUARANTEE

If the applicant is a subsidiary of another business, that parent business must guarantee the self-insured obligations of it subsidiary. A copy of this guarantee form is available upon request.

7] AUDITED FINANCIAL STATEMENT OF THE APPLICANT FOR PAST THREE YEARS.

If more than a year has passed since the date of your latest financial statement, please provide interim quarterly information.

8] COMPLETED COPY OF SELF INSURANCE CERTIFICATION QUESTIONNAIRE, FORM F207-176-000.

9] A COPY OF YOUR ACCIDENT PREVENTION PROGRAM

10] AN APPLICATION FEE OF $250.00

If you have any questions, please contact either the Certification Services Manager at (360) 902-6867 or the Senior Surety Analyst, at (360) 902-6863.