Department of Commerce
WORKERS' COMPENSATION COMMISSION
COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS
P.O. Box 5795 CHRB, Saipan MP 96950
Tel: (670) 664-8018/8024 • Fax (670) 664-8074
Website: www.commerce.gov.mp

WORKERS' COMPENSATION
CERTIFICATE OF SELF-INSURANCE AUTHORIZATION APPLICATION

1. Date: _____

2. Applicant: _____
   DBA: _____
   Address: _____
   Telephone: _____

3. Brief Description of Business: _____
   _____
   _____
   _____

4. Year Business Established: _____

5. INDIVIDUAL WITHIN ORGANIZATION RESPONSIBLE FOR SELF-INSURANCE PROGRAM

a) Name _____
   b) Title _____
   c) Address _____
   d) Telephone _____

6. THIRD PARTY ADMINISTRATION (If different from item 5 above)

   A. If by outside organization:
      a) Name of organization _____
      b) Name of administrator _____
      c) Address _____
      d) Telephone _____

7. List below, all DBA's, divisions, and subsidiaries included in its workers' compensation self-insurance plan, relationship (parent, subsidiary, dba, division, etc.). If the space provided here is insufficient, attach a separate listing to this report.

NAME RELATIONSHIP

_____

_____

_____

_____

8. Name of Carrier (Prior to Self-Insurance): _____

_____

Amount of Policy: $_____ Annual Premium: _____

Attach a copy of the policy declaration sheet and endorsements.

9. Number of employees as of end of last fiscal year: _____, Total wages paid: $_____

10. Number of employees currently on payroll: _____, Total wages paid to date: $_____

11. Number of claims received during the past three (3) years:

20____ _____ 20____ _____ 20____ _____

12. Amount of benefits paid during the last three (3) years:

20____ _____ 20____ _____ 20____ _____

13. Type of Security Offered:

a. Surety Bond: _____ b. Cash Deposit: _____ c. Real Property: _____

d. Trust Fund: _____ e. Other: (specify)_____

14. OTHER REQUIREMENTS

a) A copy of your latest Audit Report with all schedules and notes, and upon written request, such other financial information as may be acceptable to the Commission must be attached to this application.

b) If the report of the financial condition is dated more than twelve (12) months prior to the date of this application, the Commission may require interim financial statements (Balance Sheet and Profit and Loss Statement) certified by the appropriate finance officer and dated not less than three (3) months from date of this report.

c) Send application to:

Department of Commerce
Workers' Compensation Commission
P. 0. Box 5795 CHRB
Saipan, MP 96950

Review of your application will commence when all the information requested herein are provided.

The Workers' Compensation Commission will issue its decision on your application within **60 days** of receipt of your application and all information requested are completed.

Under penalty of perjury, I declare that the information provided is to the best of my knowledge and ability true and correct.

Date _____ 20_____

_____
SIGNATURE

_____
TYPE NAME OF COMPANY OFFICER

_____
TITLE