December 5, 2019

To: All Self-Insured Employers

Re: Workers’ Compensation Self-Insured Program

The Tennessee Department of Commerce and Insurance (“TDCI”) requires all self-insured employers to file their 2020 Annual Renewal Package as described below.

I. **Renewal Application Requirements:**

1) **Renewal Application** - The renewal application must be completed, signed, and notarized.
2) **Employer's TN Subsidiaries Form** - Please complete the attached form.
3) **Employer’s Company Organizational Chart** – Please file an organizational chart.
4) The deadline is **January 31, 2020**, for the above required items.

II. **Payroll Report Requirements:**

1) **Payroll Report** - A detailed payroll report for all workers covered by NCCI classification codes for the previous calendar year. The report must be signed and notarized.
2) **Intrastate Experience Modification Factor** - All employers must file with the Department their experience modification factor that is calculated in accordance with NCCI Experience Rating Manual rules. The NCCI report must be only for Tennessee’s experience modification factor. The NCCI report should have an effective date as of **January 1, 2020**, that includes the losses from 2016, 2017, and 2018 policy years.
3) Please e-mail your ERM-6 FORM at MODMAIL@NCCI.COM or mail it to the following address:

   National Council on Compensation Insurance
   Customer Service Center
   901 Peninsula Corporate Circle
   Boca Raton, FL 33487
   Phone: 1-800-622-4123
   Fax: 561-893-1191

4) The deadline is **April 1, 2020**, for the above required items.
5) Tax invoices not paid on or **before June 30, 2020**, are subject to penalty and interest.

*If the above items are not received by the due date, the Department will determine your premium tax using an experience modification factor of 2.0.*
III. Financial Statement Requirements:

1) Audited Financial Statement
2) Actuarial Opinion – Certified by a qualified actuary pursuant to Rule 0780-1-83.08(2)
3) Loss Run Report – Detailed report of all claims since inception based on your fiscal year end date. See Attached Loss Report Requirements.
4) Open Claims Report – Detailed report of all open claims since inception based on your fiscal year end date. See Attached Loss Report Requirements.
5) Claims that Exceeded their Self-Insured Retention (“SIR”) Report - Detailed report of all claims that have exceeded the SIR Level since inception based on your fiscal year end date. See Attached Loss Report Requirements.
6) The deadline is due **no later than the end of the six month after the fiscal year end date** for the above required items.

IV. Third Party Administrator’s Contract Agreement, Excess Policy, and SIR Certification as set by a qualified actuary are due before or upon the expiration date.

The changes related to the employer’s ownership, name, address, contact person, claims management, and subsidiary should be addressed in the cover letter from the Company.

The failure to file all the above required documents under Tenn. Code Ann. § 50-6-405(b)(4) and Rule 0780-1-83-.13(2) authorizes the Commissioner to assess a **civil penalty of $100 per day for each day of delinquency**, including suspension or revocation of your authorization to self-insure for Workers’ Compensation.

The TDCI is in the process of implementing an online system to assist employers in filing the required documents. The TDCI will send you a notification and instructions when this system goes live in 2020. Please make sure your mailing and e-mail addresses are correct when filing your **2020 renewal application package**.

For further information, please see the current Self-Insured Workers’ Compensation Employer Law, Tenn. Code Ann. § 50-6-405, Rules 0780-1-81 and 0780-1-83 links below.

http://www.lexisnexis.com/hottopics/michie/

If you cannot use the above links and need a copy of pertinent laws and regulations, please contact Jena Napier at Jena.Napier@tn.gov

Sincerely,

Kurt A. Polasko, CFE, ACI
Examiner In Charge
RENEWAL APPLICATION
FOR SELF-INSURED WORKERS’ COMPENSATION

1. Name of Applicant: ____________________________________ FEIN : ______________
   Address: ______________________ City: ___________ State: _______ Zip: _______
   Phone: ______________________ Email: __________________________
   Type of ownership:  ☐ Corporation  ☐ LLC  ☐ Partnership  ☐ Others
   State of Incorporation: _________________ Date of Incorporation: _______________

2. If a foreign corporation, give date of registration with the office of the Tennessee Secretary
   of State: __________________________________________________________________

3. Is applicant a subsidiary? If so, give name and address of parent company, and complete
   list of all affiliates or subsidiaries operating as a self-insured employer in Tennessee. See
   attached form.
   Parent Company: ____________________________________ FEIN: ______________
   Address: ______________________ City: ___________ State: _____ Zip: __________

4. Has there been any change in the corporate structure within the last two years?
   Yes: ☐  No: ☐  If yes, please explain: __________________________________________
   ___________________________________________________________________________

5. To whom should the correspondence regarding this application be addressed?
   Name: ___________________________ Phone: ___________________________
   Address: ______________________ City: ___________ State: _______ Zip: _______
   Fax: ___________________________ Email: ____________________________

Tennessee Department of Commerce and Insurance, Insurance Division, Financial Affairs Section
500 James Robertson Pkwy • 10th Floor, Davy Crockett Tower • Nashville, TN, 37243 • Tel: 615-741-1670
6. Who is the Third Party Administrator that will be handling claims in Tennessee?

Name: _______________________________ TPA’s license expiration date: ___________

I hereby acknowledge that:

a. That this privilege may be revoked by the Commissioner of Commerce and Insurance, as provided in Tenn. Code Ann. §50-6-405.

b. The applicant, who is carrying catastrophe or excess coverage insurance, will file a photocopy of the policy with the Department of Commerce and Insurance.

c. That the applicant shall file with the Commissioner an acceptable security deposit of at least five hundred thousand dollars ($500,000).

d. That the applicant will not solicit, receive or collect any money from employees or make any deduction from their wages for the purpose of discharging any part of the employer’s liability under the Workers’ Compensation Act and that the employer will not permit any person with employer’s knowledge to sell or try to sell medical or hospital tickets to the Company’s employees for medical, surgical or hospital treatment required by law to be furnished to injured employees.

e. If an applicant is a subsidiary, the applicant’s parent organization must guarantee the workers’ compensation obligations imposed on the applicant.

f. I am acquainted with the affairs of the applicant about which representations have made in the foregoing application and subsequent attachments and supporting documentation. I have read the application and attachments and believe them to be true to the best of my knowledge.

_____________________________________ ____________________________________________
(Print Name)             (Date)

_____________________________________ _____________________________________________
(Signature)             (Title)

(Notary)      (Seal)
PAYROLL REPORT FOR
SELF-INSURED WORKERS’ COMPENSATION SINGLE EMPLOYER

Item 1
TO THE COMMISSIONER OF THE DEPARTMENT OF COMMERCE AND INSURANCE: __________________, 20________
The undersigned, an employer operating under the provisions of the Tennessee Workers’ Compensation Act, as a Self-Insurer, submits the following information for the purpose of enabling the Commissioner of Commerce and Insurance to determine the amount of tax due the State of Tennessee under provision of Section §50-6-405, Tennessee Code Annotated.

Item 2
Name of Employer: _________________________________________________________________________________________
Address: __________________________________________________________________________________________________

Item 3
Figures contained in this report are for the purpose of adjusting the tax assessment made for the period of January 1, 20____, to December 31, 20____, and for making the assessment for the period of January 1, 20___, To December 31, 20___.

Item 4

<table>
<thead>
<tr>
<th>Code</th>
<th>Classification</th>
<th>Average number of Employees in Tennessee</th>
<th>Actual/Estimated Payroll of all employees in Tennessee for period of</th>
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<td>For the year ending December 31, 20_____</td>
<td>20_____</td>
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</table>

Total

1. CLERICAL OFFICE EMPLOYEES – This classification shall include those employees with office duties only and having no other duty of any other nature in or about the employer’s premises.
2. Unless the payroll shown above is subdivided into proper classifications, the highest rate will be used in calculating the premium.
3. If employer has multiple locations, please consolidate classifications.

Item 5
RETURN THIS COPY TO THIS OFFICE – RETAIN A COPY FOR YOUR FILES

The foregoing enumeration and description of employees includes all persons employed in the services of this employer in Tennessee in connection with the business operations above described to whom remuneration of any nature in consideration of service is paid, in whole or in part by bonuses, commissions, vacation pay, holidays or sickness periods, or on basis of piecework, or by store certificates, merchandise credits, or any substitute for money. Such form of payment shall be considered as wages to be included in the actual remuneration earned, and the total remuneration earned by each employee shall be reported excluding only the part of overtime as set forth in the basis of premium. Remuneration is subject to payroll limitations prescribed in the “Miscellaneous Values” page of the applicable NCCI loss cost filing. See https://www.NCCI.com. The President, Vice-President, Secretary or Treasurer, of this employer, as well as Partners and Limited Liability Company (LLC) Members and Executive Officers must be assigned to the classification that applies to the principal operations in which the executive officer is engaged. Exceptions to these payroll/classification rules may be obtained from your broker. The Department of Commerce and Insurance reserves the right to examine the books of the Employer at any time during the current or following year and any extension thereof so far as they relate to the remuneration earned by any employee of this employer.

________________________________
(Name of Company)

I, ___________________________________ (Title), of the above named company do hereby solemnly swear that the items of the foregoing account are correct and that they constitute the total amount of remuneration received by all employees in the State of Tennessee for the period stated therein to the best of my knowledge and belief. ______________________________________

(Official Title)

Subscribed and sworn to before me this ____________ day of ___________________, 20_________________

My Commission Expires _____________________                                             _______________________________________

(Notary Public)
Loss Report Requirements

Please complete required items below:

I. **Add Heading for all reports:**
   Employer Name and Its TN subsidiaries’ Loss Run Report (Open Claims, Exceeded SIR Level report) for the period from inception date to XX/XX/XXXX. (Based on fiscal year end date)

II. Loss Run Report should include all claims from inception date to XX/XX/XXXX (fiscal year end date).

III. Open Claims Report should include all open claims from inception date to XX/XX/XXXX (fiscal year end date).

IV. Claims that Exceeded Self-Insured Retention (“SIR”) Report should include all claims that have exceeded the SIR Level since inception date to XX/XX/XXXX (fiscal year end date).

Each report should include at the minimum with details listed below:

1) Column of Name,
2) Column of Loss Date,
3) Column of Total Incurred,
4) Column of Total Paid,
5) Column of Total Outstanding,
6) Column of SIR Level,
7) Column of Nature of Injuries,
8) Subtotal by Year, and
9) Grand Total for all years.
Self-Insured and its Affiliates or Subsidiaries operating as Self-Insured Workers' Compensation for Single Employer in Tennessee Form

<table>
<thead>
<tr>
<th>No.</th>
<th>Full Legal Name</th>
<th>FEIN#</th>
<th>Percentage of ownership</th>
<th>Physical Address</th>
<th>Effective Date of Self-Insured</th>
<th>End Date of Self-Insured</th>
<th>Type of Employment</th>
<th>Number of Employees</th>
<th>Payroll Amount</th>
<th>Contact Person Information</th>
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**Note:** Please send an updated Organizational Chart along with this attachment. Attach another sheet, if needed.