REQUIREMENTS FOR SELF-INSURED WORKERS' COMPENSATION SINGLE EMPLOYER

(per Tenn. Code Ann § 50-6-405 and Tenn. Comp. R & Reg. Ch. 0781-01-83)

Name Change

Active Self-Insured-TN

To comply with the name change requirements, please complete and submit the documents listed below through your CORE account, online filing system.

1. A Request Letter, (should be filed within 30 days of the change),
2. Board Approval or Resolution,
3. Corporate Charter, Article Name Change, or By-Law,
4. Assets and Liabilities Agreement,
5. Operating Agreement,
6. Updated List of Tennessee Subsidiary, (if applicable)
7. Updated Entities Structure Organizational Chart,
8. Return the Original C of A or Complete the Lost C of A Form,
9. Amended Security Deposit to Reflect the New Name,
10. Amended Excess Policy to Reflect the New Name,
11. Amended TPA Contract Agreement to Reflect the New Name, (if applicable),
12. Indemnity Agreement Executed by the Parent, (if applicant is subsidiary).

Pursuant to the Rule 0780-01-83.-08(3) *"employer that amends its charter, articles of corporation, or partnership agreement to change its identity business structure, or in any other manner materially alters status as it existed at the amendment or other action, notify the Commissioner of such action and provide the Commissioner with a copy of such amendment or other action."*

To comply with above statute, an Employer's failure to file any reports required under Rule 0780-1-83-.13(2), authorizes the Commissioner to assess a civil penalty of $100 per day for each day of delinquency.

AFFIDAVIT OF LOST OR MISPLACED CERTIFICATE OF AUTHORITY FOR SELF-INSURED WORKERS' COMPENSATION SINGLE EMPLOYER

To the Commissioner of Commerce and Insurance:

The Self-Insured Workers' Compensation Section has been notified of the loss of the Certificate of Authority ("C of A") issued by this Department to_____

An Affidavit of Lost or Misplaced C of A must be filed with Department before a replacement C of A will be issued.

Date: _____

Company Name: _____

Company Contact Person: _____

Address:_____

City, State, Zip: _____

- The Affidavit must be completed and signed by a principal officer of the company.
- The Affidavit must bear original (not photocopy) signatures.
- The Affidavit must be notarized.
- Upon completion of this process, the company will be billed a fee for replacing the company's C of A.

The undersigned hereby affirms as follows:

1. I am the _____of

   _____, a company licensed in the

   State of Tennessee and domiciled in the Domiciliary State.

_____ _____

(Name) (Date)

2. A diligent search has been made in the Company's files to locate the original C of A of the Company, as issued by the State. The original C of A could not be located in our files, and therefore is considered to be lost or misplaced. In the event that the original C of A is located, the Company will return the C of A to the Department of Commerce and Insurance in the State.

_____

(Principal Officer's Name - Print)

_____

(Principal Officer's Signature)

SWORN AND SUBSCRIBED before me on this,
The _____day of_____, 20_____
My commission expires: _____

(Notary Seal)

Self-Insured and its Affiliates or Subsidiaries operating as Self-Insured Workers' Compensation from Inception to current year in Tennessee Form

DATE: _____

No.	Full Legal Name	FEIN#	Percentage of ownership	Physical Address	Effective Date of Self-Insured	End Date of Self-Insured	Type of Employment	Number of Employees	Payroll Amount	Contact Person Information		
										Name	E-Mail	Phone
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												

Note: Please send an updated Organizational Chart along with this attachment. Attach another sheet, if needed.

INDEMNITY AGREEMENT FOR SELF-INSURED WORKERS' COMPENSATION SINGLE EMPLOYER

(Compete this form if parent company is in the United States and use a separate form for each subsidiary or refer to Exhibit A to be indemnified)

KNOWN TO ALL PRESENT, that we _____ corporation, organized and existing under and by virtue of the laws of the State of _____ for and in consideration of the State of Tennessee authorizing _____ , a corporation, to operate as a self-insurer under the provisions of the Workers' Compensation Law of the State of Tennessee do hereby guarantee the payment by said _____ of any and all valid claims for compensation and other benefits made against it under the said Workers' Compensation Law for injury or death to any of its employees or former employees and in the event that said _____ shall not pay or cause to be paid directly to claimants the benefits due or that may become due under said Law, then the pay or cause to be paid directly to claimants the benefits due or that may become due under said Law, then the undersigned _____ , covenants and agrees that it will pay to all such claimants the benefits due, including a reasonable attorney fee incurred by said claimants in any action brought on this agreement, with the expressed knowledge and understanding that the execution and acceptance of this agreement is for the benefit of unknown and unnamed employees and former employees of said _____ and that said _____ does hereby recognize this agreement as a direct financial guarantee to said employees or former employees.

PROVIDED HOWEVER, that _____ , shall have a right to cancel and terminate this agreement at any time upon giving the State of Tennessee at least sixty (60) days written notice of its desire to do so; provided further, that such cancellation shall not affect its liability as to any benefits payable for injuries occurring prior to the date of cancellation specified in such notice.

This agreement shall be effective as of _____ , 20_____

Signed, sealed and delivered this _____ day of _____ , 20_____

_____

BY: _____

_____

(Official Position)

ATTESTED:

_____

Secretary

(Corporate Seal)

Exhibit A

Self-Insured and its Affiliates or Subsidiaries operating as Self-Insured Workers' Compensation for Single Employer in Tennessee Form

Date: _____

No.	Full Legal Name	FEIN #	Physical Address	Effective Date of Self-Insured	End Date of Self-Insured	Type of Employment
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						