REQUIREMENTS FOR SELF-INSURED WORKERS’ COMPENSATION SINGLE EMPLOYER

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

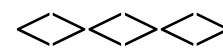
Renewal Application

To comply with the renewal application requirements, please submit the documents listed below:

1. Renewal Application, see attached form;
2. Employer’s Tennessee Qualified Self-Insured Subsidiaries, if applicable, see attached form;
3. Employer’s Tennessee Locations, if applicable, see attached form, and
4. Employer’s Corporate Structure Organizational Chart.

The deadline is January 31, 2024

The failure to file all the above required documents under Tenn. Code Ann. § 50-6-405(b)(4) and Tenn. Comp. R. & Regs. 0780-01-83-.13(2) authorizes the Commissioner to assess **a civil penalty of one hundred dollars ($100) per day for each day of delinquency** and suspend or revoke your authorization to self-insure your workers’ compensation.



RENEWAL APPLICATION
FOR SELF-INSURED WORKERS' COMPENSATION

INSTRUCTIONS: All questions below must be answered. If not applicable, enter N/A.

The undersigned entity or person hereby files this renewal application for a Certificate of Authority Self-Insured Workers' Compensation Single Employer in accordance with the provision of Tenn. Code Ann. § 50-6-405 and Tenn. Comp. R. & Regs. 0780-01-83.

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 of another company? If so, provide the name and address of the parent company, and a 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: _______________________________________

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

d. 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)

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.

Self-Insured-Employee Location Form

This Form is only for employers that do not have any affiliates or subsidiaries in Tennessee

Tennessee Self-Insured Legal Name: ____**FEIN#**___________________**Date:**______________

No.	Location Name	TN Physical Address	Effective Date became a Self-Insured	End Date as a 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										

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