



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

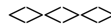
To comply with the renewal application requirements, please submit the below documents online through [CORE](#):

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

The deadline is January 31, 2025

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.

Should you have any questions, please contact TDCI.Selfinsured1013@tn.gov.





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										

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

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

1013-8090-12-4-Renewal Application-TN Locations Form