



## APPLICATION REQUIREMENTS FOR SELF-INSURED WORKERS' COMPENSATION SINGLE EMPLOYER

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

Effective: November 1, 2024

**An employer applying to be a self-insured workers' compensation single employer in the State of Tennessee must provide the following information within 30 days of your request. Reviews cannot be completed until all items are complete and received:**

1. A \$675 non-refundable application fee, pursuant to T.C.A. §50-6-405(b), 56- 4-101(2)(1), and Tenn. Comp. R. & Regs. 0780-01-83-.04(1).
2. Completed electronic application in CORE at <https://access.cloud.commerce.tn.gov/portal/public>, pursuant to Tenn. Comp. R & Regs. 0780-01-83-.04(1), biographical affidavit and background check reports. The biographical affidavit on all officers and directors can be located at [http://www.naic.org/documents/industry\\_ucaa\\_form11.pdf](http://www.naic.org/documents/industry_ucaa_form11.pdf).
3. Organizational chart
4. List of any subsidiaries or affiliates operating as a self-insured employer in TN.
5. Premium tax will be assessed at the rate of 4.4% pursuant to T.C.A. §56-4-207, and Tenn. Comp. R. & Regs. 0780-01-83-.10(1). Please note, that applications for self-insured received by this division prior to June 30 require submission of prior year end payroll reports and applications received after June 30 requires submission of estimated payroll reports for that year.
6. Applicant should have a minimum of \$350,000 workers' compensation written premium in Tennessee, pursuant to Tenn. Comp. R. & Regs. 0780-01-83-.04(3)(h).
7. Minimum security deposit of \$500,000. The security may be in the following specified forms: negotiable securities, certificates of deposit, surety bond, or a letter of credit. A depository agreement must be completed for certificates of deposit or negotiable securities pursuant to T.C.A. §50-6- 405(b)(2)(A)(i) and Tenn. Comp. R. & Regs. 0780-01-83-.05.
8. An excess insurance policy is required and should contain both specific and aggregate coverage. Pursuant to Tenn. Comp. R. & Regs. 0780-01-83-.06(1), "an employer shall obtain and maintain excess insurance, both specific and aggregate in an amount sufficient to cover its liabilities for losses not paid by the employer and as set by a qualified actuary."
9. Three most recent years of loss run reports pursuant to Tenn. Comp. R. & Regs. 0780- 01-83-.04(2)(b)(iii).
10. Three most recent years of audited financial statements, pursuant to Tenn. Comp. R. & Regs. 0780-01-83- .04 (2)(a) and (3)(h).
  - a. Must have positive working capital.
  - b. Must have positive net worth.
11. Three most recent years of experience modifications factors ("EM") if the company has been in business in Tennessee for more than 3 years. If the company is new and has just established business in Tennessee, then the EM rating will be set at 1.00 rather than considering the interstate rating. All EM must be on a calendar year basis and effective January 1, pursuant to Tenn. Comp. R. & Regs. 0780-01-83- .04(3)(h).
12. Actuarial opinion or feasibility study, pursuant to T.C.A. §50-6-405(b)(2)(B)(ii) and Tenn. Comp. R. & Regs. 0780-01-83-.04(3)(h).
13. Name, address, phone, and e-mail of the person in Tennessee who is responsible for handling claims, pursuant to T.C.A. §50-6-413.
14. Completed anti-fraud plan, pursuant to Tenn. Comp. R. & Regs. 0780-01-83-.04(3)(h) and in accordance with T.C.A. §56-47-112. These documents are confidential by statute.
15. Parent guarantee, pursuant to Tenn. Comp. R. & Regs. 0780-01-83-.04(4), if applicant is a subsidiary.
16. Completed Anti-Fraud Plan Agreement.
17. Completed Premium Taxation Agreement.
18. Completed Excess Policy Agreement.
19. Completed Surety Agreement.
20. All required documents must be attached to the electronic application in CORE.



## 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.



## TENNESSEE SELF-INSURED - EMPLOYEES WORKING LOCATIONS FORM

THIS FORM IS ONLY FOR EMPLOYERS WHO DO NOT HAVE ANY AFFILIATES OR SUBSIDIARIE IN TN

TN'S SELF INSURED LEGAL NAME : \_\_\_\_\_ FEIN# \_\_\_\_\_ DATE: \_\_\_\_\_

No.	Location Name	TN 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.



## SECURITY DEPOSIT AGREEMENT FOR SELF-INSURED WORKERS' COMPENSATION SINGLE EMPLOYER

Tennessee Code Annotated §50-6-405(b)(1)

To the Commissioner of Commerce and Insurance:

Please accept this statement as confirmation that:

\_\_\_\_\_, a company seeking a  
(Name of Applicant Company)

Certificate of Authority ("C of A") from the Tennessee Department of Commerce and Insurance to be a self-insured entity for workers' compensation, hereby acknowledges that:

Prior to, and as a condition of, receiving a C of A from the Insurance Division, the company will obtain a security deposit, in the amount no less than \$500,000, or an amount to be calculated by the Tennessee Department of Commerce and Insurance guidelines.

I, \_\_\_\_\_, hereby attest that I am qualified to confirm  
this agreement on behalf of the Company.

Sworn to and subscribed before me this

\_\_\_\_\_  
(Name)

\_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
(Title)

\_\_\_\_\_  
(Signature of Notary)

My commission expires \_\_\_\_\_

(Notary Seal)



## EXCESS POLICY AGREEMENT FOR SELF-INSURED WORKERS' COMPENSATION SINGLE EMPLOYER

Tenn. Comp. Rules & Regulations 0780-1-83-.06(1)

To the Commissioner of Commerce and Insurance:

Please accept this statement as confirmation that:

\_\_\_\_\_, a company seeking a  
(Name of Applicant Company)

Certificate of Authority ("C of A") from the Tennessee Department of Commerce and Insurance to be a self-insured entity for workers' compensation, hereby acknowledges that:

Prior to, and as a condition of, receiving a C of A from the Insurance Division, the company will obtain an excess policy that is compliant with the above mentioned rule:

- A. The limit must be statutory.
- B. An Employer shall obtain and maintain excess insurance coverage for both specific and aggregate, in an amount sufficient to cover its liabilities for losses not paid by the employer and as set by a qualified actuary.

I, \_\_\_\_\_, hereby attest that I am qualified to confirm  
this agreement on behalf of the Company.

Sworn to and subscribed before me this

\_\_\_\_\_  
(Name)

\_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
(Signature of Notary)

\_\_\_\_\_  
(Title)

My commission expires \_\_\_\_\_

(Notary Seal)



**PREMIUM TAXATION AGREEMENT FOR SELF-INSURED WORKERS'  
COMPENSATION SINGLE EMPLOYER**

Tennessee Code Ann. §50-3-101 and §56-4-207,  
and Tennessee Comp. Rules & Regulations 0780-1-83-.10(1)

To the Commissioner of Commerce and Insurance:

Please accept this statement as confirmation that:

\_\_\_\_\_, a company seeking a  
(Name of Applicant Company)

Certificate of Authority ("C of A") from the Tennessee Department of Commerce and Insurance  
to be a self-insured entity for workers' compensation, hereby acknowledges that:

Premium tax obligation is due upon receiving a C of A from the Insurance Division.

I, \_\_\_\_\_, hereby attest that I am qualified to confirm  
this agreement on behalf of the Company.

Sworn to and subscribed before me this

\_\_\_\_\_  
(Name)

\_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
(Title)

\_\_\_\_\_  
(Signature of Notary)

My commission expires \_\_\_\_\_

(Notary Seal)



## ANTI-FRAUD AGREEMENT FOR SELF-INSURED WORKERS' COMPENSATION SINGLE EMPLOYER

Tennessee Code Annotated. §56-47-112

To the Commissioner of Commerce and Insurance:

Please accept this statement as confirmation that:

\_\_\_\_\_, a company seeking a  
(Name of Applicant Company)

Certificate of Authority ("C of A") from the Tennessee Department of Commerce and Insurance to be a self-insured entity for workers' compensation, hereby acknowledges that:

Anti-Fraud plan obligation is due upon receiving a C of A from the Insurance Division.

I, \_\_\_\_\_, hereby attest that I am qualified to confirm  
this agreement on behalf of the Company.

Sworn to and subscribed before me this

\_\_\_\_\_  
(Name)

\_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_  
(Title)

\_\_\_\_\_  
(Signature of Notary)

My commission expires \_\_\_\_\_

(Notary Seal)



## ANTI-FRAUD AGREEMENT REGISTRATION FORM FOR WORKERS' COMPENSATION SINGLE EMPLOYER

Tennessee Code Annotated. §56-47-112

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

Mark One Box:

☐ Original Filing

☐ Modified Plan

Company Name: \_\_\_\_\_

Contact person: \_\_\_\_\_

Position Title: \_\_\_\_\_

Phone: \_\_\_\_\_

Location Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mark One Box: ☐ Self-Insured Employer ☐ Self-Insured Group

Is the self-insured employer or group using a Third Party Administrator ("TPA") to manage the anti-fraud plan?

☐ Yes ☐ No

TPA Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Signed: \_\_\_\_\_ By: \_\_\_\_\_

Date: \_\_\_\_\_ Title: \_\_\_\_\_

**This form, or the information required by this form, must be covered in the anti-fraud plan.**





## ANTI-FRAUD SUMMARY REPORT FOR SELF-INSURED WORKERS' COMPENSATION SINGLE EMPLOYER

Tennessee Code Annotated. §56-47-112

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

Company Name: \_\_\_\_\_

Report Prepared By: \_\_\_\_\_

Firm Name: \_\_\_\_\_

Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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### Reporting Period

1. Describe the resources committed to the combating of fraud in this report period (number of employees, investigations performed by contracted investigators, costs of the resources used).

\_\_\_\_\_

2. List the number of instances and amounts of fraud discovered in the reporting period.

\_\_\_\_\_

3. List the number and amount of fraud recovery during this reporting period.

\_\_\_\_\_

4. Describe, in as much detail as possible, any and all discovered criminal activities of an organized nature.

\_\_\_\_\_

5. List the claims costs for discovered fraud from claims activity.

\_\_\_\_\_

6. Describe the internal activities taken to detect fraud among company employees.

\_\_\_\_\_

### This Form Must be Signed and Dated

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_



**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 Worker's Compensation Act, as Self-Insurer, submits the following information for the purpose of enabling the Insurance Commissioner 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 For the year ending December 31, 20____</th><th>Actual/Estimated Payroll of all employees in Tennessee for period of 20____</th></tr></thead><tbody><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td colspan="2"></td><td>Total</td><td></td></tr></tbody></table>				Code:	Classification	Average number of Employees in Tennessee For the year ending December 31, 20____	Actual/Estimated Payroll of all employees in Tennessee for period of 20____																															Total	
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		Total																																						
	<div>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.</div> <div>2. Unless the payroll shown above is subdivided into proper classifications, the highest rate will be used in calculating the premium.</div> <div>3. If employer has multiple locations, please consolidate classifications.</div>																																							
Item 5	<div>RETURN THIS COPY TO THIS OFFICE – RETAIN A COPY FOR YOUR FILES</div> <div>The forgoing 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 located in the following link _____, for the President and Vice-President, Secretary or Treasurer, of this employer, as well as Partners and Limited Liability Company (LLC) Members. 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.</div>																																							
	<div>_____ (Name of Company)</div> <div>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)</div> <div>Subscribed and sworn to before me this _____ day of _____, 20_____.</div> <div>My Commission Expires _____ (Notary Public)</div> <div>(Notary Seal)</div>																																							



Bond # \_\_\_\_\_

Effective Date: \_\_\_\_\_

## **SURETY BOND FOR AN EMPLOYER CARRYING HIS OWN RISK FOR SELF-INSURED WORKERS' COMPENSATION SINGLE EMPLOYER**

KNOW ALL MEN BY THESE PRESENTS: That \_\_\_\_\_ a corporation  
duly incorporated under the laws of the State of \_\_\_\_\_, \_\_\_\_\_ as  
principal, and \_\_\_\_\_, a corporation duly incorporated under the  
laws of the State of \_\_\_\_\_, as surety, are held and firmly bound unto  
the State of Tennessee for the use and benefit of the employees of the principal and to the dependents of such  
employees in the sum of \_\_\_\_\_ dollars, current money of the United States  
to be paid to the State of Tennessee, to the payment whereof we hereby bind ourselves and each of us, our and each  
of our heirs, executors, successors and assigns, jointly and severally, firmly, by these presents.

Sealed with our seal and dated, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

WHEREAS, the above bounden \_\_\_\_\_ did on  
the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, file with the Commissioner of Insurance of the State of  
Tennessee, his, her, their or its application for the privilege under Section §50-6-405, Tennessee Code Annotated and  
any amendments thereto, being a part of the Workers' Compensation Insurance Law, Chapter 12, of Title 50,  
Tennessee Code Annotated, of paying compensation and operating under said Law without insuring the same; and

WHEREAS, the Commissioner of Commerce and Insurance did, on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_  
grant this privilege upon the condition that the said principal enter into a bond in the penalty sum of  
\$ \_\_\_\_\_ Dollars, conditioned, among other things, that said principal shall abide by and perform  
the requirements of the aforesaid Law and any amendments thereto, with reference to paying compensation and  
furnishing medical, surgical and other services and funeral expenses to said employees and their dependents;

NOW, THEREFORE, the condition of this obligation is such that if the above bounden \_\_\_\_\_  
Shall well and truly, from time to time, and at all times thereafter abide by and perform all requirements of the aforesaid  
Law and any amendments thereto, respecting the payment of compensation and furnishing at its own cost and expense,  
of medical, surgical and other services and funeral expenses to said employees and their dependents, then this  
obligation shall be void, otherwise to remain in full force and effect virtue in law.

This bond is and shall be construed to be a direct obligation by the principal and surety herein either jointly or severally,  
to the person who may be entitled to such sum for medical, surgical and other services, funeral expenses or  
compensation and may be sued upon and enforced in the name or names of such person or persons. This bond may be  
cancelled at any time by the surety upon giving thirty (90) days' written notice to the Commissioner of Commerce  
and Insurance of the State of Tennessee, in which event the liability of the surety shall, injury or death to any of its  
employees, as may have accrued prior to the expiration of said thirty days, it being understood that the surety shall be  
liable, within the penal sum mentioned herein, for the default of the principal in fully discharging any liability on its  
part accruing during the life of this obligation.

IN WITNESS WHEREOF, the said employer has caused these presents to be signed in its name by its president, and  
its corporate seal attached hereto, attested by its secretary, and the said surety has likewise caused these presents to be  
signed in its name by its president, and its corporate seal attached hereto, attested by its Secretary.

\_\_\_\_\_  
Secretary

\_\_\_\_\_  
Per \_\_\_\_\_  
President

\_\_\_\_\_  
Secretary

\_\_\_\_\_  
Per \_\_\_\_\_  
President or authorized officer of Surety Co.



I, \_\_\_\_\_, Secretary of the employer corporation aforesaid hereby certify that by resolution adopted on \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, the Board of Directors of the employer aforementioned directed and empowered the execution of this Bond.  
In witness whereof I hereunto set my hand and affix my officials seal. \_\_\_\_\_  
Secretary

(PLEASE ATTACH POWER OF ATTORNEY)  
(USE THIS FORM OF ACKNOWLEDGEMENT IF THE EMPLOYER IS A CORPORATION)

State of \_\_\_\_\_,  
\_\_\_\_\_ County.

This \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, personally came before me, \_\_\_\_\_, Notary Public of \_\_\_\_\_ County, State of \_\_\_\_\_, who being by me duly sworn says that he knows the common seal of \_\_\_\_\_ and is acquainted with \_\_\_\_\_ who is president of said corporation, and that he, the said \_\_\_\_\_, is the secretary of the said corporation and saw the said president sign the foregoing instrument, and saw the said common seal of said corporation affixed to said instrument by said president (or that he/she, the said \_\_\_\_\_ secretary as aforesaid, affixed said seal to said instrument), and that he/she, the said \_\_\_\_\_ signed his name in attestation of the execution of said instrument in the presence of said president of said corporation.

Witness my hand and official seal, this \_\_\_\_\_ the day of \_\_\_\_\_, 20\_\_\_\_

(Notary Seal)

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
My Commission Expires



## LETTER OF CREDIT FOR SELF-INSURED WORKERS' COMPENSATION SINGLE EMPLOYER

Clean Irrevocable Letter of Credit No. \_\_\_\_\_

Date: \_\_\_\_\_

Amount: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Applicant Names: \_\_\_\_\_

Applicant Address: \_\_\_\_\_

Beneficiary: Tennessee Dept. of Commerce and Insurance  
Insurance / Financial Affairs Section  
500 James Robertson Parkway  
Nashville, TN 37243  
**Attn: Self-Insured Workers' Compensation, Financial Affairs Section**

\_\_\_\_\_. (hereinafter referred to as "Applicant") and the Commissioner of the Tennessee Department of Commerce and Insurance (hereinafter referred to as "Commissioner").

Tennessee Department of Commerce and Insurance:

For the account of \_\_\_\_\_ we hereby establish our Clean Irrevocable Letter of Credit in the favor of the *Commissioner and /or Tennessee Department of Commerce and Insurance* for drawing up to the aggregate amount of U.S \$ \_\_\_\_\_ effectively immediately. This Letter of Credit, shall expire at \_\_\_\_\_ (**Pursuant to Tenn. Comp. Rules & Regulations 0780-1-83-.05(10)(a) issuing bank / Confirming Bank's name and address**) must be located in Tennessee at our close of business on \_\_\_\_\_ (Date).

The term "Beneficiary" includes any successor by operation of law of the named Beneficiary including, without limitation, the Commissioner, or subsequent liquidator, rehabilitator, receiver or conservator.

We hereby undertake to promptly honor your sight draft(s) drawn on us, indicating our Credit No. \_\_\_\_\_, for all or any part of this Letter of Credit if presented at \_\_\_\_\_ (**Pursuant to Tenn. Comp. Rule & Regulations 0780-1-83-.05(10)(a) issuing bank/confirming bank's name and address must be located in Tennessee**) on or before the expire date or any automatically extended expiry date.

We acknowledge that partial sight draft(s) may be submitted for less than the full amount of this Credit, the balance of which shall remain available for further sight draft(s) until the full amount set forth above, is exhausted.

Except as stated herein, this undertaking is not subject to any condition or qualification. Our obligation under this Letter of Credit shall be our individual obligation, in no way contingent upon reimbursement with respect hereto.



It is a condition of this Letter of Credit that it shall be deemed automatically extended for additional period without amendment, each of one (1) year, unless at least ninety (90) calendar days prior to the then relevant expiration date we have advised both the *Commissioner* of Commerce and Insurance and Applicant in writing, by Registered Mail, that we elect not to consider this Letter of Credit renewed for any such additional period. Failure to provide the required notice will result in an extension of this Letter of Credit until the Commissioner is given the required ninety (90) calendar days' notice.

In that event, you may draw hereunder on our prior to then relevant expiration date, up to the full amount then available hereunder, against your sight draft(s) on us, bearing the number of this Letter of Credit.

This Letter of Credit sets forth in full the terms of our undertaking, and such undertaking shall not in any way be amended or amplified by reference to any note, document, instrument or agreement referred to herein or in which this Letter of Credit is referred to or to which this Letter of Credit relates and any such reference shall not be deemed incorporated herein by reference to any note, document, instrument or agreement.

Should you have occasion to communicate regarding this Letter of Credit, specific reference to the Letter of Credit should be mentioned and all correspondence should be copied to the *Commissioner of Commerce and Insurance*, **Attn: Self-Insured Workers' Compensation**.

Except so far as otherwise expressly stated, this Letter of Credit is subject to the "Uniform Customs and Practice for Documentary Credits" fixed by the International Chamber of Commerce applicable as of the date of this Letter of Credit.

This letter of Credit is a security under Tenn. Code Ann. §50-6-405 and Tenn. Comp. Rules & Regulations. 0780-01-83 for the benefit of the Self-insurer's employees with the Department of Commerce and Insurance, State of Tennessee.

\_\_\_\_\_  
Name of Bank

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Bank Officer

\_\_\_\_\_  
Title of Bank Officer

*Subscribed and sworn to before me this* \_\_\_\_\_ *day of* \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_  
*Notary Public*

*My Commission Expires:* \_\_\_\_\_



**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 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)



**INDEMNITY AGREEMENT FOR SELF-INSURED WORKERS’  
COMPENSATION SINGLE EMPLOYER**

*(Complete if parent company is outside of the United States and a separate form for each subsidiary to be indemnified)*

KNOWN TO ALL PRESENT, that we \_\_\_\_\_ a corporation, organized and existing under and by virtue of the laws 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)