EMPLOYER’S APPLICATION FOR SELF INSURANCE
(Submit one completed copy)

To the DEPARTMENT OF LABOR:

The undersigned, an employer subject to the provisions of the Alabama Workers’ Compensation law, as last amended, hereby applies for the privilege of self-insuring the payment of compensation provided in that law, and submits the following facts under oath to the Department of Labor to enable it to determine if sufficient financial ability exists to render certain the payment of such compensation:

1. Name of Applicant _____________________________________________________________

2. Address _______________________________________________________________________

   P.O. Box _______________________________________________________________________
   (Number) (Street) (City or Town) (County) (State) (Zip)
   Telephone ( ) _____________________ AL U.C. Number ________________________________

   EMPLOYER IDENTIFICATION NUMBER ________________________________

3. The applicant is ________________________________________________________________
   (State whether individual, co-partnership, limited partnership, corporation, receiver or trustee)

4.briefly the general character of the operations performed and the articles manufactured or compounded at or away from the plant or premises of the applicant.

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

5. Description of employment:

<table>
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<tr>
<th>Location of Plant or Plants</th>
<th>Kind of Equipment</th>
<th>Estimated average number of employees at all points</th>
<th>Estimated average number of employees in Alabama</th>
<th>Estimated payroll of all Alabama employees for ensuing year</th>
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6. If a Corporation or Limited Partnership list below names of officers, directors, and residence of each:

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<tr>
<th>NAME</th>
<th>OFFICIAL TITLE</th>
<th>ADDRESS</th>
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7. If a Limited Partnership, give date of formation and duration ________________________________

8. If a Partnership, list below names of members and residence of each ________________________________

9. If Individual, give name and residence ________________________________

10. If a Corporation, answer the following: Chartered under the laws of the State of ________________________________

   Date of incorporation_________________ Authorized Capital Stock: (Common) $_________________

   (Preferred) $_________________

11. Is applicant a subsidiary? _______ Give name and address of parent company ________________________________

    (Subsidiaries must have separate applications and indemnity agreements)

12. If foreign corporation, give address of Home Office ________________________________

    ________________________________
13. Date when self-insurance is desired______________________________20____12:01 a.m.

14. Are you now complying with Section 25-5-8 of the Law, by carrying workers’ compensation insurance on your employees?  If so, indicate the name of the insurance company (not local agent) with whom you are insured.

______________________________________________________________

______________________________________________________________

15. What is the expiration date of your present policy?__________________________________

16. Are you now, or have you been within the past three years, an assigned risk for workers’ compensation insurance? (Give dates and details on separate page, if necessary)

______________________________________________________________

17. As a self-insurer, will you deal directly with your employees in workers’ compensation matters, or through an approved service organization?  If the latter method is to be used, give name and address of the organization.

______________________________________________________________

______________________________________________________________

18. Past three-year Accident Experience:  __________  __________  __________

Number of deaths  __________  __________  __________

Alabama Workers’ Compensation Premiums  $_______ $_______ $_______

Alabama Workers’ Comp Incurred Losses  $_______ $_______ $_______

19. Are there any outstanding unpaid judgments subject to execution rendered against the applicant under the provisions of the Workers’ Compensation Law, as last amended?  (Give amounts and details on separate page, if necessary)

______________________________________________________________

______________________________________________________________

______________________________________________________________
20. Applicant must attach audited or certified financial reports for the prior three years of operation.

21. Applicant must submit a $500.00 application fee with each application submitted.

Make payable to: Department of Labor Workers’ Compensation Administrative Trust Fund.

22. Name of excess insurance carrier (if any)________________________________________________________________________

Amount of Retention $__________ Specific, Aggregate, or both? ________________________________

23. Relate facts, covering past three years:

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<tr>
<th>Year Ending</th>
<th>Sales (Omit cents)</th>
<th>Expenses (including payroll)</th>
<th>Payroll</th>
<th>Profit or Loss (Specify)</th>
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24. Has the applicant, or its parent corporation, every filed for bankruptcy? _____ If yes, give details on separate sheet.

AGREEMENT CONDITIONS

25. In consideration of the approval of this application, the applicant expressly agrees:

(a) That this privilege may be revoked at any time in the discretion of the Secretary of Labor as provided in Section 25-58 (d1) of said Law, as amended.
(b) That the applicant will promptly furnish adequate hospital, medical, surgical, and burial benefits within the limits of the Law.
(c) That the applicant will discharge liability for compensation to injured employees or their dependents in accordance with said Law’s requirements.
(d) That reports will be promptly furnished the Department in strict accordance with Sections 25-5-4, 25-5-5 and 25-5-7 of said Law.
(e) That the applicant will not solicit, receive or collect from his employees, any part of the cost to him of operating under this Law.
(f) That the applicant will promptly notify the Department upon insuring his workers’ compensation liability with a private casualty insurance company, thereby cancelling his self-insurance privileges.

(g) That a copy of the company’s annual report, or statement of assets and liabilities, will be mailed to the Department at the close of each fiscal year, as evidence of continued financial ability to self-insure its liability under said Law.

(Signed)________________________________________

(Title)__________________________________________ STATE

OF __________________________ COUNTY OF __________________________

________________________________________, being first duly sworn, appeared personally and declared that the

facts set forth in the foregoing application are true to the best of his knowledge, information and belief. Subscribed

and sworn to before me, this _______ day of ________________________, 20____

(Notary Public) (SEAL) My commission

expires on the _______ day of ________________________, 20____