

# SELF-INSURER REQUEST TO ADD OR DELETE SUBSIDIARY/AFFILIATE

Michigan Department of Licensing and Regulatory Affairs  
 Workers' Compensation Agency  
 Self-Insured Programs  
 PO Box 30016  
 Lansing, MI 48909  
 www.michigan.gov/wca

Employer Records  _____	OFFICE USE ONLY Approved/Denied Effective  _____
-------------------------------	--

Name of Current Self-Insurer	Federal ID #
------------------------------	--------------

1. This is an  Addition  Deletion

2. Subsidiary/Affiliate

Name	Federal ID #		
Address	City	State	Zip Code

3. Entity to be added was chartered under the laws of the state of \_\_\_\_\_ on \_\_\_\_/\_\_\_\_/\_\_\_\_.

4. Michigan locations (attach additional sheets if necessary)

Name	Federal ID #		
Address	City	State	Zip Code

5. Effective date requested: \_\_\_\_/\_\_\_\_/\_\_\_\_

6. Reason for addition/deletion ("acquisition," "out of business," "sold," etc.)

## FOR ADDITIONS ONLY: COMPLETE THIS SECTION

R 408.43(3) of the Worker's Disability Compensation Act of 1969, as amended states: "Separate legal entities may be self-insured under a single authority if they are majority-owned by the self-insured entity submitting the application or if the same person or group of persons owns a majority interest in each entity on a single application."

7. Does the existing self-insured employer have a majority ownership in the entity that will become self-insured?

Yes  No      If Yes, % of ownership \_\_\_\_\_%

8. In the alternative, does the same person or group of persons own a majority interest in both the current self-insured and the entity to be added?  Yes  No      If Yes, attach additional sheets that list the person or group of persons who own a majority interest in each entity and their % of ownership.

**NOTE: If questions 7 and 8 have both been answered: "No," the entity does not qualify for self-insured authority with the current self-insured.**

9. Will a claims payment guaranty be furnished by parent or affiliate if required?  Yes  No

10. Total number of Michigan employees of entity to be added \_\_\_\_\_

11. Estimated amount of Michigan annual payroll for entity to be added \$ \_\_\_\_\_

12. If aggregate excess insurance is required for current program, estimate increase in retention \$ \_\_\_\_\_

**NOTE: Please attach financial statements for the new employer if not consolidated in financial statements of the primary self-insured employer.**

AUTHORIZED SIGNATURE	TITLE	DATE
----------------------	-------	------

LARA is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.

Authority: Worker's Disability Compensation Act of 1969, as amended  
 Completion: Mandatory  
 Penalty: Denial/Termination of Self-Insured Coverage