Print Reset

SELF-INSURER REQUEST
TO ADD OR DELETE SUBSIDIARY/AFFILIATE

Michigan Department of Labor and Economic Growth
Workers' Disability Compensation Agency
Self-Insured Programs
PO Box 30016
Lansing, MI 48909

www.michigan.gov/wcda

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

LEO 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 Status