STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION
Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

INSTRUCTION SHEET FOR FORM WC-21
APPLICATION FOR SELF-INSURANCE AUTHORIZATION

Instructions

Please completely fill out the WC-21 APPLICATION FOR SELF-INSURANCE AUTHORIZATION FORM.

The **Delivery Information** section below lists various delivery options. Please select the most convenient method and submit the completed form accordingly.

Please remember to sign and date the form before submitting it.

Delivery Information

Delivery by U.S. Mail
Department of Labor and Industrial Relations, Disability Compensation Division
P.O. Box 3769, Honolulu, Hawaii 96812-3769

Delivery In-Person
Department of Labor and Industrial Relations, Disability Compensation Division
Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

Delivery via Fax
Department of Labor and Industrial Relations, Disability Compensation Division
(808) 586-9219

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(Rev. 10/05)

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FORM WC-21 APPLICATION FOR SELF-INSURANCE AUTHORIZATION

To the Director of the Department of Labor and Industrial Relations (DLIR):

The undersigned, an employer, hereby makes application for permission to operate as a self-insurer pursuant to Chapter 386, Hawaii Revised Statutes, as amended, and in support of such application submits the following information:

1. Name of Applicant (if a corporation, show name exactly as it appears in the Charter or Articles of Incorporation.)	
Please Check: ☐Corporation ☐Partnership ☐Sole Proprietorship ☐Other	DOL Acct No - -
2. Mailing Address in Hawaii	
3. Location of other business locations in Hawaii	
4. Nature of Business	
5. Number of Employees in Hawaii	
6. Average monthly payroll in Hawaii for the past year	

7. If a Subsidiary Company:

(a) Name of Parent Company
Address
(b) Parent Company's Percentage of Stock Ownership

8. Will any of the applicant's operations be conducted under a name other than that shown in (1) above? _____ If yes, please provide

(a) Name
(b) Address
(c) Nature of Business

9. Date of Commencement of Business in Hawaii
10. Number of Hawaii employees to be covered by the proposed self-insurance plan

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11. Enter below the net profit or loss after taxes for the last five years.

Year	Amount
20	$
20	$
20	$
20	$
20	$

12. If this application is approved, it is proposed that the deposit of security required will be in the form of: (check one)
☐Surety Bond ☐Approved Securities

13. Individual who will sign or be responsible for obtaining signatures on the Self-Insurer's Annual Report and the surety bond or Agreement and Undertaking.

(a) Name	(b) Title
(c) Address	
(d) Telephone No. ( )	(e) Fax No. ( )

14. Complete the following relative to the applicant's Hawaii Workers' Compensation policies.

(a) Name					
(b) Title					
(c) Address					
(d) Telephone No. ( )			(e) Fax No. ( )		
Year	Payroll	Premium Before Dividend	Experience Modification	Losses Incurred	Loss Ratio

15. Has an application for workers' compensation insurance ever been rejected or a policy cancelled?
☐Yes ☐No

If yes, (a) On what date?

(b) Why?

(c) Name of Carrier

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16. Individual in your organization who will be responsible for your self-insurance program:

(a) Name
(b) Title
(c) Address
(d) Telephone No. ( )

17. Claims administration functions (claims adjusting, etc.) will be performed by:
☐(a) Self Insurer's Own Organization ☐(b) Outside of the Organization ☐(c) Other (explain)_____

18. Claims Administration:

(a) If by self-insurer's own organization:	
Name of Administrator	Title
Address	
Telephone No. ( )	
(b) If by an outside organization:	
Name of Organization	
Name of Administrator	
Address	
Telephone No. ( )	
(c) Will the administrator have the authority to promptly provide all benefits due? ☐Yes ☐No	
If no, explain limitations	

19. Will the claims administration functions be performed at more than one location? ☐Yes ☐No
If yes, on a separate page, please provide all information requested in item 18 above for each adjusting location.

20. Individual who will prepare the consolidated self-insurer's annual report.

Name	Title
Address	
Telephone No. ( )	Fax No. ( )

21. Self-insurer's annual report forms are to be mailed to: (check appropriate item)
☐(a) The individual administrators ☐(b) Consolidator of annual report ☐(c) Other (specify)_____

22. Will applicant's Workers' Compensation self-insurance program be supplemented by an insurance policy? ☐Yes ☐No
If so, a copy of the policy and any change in coverage should be filed with the Director of the DLIR.

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23. At the date of this application, is there any litigation or proceeding pending or threatened, the result of which might substantially adversely affect the financial condition, business, or operations of the applicant or any of its subsidiaries?
☐Yes ☐No

If yes, explain (If more space is needed, please attach another sheet.)

24. Required Attachments

(a) A current copy of the applicant's Independent Audit Report, complete with all schedules and notes, or upon written application, such other financial information as may be acceptable to the Director of the DLIR.

(b) If the report of the financial condition is dated more than twelve (12) months prior to the date of this application, the Director of the DLIR may require interim financial statements (Balance Sheet and Profit and Loss Statement) certified by the appropriate financial officers and dated not less than three (3) months from the date of this application.

(c) If a Corporation:
A copy of the resolution of the applicant corporation's Board of Directors authorizing the filing of an application for a certificate of consent to self-insurance and execution of the instrument of undertaking in furnishing security if required.

Dated:_____ , 20_____

_____

By:_____
(Owner, Partner or Officer)

State of _____)
)
) SS
)
_____)

_____, being first duly sworn, on oath states:

That he/she is the _____ of _____
(Owner, Partner or Officer) Name of Business

making this application to operate as a self-insurer under the Workers' Compensation Law of the State of Hawaii, that he/she has read the above application and the facts contained therein are true, that all allegations made in such application are for the purpose of inducing the Director of the DLIR to grant such application; and that the duties and responsibilities of the applicant under said law will be fully carried out at the time and in the manner therein provided.

Subscribed and sworn before me this _____ day of _____, 20_____.

_____

Notary Public, _____ Judicial Circuit

State of _____

My commission expires _____

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