State of California
Department of Industrial Relations
Office of Self Insurance Plans
11050 Olson Drive, Suite 230
Rancho Cordova, CA 95670
Phone (916) 464-7000
FAX (916) 464-7007

Our File: ____________

APPLICATION FOR A PUBLIC ENTITY CERTIFICATE OF CONSENT TO SELF INSURE

NOTE: All questions must be answered. If not applicable, enter "N/A".
Workers' compensation insurance must be maintained until certificate is effective.

APPLICANT INFORMATION

Legal Name of Applicant (show exactly as on Charter or other official documents):
El Dorado County

Street Address of Main Headquarters:
330 Fair Lane

Mailing Address (if different from above):

Federal Tax ID No.: 94-6000511

City, State, Zip Code
Placerville, CA, 95667

TO WHOM DO YOU WANT CORRESPONDENCE REGARDING THIS APPLICATION ADDRESSED?

Name: Jason Hunter Title: Risk Manager

Company Name: El Dorado County

Mailing Address: 330 Fair Lane

City: Placerville State: CA Zip + 4: 95667

Telephone Number: (530) 621-6084 Email: jason.hunter@edcgov.us

Type of Public Entity (check one):

☒ City and/or County ☐ School District ☐ Police and/or Fire District ☐ Hospital District ☐ Joint Powers Authority

☐ Other (describe): ____________

Type of Application (check one):

☐ New Application ☐ Reapplication due to Merger or Unification ☐ Reapplication due to Name Change

☒ Other (describe) Reapplication due to dissolution of JPA

Date Self Insurance Program will begin: ____________

Form No. A4-2 (2/92)

CURRENT PROGRAM FOR WORKERS' COMPENSATION LIABILITIES

☐ Currently Insured with State Compensation Insurance Fund, Policy Number:

Policy Expiration Date: ______________ Yearly Premium: $ ______________

Current Yearly Incurred (paid & unpaid) Losses: $ ______________ (FY or CY)

☒ Currently Self Insured, Certificate Number: 5015-001

Name of Current Certificate Holder: El Dorado County Risk Management Authority

☐ Other (describe): ______________

JOINT POWERS AUTHORITY

Will the applicant be a member of a workers' compensation Joint Powers Authority for the purpose of pooling workers' compensation liabilities?

☐ Yes ☒ No If yes, then complete the following:

Effective date of JPA Membership: N/A JPA Certificate No.: N/A

Name and Title of JPA Executive Officer:
N/A

Name of Joint Powers Authority Agency:
N/A

Mailing Address of JPA:
N/A

City: State: Zip + 4:
N/A

Telephone Number: N/A

PROPOSED CLAIMS ADMINISTRATOR

Who will be administering your agency's workers' compensation claims? (check one)

☐ JPA will administer, JPA Certificate No.: ______________

☒ Third party agency will administer, TPA Certificate No.: ______________

☐ Public entity will self administer ☐ Insurance carrier will self administer

Name of Individual Claims Administrator:
Dori Zumwalt

Name of Administrative Agency:
York Risk Services Group, Inc.

Mailing Address:
P.O. Box 619079

City: State: Zip + 4:
Roseville, CA 95661

Telephone Number: (800) 922-5020 FAX Number: (866) 548-2637

Number of claims reporting locations to be used to handle the agency's claims: 1

Will all agency claims be handled by the administrator listed on previous page? ☒ Yes ☐ No

AGENCY EMPLOYMENT

Current Number of Agency Employees: 1932

Number of Public Safety Officers (law enforcement, police or fire): 278

If a school district, number of certificated employees: N/A

Will all agency employees be included in this self insurance program? ☒ Yes ☐ No
If no, explain who is not included and how workers' compensation coverage is to be provided to the excluded agency employees:

INJURY AND ILLNESS PREVENTION PROGRAM

Does the agency have a written Injury and Illness Prevention Program? ☒ Yes ☐ No

Individual responsible for agency Injury and Illness Prevention Program:
Name and Title:
Jason Hunter

Company or Agency Name:
El Dorado County

Mailing Address:
330 Fair Lane

City: State: Zip + 4:

Placerville, CA,95667

Telephone Number: (530) 621-6084

SUPPLEMENTAL COVERAGE

Will your self insurance program be supplemented by any insurance or pooled coverage under a standard workers' compensation insurance policy? ☐ Yes ☒ No

If yes, then complete the following:

Name of Carrier or Excess Pool: ______

Policy Number: ______

Effective Date of Coverage: ______

Will your self insurance program be supplemented by any insurance or pooled coverage under a specific excess workers' compensation insurance policy? ☒ Yes ☐ No

If yes, then complete the following:

Name of Carrier or Excess Pool: CSAC-EIA

Policy Number: EIA 14EWC-44

Effective Date of Coverage: 7/1/2014

Retention Limits: $300k - statutory

Will your self insurance program be supplemented by any insurance or pooled coverage under an aggregate excess (stop loss) workers' compensation insurance policy? ☐ Yes ☒ No

If yes, then complete the following:
Name of Carrier or Excess Pool: ____________________

Policy Number: ____________________

Effective Date of Coverage: ____________________

Retention Limits: ____________________

RESOLUTION OF GOVERNING BOARD

See Attached Resolution-Page 5

CERTIFICATION

The undersigned on behalf of the applicant hereby applies for a Certificate of Consent to Self Insure the payment of workers' compensation liabilities pursuant to Labor Code Section 3700. The above information is submitted for the purpose of procuring said Certificate from the Director of Industrial Relations, State of California. If the Certificate is issued, the applicant agrees to comply with applicable California statutes and regulations pertaining to the payment of compensation that may become due to the applicant's employees covered by the Certificate.

Signature of Authorized Official: ____________________

Date: ____________________

Typed Name: ____________________

Title: ____________________

Agency Name: ____________________

Seal

(Emboss seal above or Notarize signature)