



SI Carrier #: _____

Effective Date: _____

FORM 7

APPLICATION FOR EMPLOYER TO INDIVIDUALLY SELF-INSURE

1. Self-Insured Business Name: _____
2. Self-Insured Street Address: _____
3. Self-Insured City, State and Zip Code: _____
4. Self-Insured Phone Number: (____) _____
5. Self-Insured FEIN: _____
6. The Self-Insured listed above is a (check one):
 - ☐ (A) Corporation: Attach a list of officers and their residential addresses
 - ☐ (B) Partnership: Attach a list of officers and their residential addresses
 - ☐ (C) Sole Proprietorship: Name and Address:

7. Are you now self-insured for workers' compensation in other states? ☐ YES ☐ NO
If yes, list states and effective dates: _____
8. Do you have applications to self-insure pending in other states? ☐ YES ☐ NO
If yes, list states: _____
9. In the most recent fiscal year, what was your workers' compensation premium and experience modification for South Carolina?
Premium Amount: _____
Experience Modification: _____
Name of Present Carrier: _____
10. Total number of employees company-wide: _____
11. If a corporation or limited partnership, list the names of officers, directors, and residence of each. If a partnership, list the names of members and residence of each (provide an attachment, if necessary).



12. If a corporation what was the: Date of charter: _____ State charter was obtained in: _____

13. Provide the following information for workers' compensation claims information for South Carolina for the three most recent years:

Year	Number of Claims	Amount Paid			Amount Incurred		
		Medical	Indemnity	Total	Medical	Indemnity	Total
				\$			\$
				\$			\$
				\$			\$
				\$			\$

14. Name, title, physical/mailling address, email address, and telephone number for contact person for claims administration:

15. Name, title, physical/mailling address, email address, and telephone number for contact person for self-insurance related issues or questions. This is the person who will be the main point of contact for anything related to self-insurance for the employer. This is also the address where all self-insurance related correspondence will be mailed.

In consideration for the approval of this application, the applicant agrees to fully comply with the terms of the South Carolina Workers' Compensation Commission Act and Regulations.

I certify and attest under penalty of perjury, under South Carolina laws, that I have thoroughly reviewed the information above and know its contents to be true, accurate and complete.

Print Name & Title

Date

Signature

MAKE APPLICATION FEE CHECK PAYABLE TO SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

Complete and Return To:
South Carolina Workers' Compensation Commission
Director, Self-Insurance
1333 Main Street, Suite 500
Columbia, SC 29201

You may file, upload, and pay electronically now. Visit our website at www.wcc.sc.gov and click on FORMS, click E-FILE beside the form you want to submit electronically. If you do not see the option to E-FILE, that means that specific form isn't ready to be electronically filed at this time and please continue to file as you have been, until the option becomes available.



INSTRUCTIONS FOR COMPLETING FORM 7

Please attach the following along with this application;

1. \$250 application fee **AND**;
2. Description of the business, including operations and articles manufactured or services performed **AND**;
3. Description of your safety program **AND**;
4. Three years audited financial statements or 10K **AND** most recent quarterly report **AND**;
5. Excess insurance quotes for South Carolina **AND**;
6. Name of carrier or bank providing the required Surety Bond (Form 8) OR Irrevocable Letter of Credit (Form 8B) **AND**;
7. Statement describing proposed claims administration, including a copy of the claims service agreement. If handling claims in-house, provide resumes of claims staff and licensed adjuster(s).
8. FEIN Verification Letter (Form CP 575) that is issued by the IRS. This is also referred to as a Tax ID Certificate. In lieu of the form issued by the IRS, we may accept tax documents reflecting the FEIN for the business being added under the program.
9. Form 7A Corporate Guaranty filled out in its entirety for each subsidiary being added under the program. If you are not adding a subsidiary and are just self-insuring the parent company, you are not required to fill out a Form 7A. If there are physical locations in SC that should be covered for subsidiaries, **please submit a form for each address you are adding using the Change Request, which is also available on our website.**

Reserved for Commission Use Only

Approved by: _____ Effective Date: _____ Carrier #: _____