



SIF #: _____

Effective Date: _____

APPLICATION FOR MEMBERSHIP IN A SELF-INSURED FUND

1. Fund Name: _____
2. Applicant's Name: _____
3. Self-Insured Business Name: _____
4. Self-Insured Street Address: _____
5. Self-Insured City, State and Zip Code: _____
6. Self-Insured Phone Number: (____) _____
7. Self-Insured Federal Identification Number: _____
8. The Self-Insured 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:

- ☐ (D) Other: Explain _____

9. Who is your present workers' compensation insurance carrier?

10. In the most recent fiscal year, what was your workers' compensation premium and experience modification for South Carolina?

Premium Amount: _____

Experience Modification: _____

11. List all employment locations in South Carolina (provide an attachment, if necessary)

Locations

Number of Employees

Locations	Number of Employees
_____	_____
_____	_____
_____	_____

12. Provide the following information for workers' compensation claims information for South Carolina for the past 3 years:

Year	Number of Claims	Amount Paid	Amount Incurred



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13. Describe the nature of your business, including products manufactured, sold or services provided.

14. Provide the following information for the current year:

Employee Class Codes	Number of Employees	Estimated Payroll

15. Fill out the included Balance Sheet.

16. Attach a \$25 application fee. Make the check payable to the SC Workers' Compensation Commission

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.

If the applicant is approved, it is agreed upon and acknowledged that the applicant, along with the other members of the Fund, will be jointly and severally liable for any liability of the Fund which is incurred during the applicants' membership.

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 CHECKS PAYABLE TO SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

Complete and Return To:

South Carolina Workers' Compensation Commission
Director, Self-Insurance
PO Box 1715
Columbia, SC 29202-1715



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**Statement of Assets & Liabilities
(Balance Sheet)
for the purposes of membership approval**

Self-Insured Business Name _____

A. Current Assets

Cash on Hand.....	\$ _____
Cash in Bank.....	\$ _____
Notes Receivable.....	\$ _____
Other.....	\$ _____
Other.....	\$ _____
Total of Section A.....	\$ _____

B. Fixed Assets

Machinery/Tools.....	\$ _____
Real Estate.....	\$ _____
Investment.....	\$ _____
Other.....	\$ _____
Other.....	\$ _____
Total of Section B.....	\$ _____

C. TOTAL ASSETS (A+B).....

\$ _____

D. Current Liabilities

Accounts Payable.....	\$ _____
Other.....	\$ _____
Other.....	\$ _____
Total of Section D.....	\$ _____

E. Long Term Debt

Notes Payable.....	\$ _____
Bonded Indebtedness.....	\$ _____
Mortgage Indebtedness.....	\$ _____
Other.....	\$ _____
Other.....	\$ _____
Total of Section E.....	\$ _____

F. TOTAL LIABILITIES (D+E).....

\$ _____

G. APPLICANT'S NET WORTH (F-C).....

\$ _____

Signature of Applicant _____ Date _____

Note: Applications with negative net worth (line G) will be declined