South Carolina Workers' Compensation Commission
SELF-INSURANCE DIVISION
P.O. Box 1715 • 1612 Marion Street
Columbia, South Carolina 29202-1715
(803) 737-5706

APPLICATION FOR MEMBERSHIP IN A SELF-INSURED FUND

1. Fund Name: ____________________

2. Applicant's Name: ____________________

3. Applicant's Address ____________________

4. Applicant's Telephone Number: (____) ____________________

5. Employer's Federal Identification Number: ____________________

6. The Employer is a: (check one)

   ☐ (A) Corporation: Attach a list of officers and their residence address.

   ☐ (B) Partnership: Attach a list of officers and their residence address.

   ☐ (C) Sole Proprietorship: Name and Residence: ____________________

   ____

   ☐ (D) Other. Explain ____________________

7. Who is your present workers' compensation insurance carrier:

   ____

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

   Premium Amount: ____________ Experience Modification: ____________

9. List all employment locations in South Carolina.
   (provide attachment if necessary)

Locations	Number of Employees

10. Provide the following information for workers' compensation claims for South Carolina for the past three years.

Year	Number of Claims	Amount Paid	Amount Incurred

For further information, refer to Article 15 of the South Carolina Workers' Compensation Commission's Regulations.

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

____

12. Provide the following employment information for the current year.

Year __________

Employee Class Codes	Number of Employees	Estimated Payroll

13. Attach a current financial statement.

14. Attach a twenty-five dollar application fee. Make the check payable to the South Carolina Workers' Compensation Commission.

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

If the applicant is approved, it is agreed 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 in the Fund.

By: Applicant's Name: ______________________________

Signature: ______________________________

Sworn and subscribed before me
this __________ day of __________ year __________

Notary Public for: ______________________________

My commission expires: ______________________________

Reserved for Commission Use Only

Fund Number: __________ Effective Date: __________

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