STATE OF MARYLAND
WORKERS' COMPENSATION COMMISSION
10 East Baltimore Street · Baltimore · Maryland · 21202
(410) 864-5100 · (800) 492- 0479 web - http://www.wcc.state.md.us

SELF-INSURED EMPLOYER'S APPLICATION to ADD a SUBSIDIARY

Part I - General

a. Approved Self-insured Employer:

Name: _____ Federal ID Number: _____
Address: Street _____
City _____ State _____ ZIP Code _____
Telephone: _____ FAX: _____
Contact Person: _____
Email address: _____

b. Maryland Claims Administrator (*Not the Attorney of Record*):

Company name: _____
Address: Street _____
City _____ State _____ ZIP Code _____
Telephone: _____ FAX: _____
Representative Name: _____
Email address: _____

c. Applicant Subsidiary

◯ **Subsidiary** ◯ **Division** ◯ **Affiliate** ◯ **Other (explain)** _____

Name: _____ Federal ID Number: _____
Home Office Address: Street _____
City _____ State _____ ZIP Code _____
Telephone: _____ FAX: _____
Date Acquired: _____ Date of Incorporation: _____ Requested Effective Date: _____

Contact Person: _____
Email address: _____
Maryland Address: Street _____
City _____ State _____ ZIP Code _____
Telephone No: _____ FAX: _____

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Part II - Employment and Related Data

Principal workers compensation classification of employees : _____

Please provide the following information for the subsidiary for each year of the last three years prior to filing this application:

Dates		No. of Employees	Annual Maryland Payroll	Experience Modifier	Workers' Compensation Premiums
From	To				

For the last 12 months prior to filing this application, please provide the following for the subsidiary:

Classes of Employees (NCCI Codes)	No. of Employees (in each class)	Annual Payroll (for each class)

(If additional space is required, please attach a separate sheet clearly marking the name of the self-insured employer and the name of the subsidiary, affiliate or division.)

No. of Accidents (SF-1 issued): _____ during the last 12-month period ending: _____

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Total claims incurred, including medical and indemnity, both paid and additions to reserve, for the following:

Period Covered	TO	FROM	AMOUNT
The last 12 month period			
Prior 12 months			
Second Prior 12 months			

Part III - Certification

I certify that to the best of my knowledge and belief, the information contained in this application is true and correct.

Name of Approved Self-Insurer: _____

By: _____ _____
(Signature) (Printed Name)

Title: _____ Date: _____

NOTES: A. Provide the three most current years of audited financial statements for the subsidiary.

B. A $250.00 non-refundable fee, check made payable to MD Workers' Compensation Commission must accompany this application.

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