Exemption No._____

FORM 290

STATE OF NEW JERSEY
DEPARTMENT OF BANKING AND INSURANCE

EMPLOYER'S APPLICATION FOR EXEMPTION FROM INSURING ALL OR PART OF ITS COMPENSATION LIABILITY

(As provided by N.J.S.A 34:15-77)

An application filed by an applicant for self-insurance under the workers' compensation law does not cover any of its subsidiary corporations. New Jersey requires that each corporation desiring to self-insure under the Workers' Compensation Law file its own individual application. If additional applications are needed, they will be sent upon request.

Name of Applicant_____

Address _____

Incorporated or organized under the laws of the State of _____ on _____

Applicant's Federal Employer Identification Number (FEIN) _____

Registered under the Securities Act of 1933 (15 U.S.C. Sec. 77 et seq.) Yes ☐ No ☐

Nature of business _____
(Retail, Manufacturing, Engineering, Construction, etc)

If the applicant is a subsidiary, complete the following:

Exact legal name of the ***ultimate parent*** _____

Date parent incorporated _____ State _____ FEIN _____

Has an application for workers' compensation insurance ever been refused or a policy canceled? Yes ☐ No ☐
If yes, attach an explanation of circumstances including date, name of jurisdiction, and name of carrier.

Has an application for self-insurance ever been denied or a certificate revoked? Yes ☐ No ☐
If yes, attach an explanation of circumstances including date and name of jurisdiction.

Is the applicant self-insured in any other jurisdiction? Yes ☐ No ☐
(If yes, see item 3 on page 3.)

Company contact for self-insurance: (Applicant) _____
Title:_____

Street address:_____

Mailing address:_____

Phone:_____ Fax:_____ Email_____

Proposed Third Party Claims Administrator (If applicable). Name of company:_____

Contact person and Title:_____

Street address:_____

Mailing address:_____

Phone:_____ Fax:_____ Email_____

Proposed Excess Insurance Carrier:_____
Policy Period:_____
Policy Limits:_____
Retention Amount:_____

Exemption No._____

The applicant agrees to discharge faithfully and promptly all payments and obligations which are now due or shall become due under the provisions of Title 34 , Chapter 15 of the "Revised Statutes" of New Jersey; to furnish to the Commissioner of Banking and Insurance such further information as is from time to time requested as a condition to the privilege of going without insurance; and to advise the said Commissioner of Banking and Insurance immediately of any accident resulting fatally to two or more employees.

_____

(Signature of Applicant Employer)

By_____

(Name)

Dated at _____, _____, 20____

AFFIDAVIT

(The person subscribing to the below affidavit should be the employer himself; or if the employer is a partnership, one of the partners; or if the employer is a corporation, its president, vice president, secretary or treasurer.)

STATE OF NEW JERSEY

County of _____

_____first being duly sworn on oath deposes and says that he is acquainted with the affairs of the above-mentioned applicant employer, to which representations and statements set forth in the foregoing application relate; that he has read the application, knows the contents thereof and that said representations and statements therein contained are true to the best of his knowledge and belief.

Subscribed and sworn to me at

_____(City/State) >

This_____day of > **SEAL**

_____,A.D. 20_____>

_____

(Signature)

_____

(Official Title)

Exemption No._____

ATTACHMENTS

Attachments detailed below are required and must be provided before the application is considered complete. **Failure to comply may result in your application processing being delayed.**		
1	Provide an organizational chart showing the hierarchial position of subsidiaries to be covered under this certificate in relation to the ultimate parent. For each entity provide the legal name, date and state of incorporation, FEIN, and SIC code. Provide the applicable d/b/a's of any operating divisions. Clearly indicate which entities with operations in this state are seeking coverage.	
2	Provide audited financial statements (annual reports) with accompanying footnotes and auditors' opinion, and 10K's, if applicable, for the three most current years. Include most current 10-Q.	
3	Provide a list of all other Self-Insured Jurisdictions and the amounts of security deposits on file.	
4	Provide a narrative description of the safety program components for your operations in this state.	
5	Provide Loss Runs (open and closed claims) for the three most current years**.**	
6	Completed Supplement 1 (see attached)	

Exemption No._____

FORM 290

Supplement 1

Exhibit of Locations of Shops and other Workplaces, Number of Employees, Payrolls and Description of Operations in New Jersey

This report covers the latest fiscal period of the Employer extending from _____to_____

Location of Factory, Office or other work place by town, city or other designation	Estimated Average Number of Employees at each Location	Division of Operations (Payroll and number of employees are to be given on separate lines for each operation at each location)	Actual Payroll Expenditure for past Year
			$

(Attach additional copies if needed)

Total estimated average number of employees (worldwide)_____, and total payroll expenditure in the past year (worldwide) $_____ for *all* operations wherever conducted.