

**DIVISION OF LABOR AND MANAGEMENT**

123 W. Missouri Ave. Pierre, South Dakota 57501  
Tel: 605.773.3681 Fax: 605.773.4211 dlr.sd.gov

**APPLICATION TO SELF-INSURE WORKERS' COMPENSATION LIABILITIES**

This application is for approval to self-insure workers' compensation liabilities from September 1, 2026 to August 31, 2027. If the application is being made after September 1, 2026, the Certificate of Exemption will be valid only from the date of execution until August 31, 2027. A renewal application will be required for self-insurance during the 2026/2027 year.

This is an application for employers seeking to self-insure workers' compensation in South Dakota. The attached schedules are to facilitate the submission of proof of solvency and financial ability to compensate under the provision of the Workers' Compensation Law of South Dakota.

***Answer all applicable questions fully. Specifically indicate N/A in any areas not applicable. If you are not completing this application electronically, please use black ink or type. If any questions are left unanswered, the application may be returned for completion, causing a delay in approval. When printing the .xls version, be sure to print ALL TABS.***

**1. STATEMENT OF EMPLOYER IN SUPPORT OF APPLICATION**

TO: State of South Dakota, Department of Labor and Regulation  
Division of Labor and Management  
123 W. Missouri Ave.  
Pierre, South Dakota 57501-2291  
Phone: 605.773.3681

The undersigned, having elected to remain under the provisions of the Workers' Compensation Law, hereby agrees to provide and pay all legal obligations under the Workers' Compensation Law, including but not limited to compensation for the injuries to employees as required by Title 62 of the South Dakota Codified Laws or as may be awarded by the South Dakota Department of Labor and Regulation. In making application for exemption from the insurance provisions of SDCL 62-5-1, the applicant hereby submits evidence of solvency and financial ability to pay compensation and other obligations contemplated.

**(1.1) Name, address, city, state, zip+4, and a valid email address**

Name: \_\_\_\_\_ Email: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip+4 \_\_\_\_\_

**(1.2) Federal Identification Number of applicant.**

**(1.3) Names and addresses, including ZIP + 4, of all businesses to be self-insured in South Dakota (if necessary, additional businesses may be added on "Additional Notes" tab).A35**

**(1.4) Federal Identification Number of all businesses to be self-insured in South Dakota.**

**(1.5) Nature of businesses.**

**(1.6) Are all businesses listed on application authorized to operate in South Dakota?**

Yes

No

**(1.7) Name and address, including ZIP + 4, of person in South Dakota on whom legal service can be made.**

**(1.8) Name(s), address(es), and title of owner(s), partners or senior corporate officers.**

**2. COMPANY BACKGROUND**

(2.1) Date Established.

(2.2) If incorporated, under laws of what state?

(2.3) Did firm succeed another firm?  Yes

No

(2.4) If yes, state whom and date of transition.

(2.5) Name(s) and address(es) of parent, subsidiary, and affiliate companies if any. Please specify affiliation.

(2.6) Is the parent, subsidiary or affiliated company guaranteeing the workers' compensation of the applicant?

Yes

No

*\*If yes, attach notarized Assumption of Self-Insurance Obligations form.*

*\*If no, the financial data below should relate only to the*

*entities to be self-insured and the guarantor.*

*entities to be self-insured.*

(2.7) List all subsidiaries and affiliates to be self-insured and state the self-insurance retention limit on each. If necessary, additional subsidiaries and affiliates may be added on "Additional Notes" tab.

(2.8) List name and address, including ZIP + 4, of all administrative branch offices and/or locations in South Dakota (if necessary, use Additional Notes tab). If applicable, specify which are subsidiaries and which are divisions of the applicant.

**3. FINANCIAL DATA**

Please provide audited annual financial statements for the three (3) most recent years. If audited annual financial statements are not available, please provide a balance sheet, income statement and statement of change in financial position for each year.

If the most recent audited annual financial statement does not report your financial position at a date within six (6) months of the beginning of the self-insurance year (September 1, 2024), provide an interim financial statement.

#### 4. INSURANCE INFORMATION

(4.1) Has applicant been approved by the South Dakota Department of Labor and Regulation to self-insure its workers' compensation liabilities in the State of South Dakota prior to this application?

Yes  No

(4.2) If yes, date applicant commenced self-insurance.

(4.3) Has applicant carried workers' compensation insurance in South Dakota during any or all of the last three years?

Yes  No

(4.4) If yes, please attach the name of insurer and attach declaration pages or binder for each policy showing policy effective date, experience modifications, and South Dakota class codes and payroll.

(4.5) If no, has applicant been an approved self-insurer during the last three (3) years?  Yes  No

(4.6) If no, how was workers' compensation coverage provided?

(4.7) Expiration date of workers' compensation policy now in effect.

(4.8) Is applicant authorized to self-insure its workers' compensation liability in any other states?

Yes  No

(4.9) If yes, please list the name of each state. If necessary, additional states may be added on "Additional Notes" tab.

(4.10) Has applicant ever been denied authority to self-insure its workers' compensation or other liability in any state, or has such authority ever been revoked or suspended?  Yes  No

(4.11) If yes, please list state(s) and date(s) (including South Dakota).

(4.12) Please fill out the Retention Limits Form below:

Year	Per Occurrence		Aggregate		Excess Insurer	Effective Date
	Retention	Excess* Limit	Retention	Coverage Limit		
2019						
2020						
2021						
2022						
2023						

\*Dollar Limit or "Statutory"

(4.13) Please provide a copy of Certificate of Insurance for the most recent year to verify excess coverage levels and insurers.

(4.14) Does the applicant intend to maintain excess coverage through the upcoming self-insurance year (September 1, 2025, to August 31, 2026)?  Yes  No

**5. ADMINISTRATION OF SELF-INSURANCE PROGRAM**

(5.1) If workers' compensation liabilities are currently self-insured, have you provided a scheme of compensation benefits whereby your South Dakota employees receive benefits that equal or exceed the benefits set forth in Title 62 (Workers' Compensation) of the South Dakota Codified Laws?

Yes  No

(5.2) If so, please submit a copy of that plan.

(5.3) If you do not have a specific scheme of compensation, is it your intent to simply follow the statutory benefit requirements?

Yes  No

(5.4) How is/will the self-insured workers' compensation claim experience be reflected in the applicant's financial statements?

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(5.5) Is the claim reserve a separate line item in the financial statement?  Yes  No

(5.6) Does the claim reserve include a provision for incurred but not reported (IBNR) claims?

Yes  No

(5.7) Is the claim reserve, if established, reflected on the balance sheet?  Yes  No

(5.8) If yes, where?

(5.9) If the response to any of the immediately preceding questions is negative (No), please provide a response from your auditor regarding FASB 112 compliance.

(5.10) How are case reserves established?

(5.11) Key Claim Administrator

Name and Title	
Name of Firm	
Address	
Telephone Number	

(5.12) Indicate whether the following services are provided in-house or by an independent contractor.

<u>Services Provided</u>	<u>In-House</u>	<u>Contracted</u>
Accounting and Record Retention	_____	_____
Actuarial	_____	_____
Claims Administration	_____	_____
General Administration	_____	_____
Insurance	_____	_____
Legal	_____	_____
Loss Control/Safety	_____	_____
Rehabilitation	_____	_____
Risk Analysis/Management	_____	_____

(5.13) Individual responsible for paying your claims.

Name and Title	_____
Name of Firm	_____
Address	_____
Telephone Number	_____

(5.14) Does this person have authority to pay all claims?

Yes       No

(5.15) If no, please specify limits.

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**6. EMPLOYEE AND PAYROLL DATA**

(6.1) Total number of persons now employed in South Dakota.

(6.2) As of what date?

(6.3) Usual number of employees in South Dakota.

(6.4) Highest number of employees at one time in South Dakota during the last calendar year (2025).

(6.5) Total number of employees nationwide.

(6.6) As of what date?

(6.7) Actual payroll during each of the last three (3) calendar years. These figures must be from January 1 to December 31. Please provide a best estimate of the total wages to be paid in 2026 and 2027.

<u>Year</u>	<u>Payroll in South Dakota</u>	<u>Nationwide Payroll</u>
2023	<hr/>	<hr/>
2024	<hr/>	<hr/>
2025	<hr/>	<hr/>
Proj. 2026	<hr/>	<hr/>
Proj. 2027	<hr/>	<hr/>

(6.8) Provide South Dakota payroll for the last two (2) calendar years and projected for the current year and next year broken down by class code. Please use class code numbers only.

**Total South Dakota**

<u>Year</u>	<u>Class Code</u>	<u>Payroll by Code</u>
2024	<hr/>	<hr/>
	<hr/>	<hr/>
	<hr/>	<hr/>
	<hr/>	<hr/>
	<hr/>	<hr/>
	<hr/>	<hr/>
	<hr/>	<hr/>
	<hr/>	<hr/>

<u>Year</u>	<u>Class Code</u>	<u>Payroll by Code</u>
2025	<hr/>	<hr/>
	<hr/>	<hr/>
	<hr/>	<hr/>
	<hr/>	<hr/>
	<hr/>	<hr/>
	<hr/>	<hr/>
	<hr/>	<hr/>
	<hr/>	<hr/>

<u>Year</u>	<u>Class Code</u>	<u>Payroll by Code</u>
Proj. 2026	<hr/>	<hr/>
	<hr/>	<hr/>
	<hr/>	<hr/>
	<hr/>	<hr/>
	<hr/>	<hr/>
	<hr/>	<hr/>
	<hr/>	<hr/>
	<hr/>	<hr/>

<u>Year</u>	<u>Class Code</u>	<u>Payroll by Code</u>
Proj. 2027	<hr/>	<hr/>
	<hr/>	<hr/>
	<hr/>	<hr/>
	<hr/>	<hr/>
	<hr/>	<hr/>
	<hr/>	<hr/>
	<hr/>	<hr/>
	<hr/>	<hr/>

**7. LOSS DATA**

Provide a history of all self-insured South Dakota losses and claim counts by accident year that have occurred up to 12/31/25, going back 12 valuation (accident) years. If applicant has not been self-insured for 12 years, provide the experience covered by private insurance if available. An accident year consists of all claims occurring during a 12-month period regardless of when the claim is reported. Please provide the following through each valuation date:

- Total number of closed counts on a **cumulative** basis
- Number of open claims on an **incremental** basis
- Total value of paid losses on a **cumulative** basis
- Total estimated case reserves on an **incremental** basis

For example, if accidents occurred in 1998 and \$500 had been paid on the claims by December 31, 1998, enter \$500 in the 1998 row under the 12/31/98 valuation date column. If during 1999, an additional \$250 was paid for accidents occurring in 1998, and \$1,000 for accidents occurring during 1999, then the following entries would be made under the 12/31/99 valuation date column: \$750 in the row for the accident year 1998 (\$500 from the preceding column plus \$250 paid during 1999) and \$1,000 in the row for the accident year 1998.

**Accident**

Year	12/31/1997	12/31/1998	12/31/1999
1997			
1998	XXXXXX	500	750
1999	XXXXXX	XXXXXX	1,000

Note: This cumulating process does not apply to the number of open claims or the outstanding case reserves. Other year valuation dates and other 12-month accident periods can be used if desired instead of those indicated as long as the changes are applied uniformly and indicated clearly.

Please be aware that if you choose to provide reported data too, it should be on a cumulative basis. Also make sure that for each specific entry, the sum of the case reserves and paid losses should equal the respective entry in the reported data. The same applies for paid, open and reported counts.

**(7.1) MEDICAL ONLY PAID CLAIM COUNT (CLOSED)**

Valuation Date \_\_\_\_\_

**Accident**

Year	12/31/2014	12/31/2015	12/31/2016	12/31/2017	12/31/2018	12/31/2019	12/31/2020	12/31/2021	12/31/2022	12/31/2023	12/31/2024	12/31/2025
2014												
2015	XXXXXX											
2016	XXXXXX	XXXXXX										
2017	XXXXXX	XXXXXX	XXXXXX									
2018	XXXXXX	XXXXXX	XXXXXX	XXXXXX								
2019	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX							
2020	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX						
2021	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX					
2022	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX				
2023	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX			
2024	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX		
2025	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	

**(7.2) LOST TIME PAID CLAIM COUNT (CLOSED)**

Valuation Date \_\_\_\_\_

Accident

Year	12/31/2014	12/31/2015	12/31/2016	12/31/2017	12/31/2018	12/31/2019	12/31/2020	12/31/2021	12/31/2022	12/31/2023	12/31/2024	12/31/2025
2014												
2015	XXXXXX											
2016	XXXXXX	XXXXXX										
2017	XXXXXX	XXXXXX	XXXXXX									
2018	XXXXXX	XXXXXX	XXXXXX	XXXXXX								
2019	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX							
2020	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX						
2021	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX					
2022	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX				
2023	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX			
2024	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX		
2025	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	

**(7.3) TOTAL PAID CLAIM COUNT (CLOSED): (7.3) = (7.1) + (7.2)**

Valuation Date \_\_\_\_\_

Accident

Year	12/31/2014	12/31/2015	12/31/2016	12/31/2017	12/31/2018	12/31/2019	12/31/2020	12/31/2021	12/31/2022	12/31/2023	12/31/2024	12/31/2025
2014												
2015	XXXXXX											
2016	XXXXXX	XXXXXX										
2017	XXXXXX	XXXXXX	XXXXXX									
2018	XXXXXX	XXXXXX	XXXXXX	XXXXXX								
2019	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX							
2020	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX						
2021	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX					
2022	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX				
2023	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX			
2024	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX		
2025	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	

**(7.4) MEDICAL ONLY OPEN CLAIM COUNT**

Accident

Year	12/31/2014	12/31/2015	12/31/2016	12/31/2017	12/31/2018	12/31/2019	12/31/2020	12/31/2021	12/31/2022	12/31/2023	12/31/2024	12/31/2025
201												
201	XXXXXX											
201	XXXXXX	XXXXXX										
201	XXXXXX	XXXXXX	XXXXXX									
201	XXXXXX	XXXXXX	XXXXXX	XXXXXX								
201	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX							
20	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX						
202	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX					
202	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX				
202	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX			
202	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX		
202	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	

**(7.5) LOST TIME OPEN CLAIM COUNT**

Valuation Date

Accident

Year	12/31/2014	12/31/2015	12/31/2016	12/31/2017	12/31/2018	12/31/2019	12/31/2020	12/31/2021	12/31/2022	12/31/2023	12/31/2024	12/31/2025
201												
201	XXXXXX											
201	XXXXXX	XXXXXX										
201	XXXXXX	XXXXXX	XXXXXX									
201	XXXXXX	XXXXXX	XXXXXX	XXXXXX								
201	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX							
20	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX						
202	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX					
202	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX				
202	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX			
202	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX		
202	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	

**(7.6) TOTAL OPEN CLAIM COUNT: (7.6) = (7.4) + (7.5)**

Accident

Year	12/31/2014	12/31/2015	12/31/2016	12/31/2017	12/31/2018	12/31/2019	12/31/2020	12/31/2021	12/31/2022	12/31/2023	12/31/2024	12/31/2025
201												
201	XXXXXX											
201	XXXXXX	XXXXXX										
201	XXXXXX	XXXXXX	XXXXXX									
201	XXXXXX	XXXXXX	XXXXXX	XXXXXX								
201	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX							
20	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX						
202	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX					
202	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX				
202	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX			
202	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX		
202	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	

**(7.7) TOTAL REPORTED CLAIM COUNT: (7.7) = (7.3) + (7.6)**

Valuation Date

Accident

Year	12/31/2014	12/31/2015	12/31/2016	12/31/2017	12/31/2018	12/31/2019	12/31/2020	12/31/2021	12/31/2022	12/31/2023	12/31/2024	12/31/2025
201												
201	XXXXXX											
201	XXXXXX	XXXXXX										
201	XXXXXX	XXXXXX	XXXXXX									
201	XXXXXX	XXXXXX	XXXXXX	XXXXXX								
201	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX							
20	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX						
202	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX					
202	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX				
202	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX			
202	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX		
202	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	

**(7.8) TOTAL PAID LOSSES**

Accident

Year	12/31/2014	12/31/2015	12/31/2016	12/31/2017	12/31/2018	12/31/2019	12/31/2020	12/31/2021	12/31/2022	12/31/2023	12/31/2024	12/31/2025
2014												
2015	XXXXXX											
2016	XXXXXX	XXXXXX										
2017	XXXXXX	XXXXXX	XXXXXX									
2018	XXXXXX	XXXXXX	XXXXXX	XXXXXX								
2019	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX							
2020	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX						
2021	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX					
2022	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX				
2023	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX			
2024	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX		
2025	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	

**(7.9) OUTSTANDING KNOWN CASE RESERVES**

Valuation Date

Accident

Year	12/31/2014	12/31/2015	12/31/2016	12/31/2017	12/31/2018	12/31/2019	12/31/2020	12/31/2021	12/31/2022	12/31/2023	12/31/2024	12/31/2025
2014												
2015	XXXXXX											
2016	XXXXXX	XXXXXX										
2017	XXXXXX	XXXXXX	XXXXXX									
2018	XXXXXX	XXXXXX	XXXXXX	XXXXXX								
2019	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX							
2020	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX						
2021	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX					
2022	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX				
2023	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX			
2024	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX		
2025	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	

**(7.10) TOTAL REPORTED INCURRED LOSS: (7.10) = (7.8) + (7.9)**

Accident	<hr/>											
Year	12/31/2014	12/31/2015	12/31/2016	12/31/2017	12/31/2018	12/31/2019	12/31/2020	12/31/2021	12/31/2022	12/31/2023	12/31/2024	12/31/2025
201												
201	XXXXXX											
201	XXXXXX	XXXXXX										
201	XXXXXX	XXXXXX	XXXXXX									
201	XXXXXX	XXXXXX	XXXXXX	XXXXXX								
201	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX							
20	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX						
202	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX					
202	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX				
202	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX			
202	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX		
202	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	
202	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX

**(7.11) NATIONWIDE TOTAL INCURRED LOSS**

Valuation Date 

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Accident	<hr/>											
Year	12/31/2014	12/31/2015	12/31/2016	12/31/2017	12/31/2018	12/31/2019	12/31/2020	12/31/2021	12/31/2022	12/31/2023	12/31/2024	12/31/2025
201												
201	XXXXXX											
201	XXXXXX	XXXXXX										
201	XXXXXX	XXXXXX	XXXXXX									
201	XXXXXX	XXXXXX	XXXXXX	XXXXXX								
201	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX							
20	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX						
202	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX					
202	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX				
202	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX			
202	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX		
202	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	
202	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX	XXXXXX

(7.12) Are incurred but not reported (IBNR) reserves calculated specifically for South Dakota?

Yes  No

(7.13) If yes, please provide an accident year history of IBNR by evaluation date.

(7.14) How much did the applicant pay in workers' compensation self-insurance claims during the last calendar year or 12-month period, consistent with how the data is reported on the preceding pages?

(7.15) MEDICAL EXPENSES \_\_\_\_\_

(7.16) DISABILITY EXPENSES

Temporary Total	_____
Temporary Partial	_____
Permanent Total	_____
Permanent Partial	_____
Rehabilitation	_____
Death Benefits	_____
<b>TOTAL DISABILITY BENEFITS</b>	<b>_____</b>

(7.17) TOTAL DISABILITY + MEDICAL PAYMENTS \_\_\_\_\_

(7.18) How much loss reserve for self-insured workers' compensation exposure in South Dakota is reflected in the applicant's financial statement?

CASH RESERVES: \_\_\_\_\_

IBNR RESERVES: \_\_\_\_\_

TOTAL: \_\_\_\_\_

(7.19) Has the applicant had any claims that exceed or are expected to exceed the self-insurance retention under any excess insurance coverage?

Yes  No

(7.20) If yes, provide the amounts paid and incurred by accident year and valuation date for each such claim along with the applicable retention amount.

(7.21) If estimates of the South Dakota outstanding case reserves are not available, please provide a copy of the most recent loss run for the self-insured period.

(7.22) Please indicate Type and Dollar Amount of Security currently posted (please check all forms of security that apply)

<u>Type</u>	<u>Dollar Amount</u>	<u>Form of Security</u>
_____	_____	- Bond
_____	_____	- Cash
_____	_____	- Certificate of Deposit
_____	_____	- Triple A Rate Government Bonds
_____	_____	- Irrevocable Letter of Credit
_____	_____	- Irrevocable Trust Account
	Total _____	

(7.23) Person responsible for completing this application.

Name and Title \_\_\_\_\_  
Company \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone Number \_\_\_\_\_  
Email \_\_\_\_\_

(7.24) Person responsible for receiving correspondence, service and other information from the South Dakota Department of Labor and Regulation on the occasion that follow-up communications must be sent to a representative for the applicant.

Name and Title \_\_\_\_\_  
Company \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone Number \_\_\_\_\_  
Email \_\_\_\_\_

**NOTE:**

*SDCL 62-5-21 provides:*

*Effective January 1, 1997, any self-insured employer shall provide medical services and health care to injured workers for compensable injuries and diseases under a managed care plan that meets the requirements established by rules promulgated by the Department of Labor [and Regulation] pursuant to chapter 1-26.*

If you cannot fill this page out electronically, use the "Print This Page" button to the right to print and sign manually. Turn in this sheet with the remainder of your documents.

## 8. CONDITIONS OF EXEMPTION

In consideration of the approval of this application, the applicant hereby agrees as follows:

Applicant will provide surety for performance under the South Dakota Workers' Compensation Law as follows:

1. A bond, on the form attached;
2. Cash;
3. Certificate of Deposit;
4. Triple A rate government bonds;
5. Irrevocable Letter of Credit, on the form attached; or
6. Irrevocable Trust Account, on the form attached;

alone or in combination, in total amount equal to the greater of;

1. Two hundred fifty thousand dollars (\$250,000.00);
2. Twice the amount of compensation claims paid by the applicant during the preceding calendar year; or
3. The amount designated by the applicant as a reserve for workers' compensation claims.

Applicant agrees to furnish necessary information to support the correct amount of surety.

Applicant agrees to abide by all of the provisions of the Workers' Compensation Law of the State of South Dakota.

Applicant agrees to fully discharge the obligations required by the provisions of the Workers' Compensation Law.

The applicant further understands and agrees that:

The self-insurance privilege extended upon approval of this application applies only to the applicant and such businesses or subsidiaries that are included in this application.

Other businesses and subsidiaries may be included in the future under the applicant's self-insurance privilege upon written approval by the Department of Labor and Regulation. After submitting such fees and financial information, and entering into any indemnification that the Department of Labor and Regulation may require, approval may be granted.

The self-insurance privilege extended upon approval of this application will expire and terminate if the applicant is sold, merged, dissolved or otherwise changes its ownership interest to the extent that the financial conditions upon which approval was extended can no longer determine the applicant's financial ability to pay compensation benefits promptly in accordance with the law.

The South Dakota Department of Labor and Regulation must be notified immediately of any changes in corporate structure, service company contracted with for handling claims or loss control, changes in in-house personnel administering the program, or any changes in South Dakota locations included in this authority.

Failure to comply with any laws, regulations, rules or requirements as set out by the South Dakota Codified Laws, this application, or the South Dakota Department of Labor and Regulation may result in revocation or suspension of the privilege to self-insure.

Any employer wishing to continue to self-insure its workers' compensation liabilities under the provisions of Title 62 of the South Dakota Codified Law must annually furnish a statement of his or her financial condition, not later than the fifteenth (15th) day of July 2023. The certificate of exemption from the insurance requirements of the Workers' Compensation Law will expire on the last day of August of each year, unless the certificate is sooner revoked or suspended by the South Dakota Department of Labor and Regulation, and the permit must be renewed annually through filing of an application and financial statements. It is understood however, that the employer, upon giving the required notice, may waive this exemption from the insurance.

If any employer wishes to avail itself of the insurance exemption of the Workers' Compensation Law, it must annually file with the South Dakota Department of Labor and Regulation, proof as to its solvency and ability to pay the compensation, benefits, and fees provided by the law, and must submit financial statements as required. If the proof submitted is satisfactory and a sufficient showing is made, the applicant will be granted permission to operate as a self-insured employer, upon making the required deposit of securities with the Department of Labor and Regulation. If, however, it is found from the statement and the proof submitted, that it does not have the financial capacity for the payment of such compensation, benefits and fees, no certificate of exemption will be granted.

(8.1) STATE of \_\_\_\_\_

(8.2) COUNTY of \_\_\_\_\_

(8.3) I (we) hereby certify that the foregoing together with all statements or papers attached to and made a part hereof are true to the best of my (our) knowledge and belief, and (we) hereby bind myself (ourselves) and my (our) heirs, executors and assigns to the complete fulfillment of all agreements here-in contained.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 2026

\_\_\_\_\_

My commission expires \_\_\_\_\_

## 9. ADDITIONAL NOTES

Use this area for any additional notes you may have.







Empty rectangular box for additional notes.