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State of California
Department of Industrial Relations
Office of Self Insurance Plans
11050 Olson Drive, Suite 230
Rancho Cordova, CA 95670
Phone (916) 464-7000
FAX (916) 464-7007

Our File: 5558

APPLICATION FOR A PUBLIC ENTITY CERTIFICATE OF CONSENT TO SELF INSURE

NOTE: All questions must be answered. If not applicable, enter "N/A".
Workers' compensation insurance must be maintained until certificate is effective.

APPLICANT INFORMATION

Legal Name of Applicant (show exactly as on Charter or other official documents):
Associated Students, California State University, Los Angeles, Inc.

Street Address of Main Headquarters:
5154 State University Drive

Mailing Address (if different from above):

Federal Tax ID No.: 95-2044300

City, State, Zip Code
Los Angeles, CA 90032

TO WHOM DO YOU WANT CORRESPONDENCE REGARDING THIS APPLICATION ADDRESSED?

Name: Mimi Long Title: Vice President

Company Name: Alliant Insurance Services, Inc.

Mailing Address: 100 Pine Street, 11th Floor

City: San Francisco State: CA Zip + 4: 94111

Telephone Number: 415-403-1423 Email: mlong@alliant.com

Type of Public Entity (check one):

☐ City and/or County ☐ School District ☐ Police and/or Fire District ☐ Hospital District ☒ Joint Powers Authority

☐ Other (describe):

Type of Application (check one):

☐ New Application ☐ Reapplication due to Merger or Unification ☐ Reapplication due to Name Change

☒ Other (describe) New Certificate No. 5558

Date Self Insurance Program will begin: October 1, 2015

CURRENT PROGRAM FOR WORKERS' COMPENSATION LIABILITIES

☐ Currently Insured with State Compensation Insurance Fund, Policy Number:

Policy Expiration Date: _____ Yearly Premium: $ _____

Current Yearly Incurred (paid & unpaid) Losses: $ _____ (FY or CY)

☐ Currently Self Insured, Certificate Number: _____

Name of Current Certificate Holder: _____

☒ Other (describe): Associated Student has not purchased WC insurance in the past as it has not had employees.

JOINT POWERS AUTHORITY

Will the applicant be a member of a workers' compensation Joint Powers Authority for the purpose of pooling workers' compensation liabilities?

☒ Yes ☐ No If yes, then complete the following:

Effective date of JPA Membership: July 1, 2015 JPA Certificate No.: 5558

Name and Title of JPA Executive Officer:

Robert Eaton

Name of Joint Powers Authority Agency:

California State University Risk Management Authority (CSURMA)

Mailing Address of JPA:

c/o Alliant Insurance Services, Inc., 100 Pine Street, 11th Floor

City: State: Zip + 4:

San Francisco, CA 94111-5101

Telephone Number: 415-403-1400

PROPOSED CLAIMS ADMINISTRATOR

Who will be administering your agency's workers' compensation claims? (check one)

☐ JPA will administer, JPA Certificate No.: _____

☒ Third party agency will administer, TPA Certificate No.: 5558-23-011

☐ Public entity will self administer ☐ Insurance carrier will self administer

Name of Individual Claims Administrator:

Cindy Parker, Claims Director

Name of Administrative Agency:

Sedgwick CMS

Mailing Address:

10690 White Rock Road, Suite 100

City: State: Zip + 4:

Rancho Cordova, CA 95670

Telephone Number: 916-636-1571 FAX Number: 510-817-3345

Number of claims reporting locations to be used to handle the agency's claims: One

Will all agency claims be handled by the administrator listed on previous page? ☒ Yes ☐ No

AGENCY EMPLOYMENT

Current Number of Agency Employees: _____

Number of Public Safety Officers (law enforcement, police or fire): 0

If a school district, number of certificated employees: N/A

Will all agency employees be included in this self insurance program? ☒ Yes ☐ No
If no, explain who is not included and how workers' compensation coverage is to be provided to the excluded agency employees:

INJURY AND ILLNESS PREVENTION PROGRAM

Does the agency have a written Injury and Illness Prevention Program? ☒ Yes ☐ No

Individual responsible for agency Injury and Illness Prevention Program:
Name and Title:
Intef Weser

Company or Agency Name:
Associated Students, California State University, Los Angeles, Inc.

Mailing Address:
5154 State University Drive

City: State: Zip + 4:

Los Angeles, Inc. 90032

Telephone Number: 323-343-5858

SUPPLEMENTAL COVERAGE

Will your self insurance program be supplemented by any insurance or pooled coverage under a standard workers' compensation insurance policy? ☐ Yes ☒ No

If yes, then complete the following:

Name of Carrier or Excess Pool: _____

Policy Number: _____

Effective Date of Coverage: _____

Will your self insurance program be supplemented by any insurance or pooled coverage under a specific excess workers' compensation insurance policy? ☒ Yes ☐ No

If yes, then complete the following:

Name of Carrier or Excess Pool: Safety National Casualty Corporation

Policy Number: SP4049264

Effective Date of Coverage: 7/01/15 - 7/01/16

Retention Limits: $500,000

Will your self insurance program be supplemented by any insurance or pooled coverage under an aggregate excess (stop loss) workers' compensation insurance policy? ☒ Yes ☐ No

If yes, then complete the following:
Name of Carrier or Excess Pool: CSAC Excess Insurance Authority

Policy Number: EIA-PE 15 EWC-143

Effective Date of Coverage: July 1, 2015

Retention Limits: 1st Layer - $125,000 Per Occurrence / 2nd Layer - $375,000 Each Occurr

RESOLUTION OF GOVERNING BOARD

See Attached Resolution-Page 5

CERTIFICATION

The undersigned on behalf of the applicant hereby applies for a Certificate of Consent to Self Insure the payment of workers' compensation liabilities pursuant to Labor Code Section 3700. The above information is submitted for the purpose of procuring said Certificate from the Director of Industrial Relations, State of California. If the Certificate is issued, the applicant agrees to comply with applicable California statutes and regulations pertaining to the payment of compensation that may become due to the applicant's employees covered by the Certificate.

Signature of Authorized Official:

Date:

Typed Name:

Title:

Agency Name:

Associated Student, California State University, Los Angeles, Inc.

Seal

(Emboss seal above or Notarize signature)

RESOLUTION NO.:_____ DATED: _____

A RESOLUTION AUTHORIZING APPLICATION
TO THE DIRECTOR OF INDUSTRIAL RELATIONS, STATE OF CALIFORNIA
FOR A CERTIFICATE OF CONSENT TO SELF INSURE
WORKERS' COMPENSATION LIABILITIES

At a meeting of the Board of Directors
(enter title)

of the Associated Student, California State University, Los Angeles, Inc.
(enter name of public agency, district)

a CSU Auxiliary Organization
(enter type of agency) organized and existing under the laws of

the State of California, held on the _____ day of _____ , 20_____ , the

following resolution was adopted:

RESOLVED, that the Board of Directors
(enter position titles)

be and they are hereby severally authorized and empowered to make application to the Director of Industrial Relations, State of California, for a Certificate of Consent to Self Insure workers' compensation liabilities on behalf of the

Associated Student, California State University, Los Angeles, Inc.
(enter name of district)

and to execute any and all documents required for such application.

I, _____ , the undersigned _____
(enter name) (enter title)

of the Board of the said Associated Student, California State University, Los Angeles, Inc.
(enter name of agency)

a CSU Auxiliary Organization
(enter type of agency) , hereby certify that I am the _____
(enter title)

of said CSU Auxiliary Organization
(enter type of agency) , that the foregoing is a full, true and correct copy of the resolution duly

passed by the Board at the meeting of said Board held on the day and at the place herein specified and that said resolution has never been revoked, rescinded, or set aside and is now in full force and effect.

IN WITNESS WHEREOF: I HAVE SIGNED MY NAME AND AFFIXED THE SEAL OF THIS

Seal

Associated Student, California State University, Los Angeles, Inc.
(enter type of agency)

THIS _____ DAY OF _____ , _____

_____
(Signature)