Agreement and Undertaking (Self-Insured Employer)

Reset Print

U.S. Department of Labor
Office of Workers' Compensation Programs

Authorization of an employer to be self-insured under the Federal Coal Mine Health and Safety Act of 1969, as amended may be denied unless this agreement form has been received (30 USC 933).
Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The information collected will be used to assure the prompt payment of compensation benefits to injured employees and furnishing the information is required (20 CFR 726.110).

OMB No. 1240-0039
Expires: 06-30-2027

Name and Mailing Address of Self-insurer

Name:

Address:

City: State: ZIP:

Type of Business

Having applied to the Office of Workers' Compensation Programs (OWCP) for the privilege of giving security for the payment of compensation benefits directly by furnishing satisfactory proof to the OWCP of our financial ability to pay such compensation benefits, which authorization has been received.

WE DO HEREBY UNDERTAKE AND AGREE AS A CONDITION PRECEDENT TO SUCH AUTHORIZATION TAKING EFFECT THAT:

1. We will, and hereby do, make an initial deposit to secure our liability to pay compensation benefits provided in the Act in the amount of the indemnity bond or securities listed below.

Total Value of Securities Deposited $ OR Amount of Indemnity Bond $

Where Deposited Name of Surety Company

Par Value of Securities	Deposit Value of Securities	Issued By	Rate of Interest	Due Date	Number of Certificate
$	$				
TOTAL					

If, in the opinion of the OWCP, we are in default in the payment of compensation or other benefits required by the Act, we hereby authorize the OWCP to sell the securities or any of them as may be required, as well as any others hereafter deposited, or bring suit under the bonds, in order to procure prompt payment of all benefits provided by the Act. Such securities, as well as any others hereafter deposited, are to be held subject to the order of the OWCP, with power to collect the interest and the principal as the same become due. In the absence of default, the interest collected by the depository bank upon securities deposited by us shall be paid to us by the bank.

2. We will comply with the regulations for self-insurers promulgated by the OWCP, including such modifications thereof as the OWCP may make from time to time.

3. If required by the OWCP, we will obtain and maintain excess or catastrophic insurance, in amounts to be determined by the OWCP.

4. We will comply with the orders of the OWCP requiring the deposit of additional indemnity bonds or securities proof of our financial condition and the verification thereof, statements of our accident/occupational disease experience and payroll exposure and in any other way.

Public Burden Statement

We estimate that it will take an average of 15 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, Division of Coal Mine Workers' Compensation, U.S. Department of Labor, 200 Constitution Avenue, N.W., Suite C3520-DCMWC, Washington, D.C. 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE**

pertaining to the exercise by us of the authorization of self-insurance, within the time specified in any notice mailed to us by the OWCP at our last given post office address, failing which we consent that this authorization to pay compensation benefits directly, may forthwith be revoked by the Office of Workers' Compensation Programs.

5. We further agree to the following special conditions:

The foregoing deposits and promises are hereby tendered to the OWCP as fulfillment on our part of the conditions under which the OWCP has authorized us to give security for the payment of compensation benefits directly by furnishing satisfactory proof of our financial ability to pay such compensation benefits.

Signed at _____

this _____ day of _____ , 20 _____

_____

BY _____

IF THE EMPLOYER/OPERATOR IS A CORPORATION USE THIS FORM OF ACKNOWLEDGEMENT

STATE OF _____

COUNTY OF _____

On the _____ day of _____, in the year 20 _____ , before me personally came _____ , to me known, who being by me duly sworn did depose and say that he/she resides in _____ ; that he/she is the _____ of _____ the corporation
(President or other Officer) (Name of Corporation)

described in and which executed the above instrument; that he/she knows the seal of said corporation, that the seal affixed to said instrument is such corporate seal; that it was so affixed by order of the Board of Directors of said corporation and that he/she signed his/her name thereto by like authority.

_____

Notary Public (SEAL)

IF THE EMPLOYER/OPERATOR IS AN INDIVIDUAL USE THIS FORM OF ACKNOWLEDGEMENT

STATE OF _____

COUNTY OF _____

On the _____ day of _____ , in the year 20 _____ before me personally came _____ , to me known and known to me to be the person described in and who executed the above instrument and acknowledged to me that he/she executed the same.

_____

Notary Public (SEAL)

IF THE EMPLOYER/OPERATOR IS A PARTNERSHIP USE THIS FORM OF ACKNOWLEDGEMENT

STATE OF _____

COUNTY OF _____

On the _____ day of _____ , in the year 20 _____ before me personally came _____ , described on the foregoing instrument to me known and known to me to be a member of the said firm and the person who executed said instrument and acknowledged to me that he/she executed the same on behalf of said firm.

_____

Notary Public (SEAL)