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
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State of California
Department of Industrial Relations
OFFICE OF SELF-INSURANCE PLANS

APPLICATION FOR CERTIFICATE OF CONSENT TO SELF-INSURE AS A PUBLIC AGENCY EMPLOYER SELF-INSURER

All questions must be answered. If not applicable, enter "N/A".

To the Director of the Department of Industrial Relations: The public agency employer identified below submits the following information to obtain a Certificate of Consent to Self-Insure the payment of workers' compensation under California Labor Code Section 3700.

LEGAL NAME OF APPLICANT (Show exactly as on Charter or other official documents):

CITY OF FORT BRAGG

Address: 416 NORTH FRANKLIN STREET

City: FORT BRAGG State: CA Zip + 4: 95437 - _____

Federal Tax ID # of Group: 94-6000335

CONTACT - Who Should Correspondence Regarding This Applicant Be Addressed To:

Name: AMY NORTHAM Title: GENERAL MANAGER

Company Name: REDWOOD EMPIRE MUNICIPAL INSURANCE FUND (REMIF)

Address: 414 W. NAPA STREET 2ND FLOOR SUITE C

City: SONOMA State: CA Zip + 4: 95476 - _____

Phone: (707) 938-2388 E-Mail: anortham@remif.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 (Merger/Unification) ☐ Reapplication (Name Change)

☐ Other (describe): THE CITY HAS RESOLVED TO MOVE FROM ITS CURRENT JPA REDWOOD EMPIRE MUNICIPAL INSURANCE FUND, (REMIF-MASTER CERTIFICATE 5013) TO CALIFORNIA INTERGOVERNMENTAL RISK AUTHORITY (CIRA-MASTER CERTIFICATE 5017) EFFECTIVE 7/1/2021.

NOTE: ONLY CLAIMS WITH DATES OF INJURY AFTER 7/1/2021 WILL BE INCLUDED IN THIS MOVE. REMIF WILL MAINTAIN RESPONSIBILITY FOR ALL CLAIMS WITH DATES OF INJURY PRIOR TO 7/1/2021.

Date Self-Insurance Program will begin: 07/01/2021

CURRENT WORKERS' COMPENSATION PROGRAM

☐ Currently Insured with State Fund Policy # _____ Expiration Date: _____

☑ Currently Self Insured, Certificate # 5013-013

☐ Other (describe): _____

CLAIMS ADMINISTRATION

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

☐ JPA will administer

☑ Third Party Administrator, TPA Certificate # 048-01

☐ Public entity will self-administer ☐ Insurance Carrier will administer

Name of Third Party Administrator:

Name: DOUGLASS GIBB Title: CLAIMS MANAGER

Company Name: ATHENS ADMINISTRATOR

Address: P.O. BOX 696

City: CONCORD State: CA Zip + 4: 94522 - _____

Phone: (925) 826-1283 E-Mail: dgibb@athensadmin.com

# of claims reporting locations to be used to handle Agency's claims: 1

Does applicant currently have a California Certificate of Consent to Self-Insure? ☑ Yes ☐ No

If yes, what is the current Certificate Number: 5013-013

Total Number of Affiliate's California employees to be covered by Group: N/A

AGENCY EMPLOYER

Current # of Agency Employees: 56 # of Public Safety Employees (police//fire): 13

If school District, # of certificated employees: N/A

Will all Agency employees be covered by this self-insurance plan? ☑ Yes ☐ No

If 'No', explain who is not covered and how workers' compensation coverage will be provided to the excluded employees:

JOINT POWERS AUTHORITY

Will applicant be a member of a JPA for workers' compensation ?

☑ Yes ☐ No (If 'yes', complete the following)

Effective date of JPA Membership: 07/01/2021 JPA Certificate # 5017

Name of JPA: CALIFORNIA INTERGOVERNMENTAL RISK AUTHORITY (CIRA)

NOTE: CIRA FORMERLY KNOWN AS PUBLIC AGENCY RISK SHARING AUTHORITY OF CALIFORNIA (PARSAC). NAME CHANGE EFFECTIVE 7/1/2021. REMIF WILL MAINTAIN RESPONSIBILITY FOR ALL CLAIMS WITH DATES OF INJURY PRIOR TO 7/1/2021. ONLY CLAIMS WITH DATES OF INJURY ON OR AFTER 7/1/2021 WILL BE INCLUDED IN THIS MOVE.

AGENCY SAFETY PROGRAM

Does the Agency have a written Injury and Illness Prevention Program (IIPP)? ☑ Yes ☐ No

Individual responsible for Agency workplace safety and IIPP program:

Name: TABITHA MILLER Title: CITY MANAGER

Company Name: CITY OF FORT BRAGG

Address: 416 NORTH FRANKLIN STREET

City: FORT BRAGG State: CA Zip + 4: 95437 - _____

Phone: (707) 961-2823 E-Mail: tmiller@fortbragg.com

SUPPLEMENTAL COVERAGE

1.) Will your program be supplemented by any insurance or pooled coverage under a **STANDARD** workers' compensation insurance policy? ☐ Yes ☑ No (If 'Yes', complete the following):

Name of Excess Pool/Carrier: N/A

Policy #: N/A Effective Date of Coverage: _____

2.) Will your program be supplemented by any insurance or pooled coverage under a **SPECIFIC EXCESS** workers' compensation insurance policy? ☑ Yes ☐ No (If 'Yes', complete the following):

Name of Excess Pool/Carrier: PENDING (CURRENTLY INSURED WITH SAFETY NATIONAL)

Policy #: PENDING Effective Date of Coverage: 07/01/2021

Retention Limits: PENDING (CURRENTLY $1M FOR PEACE AND FIRE AND $750K FOR ALL OTHER)

3.) Will your program be supplemented by any insurance or pooled coverage under an **AGGREGATE EXCESS** (stop loss) specific excess workers' compensation insurance policy? ☐ Yes ☑ No
(If 'Yes', complete the following):

Name of Excess Pool/Carrier: _____

Policy #: _____ Effective Date of Coverage: _____

Retention Limits: _____

RESOLUTION FROM GOVERNING BOARD

Attach a properly executed Governing Board Resolution. See attached sample resolution on 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.

X_____ DATE: _____

SIGNED: Authorized Official / Representative

Tabatha Miller

Printed Name

City Manager

Title

CITY OF FORT BRAGG

Agency Name

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 _____
(Enter Name of the Board)

of the CITY OF FORT BRAGG
(Enter Name of Public Agency, District, Etc.)

a CITY
(Enter Type of Agency, i.e., County, City, School District, etc.) 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 above named public agency is 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 and representatives of Agency are authorized to execute any and all documents required for such application.

IN WITNESS WHEREOF: I HAVE SIGNED AND AFFIXED THE AGENCY SEAL.

X_____ DATE: _____
SIGNED: Board Secretary or Chair

_____
Printed Name

_____
Title

Affix Seal Here

_____
Agency Name