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):

Consolidated Fire Agencies

Address: 1743 Miro Way

City: Rialto State: CA Zip + 4: 92376 -

Federal Tax ID # of Group: 38-3878492

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

Name: Nathan Cooke Title: Interim Comm Director

Company Name: Consolidated Fire Agencies

Address: 1743 Miro Way

City: Rialto State: CA Zip + 4: 92376 -

Phone: (909) 356-2302 E-Mail: ncooke@confire.org

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): _____

Date Self-Insurance Program will begin: 07/01/2023

CURRENT WORKERS' COMPENSATION PROGRAM

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

☐ Currently Self Insured, Certificate # _____

☑ Other (describe): Insured as a department within the County of San Bernardino

CLAIMS ADMINISTRATION

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

☐ JPA will administer

☑ Third Party Administrator, TPA Certificate # 152

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

Name of Third Party Administrator:

Name: Amber Davis Title: Director of Claims - Public Entity

Company Name: LWP Claims Solutions

Address: PO Box 340916

City: Sacramento State: CA Zip + 4: 95834 - _____

Phone: (916) 609-3654 E-Mail: a_davis@lwpclaims.com

# of claims reporting locations to be used to handle Agency's claims: 2

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

If yes, what is the current Certificate Number: _____

Total Number of Affiliate's California employees to be covered by Group: _____

AGENCY EMPLOYER

Current # of Agency Employees: 99 # of Public Safety Employees (police//fire): 0

If school District, # of certificated employees: _____

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: 07/01/2023 JPA Certificate # 5017

Name of JPA: California Intergovernmental Risk Authority

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: Mike Bell Title: Interim Assistant Director

Company Name: Consolidated Fire Agencies

Address: 1743 Miro Way

City: Rialto State: CA Zip + 4: 92376 -

Phone: (909) 816-4851 E-Mail: mbell@confire.org

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: Safety National

Policy #: SP 4066628 Effective Date of Coverage: 07/01/2023

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: _____

Policy #: _____ Effective Date of Coverage: _____

Retention Limits: _____

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

Nathan Cooke

Printed Name

Interim Director

Title

Consolidated Fire Agencies

Agency Name