Exemption No.____________________________

FORM 291

____

STATE OF NEW JERSEY
DEPARTMENT OF BANKING AND INSURANCE

____

EMPLOYER'S APPLICATION FOR RENEWAL OF EXEMPTION FROM INSURING ALL OR PART OF ITS COMPENSATION LIABILITY

(As provided by N.J.S.A 34:15-77)

Name of employer____

Address ____

Incorporated or organized under the laws of the State of ____________________on____________________

Employer's Federal Employer Identification Number (FEIN) ______________________________

Registered under the Securities Act of 1933 (15 U.S.C. Sec. 77 et seq.) Yes ☐ No ☐

Nature of business ____
(Retail, Manufacturing, Engineering, Construction, etc)

If the employer is a subsidiary, complete the following:

Exact legal name of the ***ultimate parent*** ______________________________

Date parent incorporated________________State ________________FEIN____________________

Has an application for workers' compensation insurance ever been refused or a policy canceled? Yes ☐ No ☐
If yes, attach an explanation of circumstances including date, name of jurisdiction, and name of carrier.

Has an application for self-insurance ever been denied or a certificate revoked? Yes ☐ No ☐
If yes, attach an explanation of circumstances including date and name of jurisdiction.

Is the employer self-insured in any other jurisdiction? Yes ☐ No ☐
(If yes, see item 3 on page 3.)

Company contact for self-insurance: (Applicant)______________________________

Title:____

Street address:____

Mailing address:____

Phone:________________________Fax:____________________Email____________________

Third Party Claims Administrator (If applicable). Name of company:______________________________

Contact person and Title:____

Street address:____

Mailing address:____

Phone:________________________Fax:____________________Email____________________

Excess Insurance Carrier:____

Policy Period:____

Policy Limits:____

Retention Amount:____

Exemption No.____________________________

FORM 291

LOSS EXHIBIT

A. Total amount of compensation (indemnity only) PAID during past year $______________

B. Total amount of medical, hospital and surgical expense for the past year including cost of supplies and equipment for employer's plant hospital (paid $ ______________) total incurred $______________

C. Outstanding Indemnity Reserve (total of reserve as per last column of 291A) $______________

D. Total incurred loss for past year [A. + B. + C. - C. (prior year)] $______________

____
(Signature of Employer)

By______________________________________
(Name)

Dated at ______________________________, ____, 20____

AFFIDAVIT

(The person subscribing to the below affidavit should be the employer himself; or if the employer is a partnership, one of the partners; or if the employer is a corporation, its president, vice president, secretary or treasurer.)

STATE OF ____________________

COUNTY OF __________________

____first being duly sworn on oath deposes and says that he is acquainted with the affairs of the above-mentioned employer, to which representations and statements set forth in the foregoing application relate; that he has read the application, knows the contents thereof and that said representations and statements therein contained are true to the best of his knowledge and belief.

Subscribed and sworn to me at

_____________________________________(City/State) >

This__________________________________day of >

______________________________,A.D. 20________________>

SEAL

____
(**Signature**)

____
(**Official Title**)

Exemption No.___________________________

FORM 291

ATTACHMENTS

Attachments detailed below are required and must be provided before the renewal application is considered complete. **Failure to comply may result in your renewal being denied**		
1	Completed Certification Form (see attached)	
2	Provide audited financial statements (annual reports) with accompanying footnotes and auditors' opinion, and 10K's, if applicable, for the most current year.	
3	Provide a list of all other Self-Insured Jurisdictions and the amounts of security deposits on file.	
4	Provide a narrative description of the safety program components for your operations in this state.	
5	Provide Loss Runs (open claims) for the period of self insurance. (use form 291A).	
6	Completed Supplement 1 (see attached)	

Exemption No.___________________________

FORM 290

SUPPLEMENT 1

Exhibit of Locations of Shops and other Workplaces, Number of Employees, Payrolls and Description of Operations in New Jersey

This report covers the latest fiscal period of the Employer extending from ____________to____________

Location of Factory, Office or other work place by town, city or other designation	**Estimated Average Number of Employees at each Location**	**Division of Operations (Payroll and number of employees are to be given on separate lines for each operation at each location)**	**Actual Payroll Expenditure for past Year**
			$

(Attach additional copies if needed)

Total estimated average number of employees (worldwide)___________________, and total payroll expenditure in the past year (worldwide) $_______________ for *all* operations wherever conducted.

CERTIFICATION (11:2-33.4(a) 5

The certificate holder recognizes that it may be subject to examination by the Commissioner as required pursuant to the New Jersey Administrative Code 11:2-33.4(a) 5.

____

(Name of Company)

BY: ____

(Person's Name) and (Title)
Printed or Typed

____

(Person's Signature) and (Date)