Go to Form

Instructions for Completing the

One Year Request for Certification

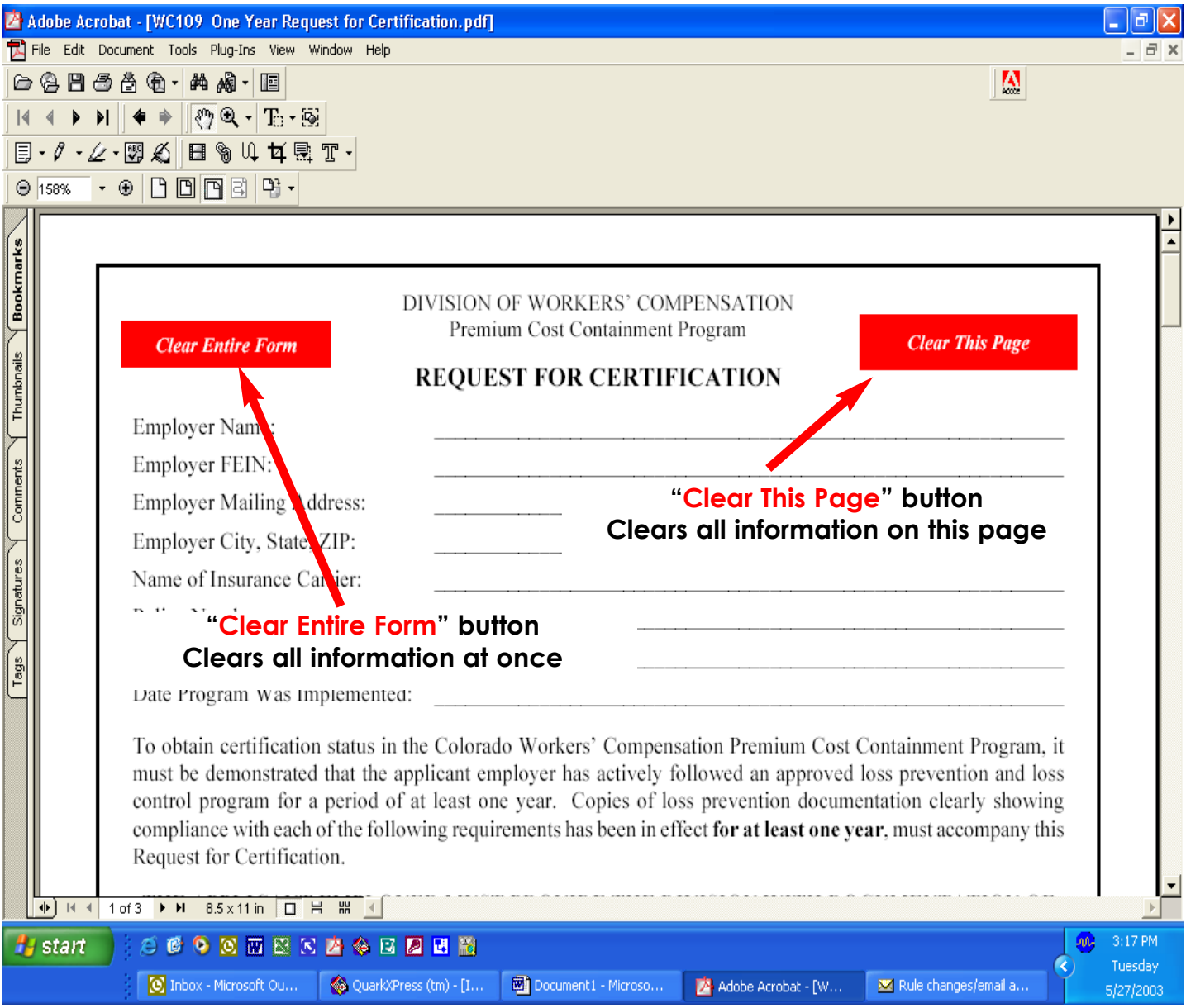
Please read all pages

This form is "fillable." That means you can type the information onto the form from your computer and print the form. You will *not* be able to save the form onto your computer's hard drive.

When you open the form, click in the "Employer Name" box (field), complete the information, and use the tab key to navigate to the next field. Do not use the Enter key; pressing the Enter key will only page down. Each field has been *limited*. This means that you *cannot* continue to type information into a field if it doesn't fit into the space provided.

Use numbers *only* to fill in the fields for phone number, fax number and dollar amounts. Do not use parentheses or dollar signs; when you tab out of the field, it will fill in automatically.

To clear or delete all the information you have typed onto the form, click on the red "Clear Entire Form" button. To clear all the information on a single page, click on the red "Clear This Page" button To change the information in one field, use the backspace or delete key.


Adobe Acrobat - [WC109 One Year Request for Certification.pdf]
File Edit Document Tools Plug-Ins View Window Help
Bookmarks
Thumbnails
Comments
Signatures
Tags
Clear Entire Form
DIVISION OF WORKERS' COMPENSATION
Premium Cost Containment Program
REQUEST FOR CERTIFICATION
Clear This Page
Employer Name:
Employer FEIN:
Employer Mailing Address:
Employer City, State, ZIP:
Name of Insurance Carrier:
Date Program Was Implemented:
"Clear This Page" button
Clears all information on this page
"Clear Entire Form" button
Clears all information at once
To obtain certification status in the Colorado Workers' Compensation Premium Cost Containment Program, it must be demonstrated that the applicant employer has actively followed an approved loss prevention and loss control program for a period of at least one year. Copies of loss prevention documentation clearly showing compliance with each of the following requirements has been in effect for at least one year, must accompany this Request for Certification.
1 of 3
8.5 x 11 in
start
Inbox - Microsoft Ou...
QuarkXPress (tm) - [I...
Document1 - Microso...
Adobe Acrobat - [W...
Rule changes/email a...
3:17 PM
Tuesday
5/27/2003

Back to Instructions

DIVISION OF WORKERS' COMPENSATION
Premium Cost Containment Program

Clear Entire Form

Clear This Page

REQUEST FOR CERTIFICATION

Employer Name: _____

Employer FEIN: _____

Employer Mailing Address: _____

Employer City, State, ZIP: _____

Name of Insurance Carrier: _____

Policy Number: _____

Nature of Business: _____

Date Program Was Implemented: _____

To obtain certification status in the Colorado Workers' Compensation Premium Cost Containment Program, it must be demonstrated that the applicant employer has actively followed an approved loss prevention and loss control program for a period of at least one year. Copies of loss prevention documentation clearly showing compliance with each of the following requirements has been in effect **for at least one year**, must accompany this Request for Certification.

THE APPLICANT EMPLOYER MUST PROVIDE THE DIVISION WITH DOCUMENTATION OF THE FOLLOWING COST CONTAINMENT PROGRAM REQUIREMENTS

1. Formal Declaration of an Organization-wide Loss Prevention and Loss Control Policy (enclose a signed and dated copy).
   a. The policy reflects the philosophy of top management.
   b. The safety and health of all employees are a top priority.
2. Formal Creation of a Safety Committee or Coordinator (enclose signed and dated documentation).
   a. Committee or coordinator has clearly defined tasks and objectives.
   b. Discuss/recommend safety policies and objectives.
   c. Identify unsafe conditions and practices.
   d. Investigate all accidents.
   e. Conduct safety committee meetings and promote safety awareness.
   f. Establish and update safety rules.
3. Clearly Defined and Conspicuously Posted Safety/Loss Prevention Rules (enclose a signed and dated copy).
   a. Hazards are identified and accident prevention rules are clearly communicated.
   b. All employees are made aware of the safety rules.
   c. Safety rules are applicable and updated as needed.
4. All Employees Undergo Safety Awareness and Loss Prevention Training (enclose signed and dated verification of employee safety training).
   a. The supervisor has provided and documented individual job/task safety training.
   b. Ongoing safety meetings are held for all employees and attendance (employee sign-off) recorded.
5. Written Designation of a Medical Provider (enclose a signed and dated copy).
   a. Provider is knowledgeable of fee schedules and agrees to honor designated provider agreements.
   b. Provider communicates with the employer on issues such as case management and modified duty.
   c. Employer will keep in contact with the injured worker and will inform employees on matters concerning the designated medical provider.

Clear This Page

6. Written Policies and Procedures on Claims Management (enclose a signed and dated copy).
   a. Employer has investigated all incidents for third-party potential (enclose a completed investigation).
   b. Employer ensures that the insurance carrier is contacted in a timely manner and confirms that the employee was working at the time of the accident.
   c. Employer coordinates with the insurance carrier (at least annually) on issues such as loss runs review, outstanding reserves, and employee classification.
   d. Employer, when practicable, institutes a modified duty program in conformance with the attending physician's restrictions (enclose modified duty documentation).

7. Use the following chart to provide a summary for EACH of the last three full **policy periods**, and the current **policy year-to-date** of your organization's injuries, costs, and total employee hours worked. **This information MUST be provided by POLICY period.** Information should be taken from insurance carrier loss reports and payroll records. *Read the attached instructions before completing*.

Policy Period		No. Of Injuries During Policy Period	Total Costs Incurred on All Claims During Policy Period	Total Employee Hours Worked During Policy Period
Effective Date	Expiration Date			

8. A currently valued copy (valued no more than 30 days prior to the date of application) of your insurance carrier's detailed, gross loss reports for the last three full policy years, and the current policy year-to-date MUST be included with this request for certification. *Read the attached instructions for further information*.

NOTE: An on-site evaluation of the employer's Cost Containment Program may be conducted.

By signing this request, the contact person affirms that the above requirements have been met and acknowledges the Premium Cost Containment Program may contact the applicant employer's workers' compensation insurance carrier to obtain information relative to this request.

Signature of Contact Person

Date of Signature

Type or Print Name of Contact Person

E-mail Address

Contact Person's Telephone Number

Fax Number

PLEASE RETURN THE COMPLETED FORM CONTAINING THE ORIGINAL SIGNATURE OF THE CONTACT PERSON. ATTACH ALL REQUIRED DOCUMENTATION.

Premium Cost Containment Program Board
Division of Workers' Compensation
633 17th St., Suite 400
Denver, CO 80202-2117

INSTRUCTIONS FOR COMPLETING ITEMS 7 & 8

Please read before completing Request for Certification form.

ITEM 7 - Summary Chart

1) **Policy Period** is defined as the policy year or partial policy year reflected on loss reports. These periods might not coincide with the calendar year. **DO NOT** convert policy periods to calendar years (i.e., If policy period is shown on loss reports as July 1 - June 30, the policy period should be reported as shown).

2) **Number of Injuries** is defined as the number of claims reported to your insurance carrier. In some cases, this will include reports of injuries that have incurred no costs. (*All injuries should be reported to your carrier, regardless of severity*). OSHA reporting requirements are not a consideration.

3) **Total Costs on All Claims** is defined as the gross incurred amount, and includes both paid and outstanding reserve amounts. This includes medical costs, indemnity costs, and miscellaneous expenses. Deductible amounts paid by the insured employer must also be included in this figure.

4) **Total Employee Hours Worked** is defined as the total number of hours worked by **all** employees during **each** indicated policy period. There is no need to break this figure down into "regular" and "overtime" hours, nor is it necessary to differentiate between "exempt" and "nonexempt" employee hours. Hours **MUST NOT** be extended beyond the valuation date of loss reports (i.e., if loss reports are valued as of June 30, hours worked should be reported only through June 30 even though the date of the application may be July 20).

ITEM 8 - Loss Reports

Currently Valued loss reports from your insurance carrier covering the last **three** full policy periods and the current policy year-to-date must accompany all requests for certification or recertification. In order to be currently valued, **ALL** loss reports must have been printed within thirty days of the date of application.

Only actual detailed, gross valuation loss reports are acceptable. On-line printouts, summary loss reports and loss reports that do not include deductible amounts are unacceptable for program purposes. Summaries prepared by agents or brokers and in-house accounting program printouts are generally not acceptable.

Original signatures are required. Failure to properly complete this request form or provide the required loss reports will delay the processing of your request.

If you have any questions, please contact the Premium Cost Containment Program
303.318.8644