

# PENDING APPROVAL

## OKLAHOMA COUNTY BOARD OF COUNTY COMMISSIONERS

### AGENDA ITEM REQUEST SHEET

FOR THE January 27, 2010 AGENDA

DEPARTMENT: Human Resources/Health & Safety REQUESTED BY: Dan Matthews

REQUISITION NO.: 10905876 REQUISITION SHEET ATTACHED:        YES        N/A

NAME OF FUNDS: General Fund/Workers' Compensation

FUND NUMBERS:                   /                  /                  

DOES THE AGENDA ITEM CONTAIN PRIVACY-PROTECTED OR SECURITY INFORMATION?        YES   X   NO

AGENDA ITEMS CONTAINING PRIVACY-PROTECTED OR SECURITY INFORMATION WILL NOT BE HYPERLINKED TO THE AGENDA.

NUMBER OF ORIGINAL DOCUMENTS TO BE RETURNED TO YOUR DEPARTMENT:                   

AGENDA ITEM READS AS FOLLOWS:

Discussion and possible action to approve "Employer's application for permission to carry its own risk without insurance" to the Oklahoma workers' compensation court and designation ok service agent. The renewal requires the issuance of payment in the amount of \$500.00.

APPROVED BY DA  
(If Applicable)

APPROVED BY ENGINEER  
(If Applicable)

APPROVED BY PURCHASING  
(If Applicable)

\_\_\_\_\_  
ASSISTANT DISTRICT ATTORNEY

\_\_\_\_\_  
COUNTY ENGINEER

\_\_\_\_\_  
PURCHASING AGENT

Please initial that document has been reviewed for privacy-protected or security information

DISTRICT ATTORNEY:        YES        N/A


COUNTY CLERK:        YES        N/A

Indicate any privacy-protected information that exists \_\_\_\_\_

**(NOTE: THE CHAIRMAN/CHIEF DEPUTY MUST APPROVE ALL EMERGENCY REQUESTS FOR ANY ITEM SUBMITTED AFTER THE DEADLINE)**

DATE OF REQUEST: \_\_\_\_\_ APPROVED BY: \_\_\_\_\_

CHAIRMAN

 # 11004402

# PENDING APPROVAL

FORM 1B

OKLAHOMA WORKERS' COMPENSATION COURT  
1915 NORTH STILES AVENUE  
OKLAHOMA CITY, OK 73105-4918  
(405) 522-8600

## EMPLOYERS APPLICATION FOR PERMISSION TO CARRY ITS OWN RISK WITHOUT INSURANCE

To: The Oklahoma Workers' Compensation Court

Date January 19, 2010

The undersigned, an employer subject to the provisions of the Workers' Compensation Act, hereby applies for permission to carry its own risk without insurance. To enable the Workers' Compensation Court to determine whether or not the applicant possesses sufficient financial ability to render certain the payment of any award made by the Court, said applicant hereby states the following:

1. Employer's Name County of Oklahoma County O.R. # 14772

2. Employer's Federal Identification Number 73-6006400

3. Home Office Address 320 Robert S. Kerr, Rm #222, Oklahoma City, OK 73102

4. Oklahoma principal office address 320 Robert S. Kerr, Rm #222, Oklahoma City, OK 73102

5. Incorporated or organized under the laws of the State of Oklahoma

6. If foreign corporation, give date licensed to do business in Oklahoma N/A

7. Nature of business Government

8. General Information on Company:

a. Years engaged in continuous business 104, In Oklahoma 104

b. Payroll in each of the preceding three (3) years:

Year: 2009, \$ 48,522,660; Year: 2008, \$ 48,390,658; Year: 2007, \$ 46,059,231

Payroll in Oklahoma in each of the preceding three (3) years:

Year: 2009, \$ 48,522,660; Year: 2008, \$ 48,390,658; Year: 2007, \$ 46,059,231

c. Number of employees presently employed 2,532  
In Oklahoma 2,532

d. Estimated payroll in Oklahoma for the next twelve (12) months \$49,007,886

9. Excess Insurance Information:

a. Name of carrier Midwest Employers Casualty Company

b. Policy dates: Effective 7/1/2009 Expiration 7/1/2010

c. Under this policy: Self Insured Retention \$600,000 Limits of Liability Statutory

*Note: A certificate of excess insurance or a valid binder issued by said carrier must be attached to this application. A copy of the policy must follow.*

10. Estimated manual premium for your company \$88,453

# PENDING APPROVAL

11. A. In the section below, state the loss history for the past five (5) fiscal/calendar years. Copy the requested information from your loss runs (if the hard copy of your loss runs are required you will be notified). Also include the current year's history, indicating how many months of the current year are included:

Total incurred losses in Oklahoma (include for all injuries, both open & closed claims)

| Year     | \$ Medical Paid | \$ Indemnity Paid | \$ Total Paid | \$ Total Reserves Outstanding |
|----------|-----------------|-------------------|---------------|-------------------------------|
| 09/10 mo | \$60,305        | \$0               | \$60,305      | \$311,828                     |
| 08/09    | \$189,332       | \$128,778         | \$318,110     | \$277,250                     |
| 07/08    | \$410,864       | \$380,997         | \$791,861     | \$876,101                     |
| 06/07    | \$628,881       | \$353,993         | \$982,874     | \$415,893                     |
| 05/06    | \$265,740       | \$317,764         | \$583,505     | \$0                           |

|       | Cases Opened | Cases Reopened | Cases Closed | Death Cases |
|-------|--------------|----------------|--------------|-------------|
| 09/10 | 71           | 0              | 26           | 0           |
| 08/09 | 135          | 0              | 119          | 0           |
| 07/08 | 126          | 0              | 124          | 1           |
| 06/07 | 134          | 0              | 133          | 0           |
| 05/06 | 133          | 0              | 133          | 0           |

B. Total Self Insurance Reserves Outstanding: \$ 1,431,466  
(for all years of self insurance)

Net obligation of Oklahoma County. ( Two claims are in excess recovery as of November 2009)

Total Self Insured Open Cases: 65  
(for all years of self insurance)

12. A. Enclose current audited financial report, including balance sheets, income statements & notes.
- B. A governmental entity must provide a definite statement of the amount it has specifically appropriated for workers' compensation claims for the latest and the next fiscal year. Also, a description of how workers' compensation claims are funded must be submitted.
13. A. Is the applicant a subsidiary of another employer? No If yes, submit the parent company's financial statements.
- B. Does the applicant have subsidiary companies that it wants to include under this permit? No  
(attach a list of the names and addresses of ALL entities to be included under this permit, including subdivisions)
- C. If you answered yes to either question 13A or 13B, attach a copy of a written agreement whereby the ultimate parent employer guarantees that it will be fully responsible for any liabilities that its subsidiaries may incur under the Oklahoma Workers' Compensation Act.
14. A. Name and address of the company's Third Party Administrator for the servicing of the self insurance claims.  
Consolidated Benefits Resources, L.L.C.  
P.O. Box 581630, Tulsa, OK 74116
- B. If an approved Third Party Administrator is not employed, please submit qualifications of benefits administrator.





PTD/ DEATH Claim Tracker for Workers Compensation Court

| Client Name:   | Oklahoma County | Own Risk #           | 14772                 |                      |                        |  |                          |                          | 11/20/2009 |
|----------------|-----------------|----------------------|-----------------------|----------------------|------------------------|--|--------------------------|--------------------------|------------|
| Claimant Name  | Court claim #   | Date of Injury/death | Status (PTD or Death) | Medical Paid to date | Indemnity Paid to date | Outstanding Medical and Indemnity Reserves | Excess Insurance Carrier | Self-Insurance Retention |            |
| Dotson, Tommie | 1993-22504J     | 11/12/1993           | PTD                   | \$ 8,911.34          | \$ 185,791.29          | \$ 3,010.66                                | None                     | None                     |            |
| Vallion, John  |                 | 5/6/2008             | Death                 | \$ -                 | \$ 133,119.80          | \$ 255,044.99                              | Midwest Employee         | \$500,000.00             |            |

# PENDING APPROVAL



**Midwest Employers Casualty Company**  
**SPECIFIC AND AGGREGATE EXCESS**  
**WORKERS COMPENSATION AND EMPLOYERS LIABILITY INDEMNITY POLICY**

Policy No.: EWC006746

## SCHEDULE

1. Insured: County of Oklahoma County
  
2. Mailing Address: 320 Robert S. Kerr  
Oklahoma City, OK 73102
  
3. Named States: Oklahoma
  
4. Excluded States: None
  
5. Policy Period:  
(a) From: 07/01/2009  
(b) To: 07/01/2010  
Both days at 12:01 A.M. standard time at the Insured's address shown in Item 2 of this schedule.
  
6. Specific Retention:  
(a) Each Accident: See Endorsement  
(b) Each Employee for Disease: See Endorsement
  
7. Specific Limit Each Accident:  
(a) Policy Part One, Workers' Compensation: STATUTORY  
(b) Policy Part Two, Employers Liability: \$1,000,000
  
8. Specific Limit Each Employee for Disease:  
(a) Policy Part One, Workers' Compensation: STATUTORY  
(b) Policy Part Two, Employers Liability: \$1,000,000
  
9. Aggregate Retention:  
(a) Rate as a Percentage of Normal Premium: 102.19%  
(b) Estimated Normal Premium: \$2,071,495  
(c) Minimum Retention: \$2,074,524
  
10. Aggregate Limit: \$1,000,000

# PENDING APPROVAL



**Midwest Employers Casualty Company**  
SPECIFIC AND AGGREGATE EXCESS  
WORKERS COMPENSATION AND EMPLOYERS LIABILITY INDEMNITY POLICY

Policy No.: EWC006746

## SCHEDULE

11. Classification of Operations: See Endorsement

12. Premium:

|  |          |
|--|----------|
| (a) Rate as a Percentage of Normal Premium:                    | 4.27%    |
| (b) Policy Minimum Premium:                                    | \$79,608 |
| (c) Total Estimated Policy Premium:                            | \$88,453 |
| (d) Deposit Premium:   | \$88,453 |
| (e) Deposit Flat Charges:                                      | n/a      |
| (f) Total Deposit Premium and Flat Charges Payable as Follows: |          |

| Amount      | Due        |
|-------------|------------|
| \$88,453.00 | 08/12/2009 |

13. Endorsement Serial Numbers: See Endorsement Schedule

14. Service Company: Consolidated Benefits Resources  
P.O. Box 13770  
Oklahoma City, OK 73113-

Countersigned

MIDWEST EMPLOYERS CASUALTY COMPANY

William E. Beckman, Jr. 8-20-09

Donna L. Knowling

Licensed Resident Agent

Date

Authorized Representative

# PENDING APPROVAL

## Section 111 Mandatory Reporting Profile Report

Reporter ID: 000012690

Date: 06/02/2009  
Profile Changed: 05/22/2009

COBC EDI Representative: Fiona Scott  
Email: fscott@ghimedicare.com

Phone: (646) 447-2019

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### Company Information:

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TIN: 736006400

NAIC:

Name: OKLAHOMA COUNTY  
Address: 320 ROBERT S. KERR, ROOM 222

Phone: (405) 713-1371  
Fax: (405) 713-1865

OKLAHOMA CITY OK 73102-

Reporter Type: Non-GHP  
Line of Business: X Liability X Worker's  
Compensation

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### Authorized Representative:

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Name: MARILYN JONES  
Title: SAFETY COORDINATOR  
Address: 320 ROBERT S. KERR, ROOM 222

Phone: (405) 713-1372

OKLAHOMA CITY OK 73102-

Email: MJONES@OKLAHOMACOUNTY.ORG

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### Account Manager/Technical Contact:

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Name: JIM GRAFLUND  
Title: TECHNICIAN  
Address: PO BOX 581630

Phone: (918) 831-0302

TULSA OK 74158-

Email: JGRAFLUND@CBREMAIL.COM

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### Submission Agent (if applicable):

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Company: CONSOLIDATED BENEFITS RESOURCES  
Name: JIM GRAFLUND  
Address: P.O. BOX 581630

Phone: (918) 831-0302

TULSA OK 74158-1630

# PENDING APPROVAL

## Section 111 Mandatory Reporting Profile Report

Reporter ID: 000012690

Date: 06/02/2009

Profile Changed: 05/22/2009

COBC EDI Representative: Fiona Scott

Email: fscott@ghimedicare.com

Phone: (646) 447-2019

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### Corporate Information:

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### Reporting Information:

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|                                     |       |
|-------------------------------------|-------|
| Submission Period:                  | 01    |
| Scheduled Submission Dates (mm/dd): | 01/01 |
|                                     | 04/01 |
|                                     | 07/01 |
|                                     | 10/01 |
| Est. No. Paid Claims:               | 39    |

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COBC EDI Representative: Fiona Scott

Email: fscott@ghimedicare.com

Phone: (646) 447-2019

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**File Transmission Method:**

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**Query-Only File:**

Transmission Methodology: SFTP

CMS Mailbox:

## Section 111 Mandatory Reporting Profile Report

Reporter ID: 000012690

Date: 06/02/2009

Profile Changed: 05/22/2009

COBC EDI Representative: Fiona Scott

Email: fscott@ghimedicare.com

Phone: (646) 447-2019

Please review and sign this page if information is correct. Return signed page to COB Contractor:

via Fax: (646) 458-6761

via Email: [COBVA@GHIMedicare.com](mailto:COBVA@GHIMedicare.com) <mailto:COBVA@GHIMedicare.com>

via mail: MEDICARE - COB

Section 111 Mandatory Reporting Program

P.O. Box 660

New York, NY 10274-0660

### SAFEGUARDING & LIMITING ACCESS TO EXCHANGED DATA

I, the undersigned Authorized Representative of the Responsible Reporting Entity (RRE) defined above, certify that the information contained in this Registration is true, accurate and complete to the best of my knowledge and belief, and I authorize CMS to verify this information. I agree to establish and implement proper safeguards against unauthorized use and disclosure of the data exchanged for the purposes of complying with the Medicare Secondary Payer Mandatory Reporting Provisions in Section 111 of the Medicare, Medicaid and SCHIP Extension Act (MMSEA) of 2007. Proper safeguards shall include the adoption of policies and procedures to ensure that the data obtained shall be used solely in accordance with Section 1106 of the Social Security Act [42 U.S.C. § 1306], Section 1874(b) of the Social Security Act [42 U.S.C. § 1395k(b)], Section 1862(b) of the Social Security Act [42 U.S.C. § 1395y(b)], and the Privacy Act of 1974, as amended [5 U.S.C. § 552a]. The Responsible Reporting Entity and its duly authorized agent for this Section 111 reporting, if any, shall establish appropriate administrative, technical, procedural, and physical safeguards to protect the confidentiality of the data and to prevent unauthorized access to the data provided by CMS. I agree that the only entities authorized to have access to the data are CMS, the RRE or its authorized agent for Mandatory Reporting. RREs must ensure that agents reporting on behalf of multiple RREs will segregate data reported on behalf of each unique RRE to limit access to only the RRE and CMS and the agent. Further, RREs must ensure that access by the agent is limited to instances where it is acting solely on behalf of the unique RRE on whose behalf the data was obtained. I agree that the authorized representatives of CMS shall be granted access to premises where the Medicare data is being kept for the purpose of inspecting security arrangements confirming whether the RRE and its duly authorized agent, if any, is in compliance with the security requirements specified above. Access to the records matched and to any records created by the matching process shall be restricted to authorized CMS and RRE employees, agents and officials who require access to perform their official duties in accordance with the uses of the information as authorized under Section 111 of the MMSEA of 2007. Such personnel shall be advised of (1) the confidential nature of the information; (2) safeguards required to protect the information, and (3) the administrative, civil and criminal penalties for noncompliance contained in applicable Federal laws.

Signature of Authorized Representative: \_\_\_\_\_

Date: \_\_\_\_\_

OKLAHOMA COUNTY Printed Requisitions Report

Report Date: 19-JAN-2010 10:10  
Page: 2 of 2

Requisition: 11004402  
Requisition Type: Purchase Requisition  
Creation Date: 19-JAN-10  
Description: Application fee  
Note To Approver:  
Notes:

Preparer: Holt, Bradford C  
Approver: Ellis, Becky A  
Currency: USD

| Line | Line Type | Item             | Rev Category | Description  | Unit | Quantity/Amount | Unit Price | Line Amount |
|------|-----------|------------------|--------------|--|------|-----------------|------------|-------------|
| 1    | Service   | 477-10-000       | SERVICE.FEES | Application fee for                                | Each | 1.00            | 500        | 500.00      |
|      |           | Holt, Bradford C | Supplier     | own risk workers<br>compensation<br>insurance.     |      |                 |            |             |
|      |           |                  |              | 11004402 - WORKER'S COMPENSATION COURT - ORDER - - |      |                 |            |             |

Allocated To Account: 4020.0001.54532.2010.00000.0000.0000

Distributions: 1  
Justification:  
Note To Approver:  
Notes:

Total: 500.00

Previous Approvals:

| Sequence Date | Approver         | Action  | Note |
|---------------|------------------|---------|------|
| 0 19-JAN-10   | Holt, Bradford C | Reserve |      |
| 1 19-JAN-10   | Holt, Bradford C | Submit  |      |
| 2 19-JAN-10   | Holt, Bradford C | Forward |      |
| 3 19-JAN-10   | Ellis, Becky A   | Approve |      |

Approval Action (Circle One):

Approve Forward Reject

Forward To:

Note:

Signature:

21004402