Matthew G. Bevin
Governor

Jenean M. Hampton
Lieutenant Governor

KENTUCKY LABOR CABINET
Department of Workers' Claims
657 Chamberlin Avenue
Frankfort, KY 40601
Telephone: (502) 564-5550
www.labor.ky.gov/workersclaims

Derrick K. Ramsey
Secretary

Dwight T. Lovan
Commissioner

RE: Application for Self-Insurance—Commonwealth of Kentucky

Employers seeking certification as a self-insured entity with the Kentucky Department of Workers' Claims must first submit their three (3) most recent certified financial statements and a completed Form SI-02 "Employers Application For Permission To Carry His Own Risk Without Insurance" at least two (2) months in advance of the proposed inception date for approval. Upon completion of the Department's review of the financial statements and Form SI-02 application, the Department of Workers' Claims will then notify the applicant if it will initially be considered for approval.

If a company's financial statements are initially approved, the following completed forms and information must be submitted to the Department of Workers' Claims:

(1) All individual self-insurers must electronically submit loss report data on an annual basis in order to calculate the required security and simulated premium amounts. Loss data of 5 years is required. An example of the required format for the loss report (Form SI-08) is enclosed. Please note that updated loss data will be required annually for losses that may have occurred prior to becoming self-insured. These loss reports will be required to be submitted electronically and meet all the guidelines for loss data submitted for losses occurring while the employer was self-insured. For more detail, please visit the Self-Insurance Branch's webpage at: http://labor.ky.gov/workersclaims/sac/Pages/Self-Insurance-Branch.aspx and select Data Reporting Instructions.

(2) **Lost time Injury Reports** for the previous five years are required for calculation of the required security amount. The required security amount is based upon an average of indemnity and medical losses during the three (3) highest years of the preceding five (5) years, or a minimum security of **$500,000.00.** Please note that if the applicant has less than five (5) years of doing business in this state there may be issues we will need to address concerning the simulated premium amount. For further information please contact Mike Watts at (502) 782-4510.

(3) After the security is calculated, the applicant will then be notified of the total security amount required by the Department of Workers' Claims. The Department of Workers' Claims currently allows the following surety instruments to be utilized: 1) Continuous Bond; 2) Letter of Credit. Please note: If a Continuous Bond is chosen as the surety instrument, the bonding company must have a current **AM Best** ranking of **A- or Better**.

Please note that any entity leaving the self-insurance program will be required to maintain their current security amount for a period **not less than five (5) years** with the Department of Workers'' Claims. After this five-year period, the Department may effectively reduce the amount of security on file, if applicable, with a written review request.

Please be advised, in accordance with 803 KAR 25:021 Section 5 subsection (5), if an employer is no longer self-insured, the amount of security shall be set by the Commissioner in accordance with the minimum amounts established as follows: a) A minimum security of $250,000 shall be maintained for a period of ten (10) years; b) A minimum security of $100,000 shall be maintained for the eleventh to twentieth year after the employer's departure from self-insured status.

(4) The Department of Workers' Claims requires a **Self-Insurers' Guarantee Agreement** for all subsidiaries that are to be included under an applicant's self-insured program. Applicants are required to list the name and address of each location that is to be covered along with all pertinent Federal ID numbers.

(5) Every application for individual self-insurance shall include: If the applicant is a corporation, a resolution by the Board of Directors, authorizing and directing the corporation to undertake to self-insure.

(6) SPECIFIC EXCESS INSURANCE: The Department of Workers' Claims requires each individually self-insured company to provide a certificate or declaration page of specific excess insurance that clearly states the following:

A. Indemnity limit of either "**Statutory**" or at least **$10,000,000 per occurrence**.
B. Retention level of **$1,000,000 or less**.
C. Documentation that all divisions and/or subsidiaries included in the self-insurance program are also covered by the excess policy. If the certificate or declaration page does not indicate this, please provide a copy of the attached addendum listing the entities which are covered.

(7) If a service organization is used, Department of Workers' Claims regulations require a statement from the service organization and self-insured employer stating that the contract between the two parties meets the requirements set forth in 803 KAR 25:021 Section 3 subsection (4). (See attached service contract provision verification example).

(8) In accordance with House Bill 1, as of March 1, 1997, (Non Coal) entities approved for Self-Insurance will be required to become members of the Kentucky Individual Self Insurers Guaranty Fund, and therefore be responsible for any and all assessments as required by the Fund. Note: By statute, Self-Insured Coal Companies maintain a separate Guaranty Fund.

(9) Please be advised that all financial records submitted to the Department of Workers' Claims are considered to be of public record and therefore are subject to the Commonwealth of Kentucky's Open Records Laws.

(10) **After final approval** by the Commissioner of The Department of Workers' Claims, newly self-insured companies will be forwarded an instruction packet in regards to the calculation of their required simulated premium. The initial premium calculation report must be submitted within **thirty (30)** days of the self-insurance inception date.

After these required items are submitted, the applicant will then be notified of any additional filings required for certification.

If you have any questions or need assistance in this process, please contact this office.

FORM SI-02 **DEPARTMENT OF WORKERS' CLAIMS**
REV. 01/04 **FRANKFORT, KENTUCKY 40601**

EMPLOYERS APPLICATION FOR PERMISSION TO CARRY HIS OWN RISK WITHOUT INSURANCE

TO THE DEPARTMENT OF WORKERS' CLAIMS OF KENTUCKY: _____ , 20____.

The undersigned, an employer subject to the provisions of The Kentucky Workers' Compensation Act, hereby applies for a certificate of his-its financial ability to pay compensation directly, without insurance to injured employees, and determine whether he-it possesses sufficient financial ability to render certain the payment of such compensation, said applicant under oath hereby states the following facts: (Where space is insufficient to answer any question, extend answer on attached page or pages.)

1. Name of applicant: _____

2. Address: _____
(Number) (Street) (City or Town)

_____
(County) (State)

3. The applicant is _____(State whether individual, co-partnership, corporation, receiver or trustee.)

3.a If consolidated balance sheet give list of subsidiary companies included: _____
_____
_____

4. Describe briefly the general character of the operations performed and the articles manufactured or compounded at or away from the plant or the premises of the applicant.
_____

5. Description of Employment: _____
_____

Location of Plant Or Plants	**Kind of Employment**	**Average # of Employees at all points**	**Average # of Employees in Kentucky**	**Actual Payroll For all employees In Kentucky**
TOTALS:				

6. If a corporation, partnership, or Limited Partnership, list below names of officers, directors, and residence of each.
_____

7. Safety, sanitation and welfare conditions:
Is your plant inspected otherwise than by State authority? _____
If so, by whom? _____
Have you fulfilled all safety requirements of the Labor or Mines and Mineral Departments?
_____

Have you a committee of safety whose duty is to recommend safety devices and to secure compliance with statutes or general orders of the above-mentioned agencies as to safety and sanitation? _____

Do you maintain a hospital in connection with your establishment? _____
If so, state description of its equipment and service: _____

8. Federal Employer I.D. # _____ State Employer I.D. # _____
Federal and State I.D. #'s are needed for each subsidiary, if any are to be included.

9. In consideration of the approval of this application the applicant hereby expressly agrees as follows:

a. That this privilege may be revoked at any time in the discretion of The Department of Workers' Claims.

b. That the applicant will fully discharge by cash payment all installments of compensation for partial disability, promptly, when due, and liability for physician fees, hospital service, hospital supplies within 30 days after such liability shall be determined either by an agreement or an award.

c. If The Department of Workers' Claims so requires, the applicant, within thirty days after his-its continuing liability to pay compensation to an injured employee for a definite period for a permanent injury or to the dependents of a deceased employee, for his death, has been determined either by an agreement or an award, will make a special deposit, with some bank or trust company within the Commonwealth of Kentucky to be approved by the Department of Workers' Claims of the full amount of such terms that it can be withdrawn only on the checks of the applicant, payable to the person or persons entitled thereto, and having attached thereto a voucher for the amount thereof, executed by the person or persons to whom such check is payable.

d. The applicant agrees to file with the Department of Workers' Claims for its approval before the granting of this application, an acceptable security, indemnity of bond, to secure to such an extent as the Department of Workers' Claims may direct the payment of compensation liabilities as they are incurred.

10. Requested effective date to become self-insured: _____

_____
If Corporation

By _____
President and Managing Officer

COMMONWEALTH OF KENTUCKY
COUNTY OF _____

_____ , being first duly sworn, upon oath, says that the facts set forth in the foregoing application are true.

_____

Subscribed and sworn to before me, this _____ day of _____, 20_____.

_____
Notary Public

My commission expires on the _____ day of _____, 20_____.

KENTUCKY DEPARTMENT OF WORKERS' CLAIMS
Frankfort, Kentucky 40601

REQUEST FOR INFORMATION

It is the responsibility of each self-insured employer to provide the Department of Workers' Claims with accurate, up-to-date information for our records. The Self Insurance Branch is to be informed of any change in the administration of the self-insured employer's Workers' compensation program, including contact names, telephone numbers, third party administrators, and self-administered policies.

To the Department of Workers' Claims: _____, 20 _____

Applicant:

Company Name: _____

Self-Insurance Inception Date: _____

Federal Employer ID Number: _____

Address: _____

City: _____ State: _____ Zip: _____

County: _____

Contact Name: _____

Phone: _____ Fax: _____

Email: _____

Administration of Self-Insurance Program:

Is the administration of the self-insurance program handled in-house?

☐ Yes ☐ No

If the administration of the self-insurance program is handled by a Third Party Administrator, please provide the following information:

Company Name: _____

Address: _____

Contact Name: _____

Phone: _____ Fax: _____

Email: _____

KENTUCKY DEPARTMENT OF WORKERS' CLAIMS
Frankfort, Kentucky 40601

REQUEST FOR INFORMATION

Claims Administration:

Is the administration of claims handled in-house?

☐ Yes ☐ No

If No, you **must** list the current and all previous Third Party Administrators in chronological order for the entire self-insurance period.

Current Company

Inception Date: _____

Company Name: _____

Address: _____

Contact Name: _____

Phone: _____ Fax: _____

Email: _____

Former Company

Inception Date: _____ End Date: _____

Company Name: _____

Address: _____

Contact Name: _____

Phone: _____ Fax: _____

Email: _____

If additional pages are needed in order to list all former TPA's, please utilize the format above.

KENTUCKY DEPARTMENT OF WORKERS' CLAIMS
Frankfort, Kentucky 40601

REQUEST FOR INFORMATION

Subsidiary/Division/Location Information:

Please list all **entities (including all subsidiaries and divisions)** doing business within the Commonwealth of Kentucky that are to be included under the self-insurance program. Divisions should be listed under the appropriate corporate name. The corresponding address of each work location is to be included.

Please Note:

Self-Insurers Guarantee Agreement (Form SI-01) must be on file for each subsidiary listed. If there is **no** Guarantee Agreement on file, the subsidiary **will not** be listed as being covered under the self-insurance program.

It is the **responsibility of the self-insured employer to notify the Self-Insurance Branch of any and all changes** involving the subsidiaries, divisions, and work locations located within the Commonwealth of Kentucky. Written notification should be forwarded to The Department of Workers' Claims Self-Insurance Branch at the earliest opportunity indicating any locations to be added to or deleted from the self-insurance program as well as any changes in name or address of work locations.

Subsidiary:

Name: _____ FEIN: _____

Address: _____

Division: 1. _____
(Name and Address)

Locations: A. _____
(Name and Address)

Division: 2. _____
(Name and Address)

Location: A. _____
(Name and Address)

If additional pages are needed in order to list all entities to be included, please utilize the format above.

Please ensure that this 'Request for Information' page is completed in its entirety in order for the Self-Insurance Certification process to be completed.

It is the policy of the Department of Workers' Claims Self-Insurance Branch for this information to be provided **each year** as part of the recertification process. This information is essential in maintaining complete and accurate records on all Self-Insured employers.

Please Note:

The self-insured employer is responsible for notifying the Department of Workers' Claims Self-Insurance Branch, in writing, of **any changes** to this information which occur at any time during the approved period of self- insurance.

ENCLOSURE A

Form SI-08 Rev. 10/05

Employer Name:_____

Loss Experience Report for Calendar Year(s):_____

Social Security Number	Employee Last Name	Employee First Name	Injury Date	NCCI Body Part and/or Nature of Injury Code	Indicator	OWC Agency Claim Number	Indemnity Paid as of 12/31/YR	Medical Paid as of 12/31/YR	Vocational Rehab. Paid as of 12/31/YR	Indemnity Reserve as of 12/31/YR	Medical Reserve as of 12/31/YR	Vocational Rehab. Reserve as of 12/31/YR	SIR

*** Please Total Each Individual Year**

COMMONWEALTH OF KENTUCKY
WORKERS' COMPENSATION NOTICE

Employees of this business are covered by the Kentucky Workers' Compensation Act (KRS Chapter 342). Conspicuous posting of this Notice is required by law.

Employer Name: _____
Address: _____
Workers Compensation Carrier
(or third party administrator): _____
Policy #:_____, effective _____ to _____
Address: _____
Telephone: _____, Contact Person _____

EMPLOYEES: IF INJURED – NOTIFY your supervisor IMMEDIATELY; when possible Notice should be in writing. FAILURE to notify your supervisor could result in denial of benefits. OBTAIN MEDICAL CARE. Your employer must pay for ALL NECESSARY MEDICAL CARE to treat a workplace injury. The employee may select the physician or medical facility to render care. If the employer is enrolled in an approved Managed Care Plan employee selection of physicians is LIMITED to the Approved Provider Network, except in certain emergencies. FOR INJURIES REQUIRING CONTINUING CARE the EMPLOYEE MUST DESIGNATE A TREATING PHYSICIAN, a form to do so will be furnished by your employer or its insurance carrier.

This employer IS ☐ IS NOT ☐ participating in a Managed Care Plan for medical care. The name of the Managed Care Plan is _____, its representative is _____, phone number _____.

DISABILITY BENEFITS to replace wages lost due to a workplace injury are payable under the Workers Compensation Act after seven (7) day of disability. A CLAIM MUST BE filed with the Department of Workers' Claim WITHIN TWO YEARS of the date of injury, or last payment of temporary total disability benefits.

NEED ASSISTANCE? Contact your employer's claim representative. If your questions about workers' compensation rights are not promptly answered call THE KENTUCKY DEPARTMENT OF WORKERS CLAIMS at 1-800-554-8601 to speak to an Ombudsman or Workers' Compensation Specialist.

EMPLOYER SUPERVISORS – NOTIFY MANAGEMENT IMMEDIATELY OF ALL INJURIES SO THAT TIMELY REPORT CAN BE MADE AS REQUIRED BY LAW.

04/09/09

Form SI-03
Rev. 01/04

COMMONWEALTH OF KENTUCKY
DEPARTMENT OF WORKERS' CLAIMS
FRANKFORT, KENTUCKY 40601

CONTINUOUS BOND

_____
_____
_____
a company authorized to transact surety business in the Commonwealth of Kentucky, as **Surety,** and _____
_____
_____
a self-insured employer, as **Principal**, are hereby held and firmly bound to the Department of Workers' Claims in the aggregate sum of $_____the payment of which the **Surety** and **Principal** bind themselves, their successors and assigns, jointly and severally.

1. In accordance with Chapter 342 of the Kentucky Revised Statutes and the administrative regulations promulgated thereunder (the "Kentucky Workers' Compensation Act," as it may be amended from time to time), the **Principal** has been certified to self-insure its workers' compensation liability and files this bond to satisfy its obligation to provide an acceptable bond to secure, to the extent the Commissioner of the **Department of Workers' Claims** directs, the payment of workers' compensation liabilities as they are incurred. If the **Principal** shall discharge promptly and completely all of its liabilities under the Kentucky Workers' Compensation Act, then the obligations under this bond shall be null and void; otherwise the obligations remain in full force and effect, subject only to other provisions of this bond.

2**. Surety** agrees that the obligations of this bond shall extend to all past, present, future and potential liability of the **Principal** as an employer that is self-insured for workers' compensation liabilities in Kentucky.

3. This is a continuous bond and shall apply to new as well as existing workers' compensation liabilities incurred by the **Principal** until the bond is terminated by the **Surety**, as hereinafter provided, or until the **Principal's** status as a self-insurer has been revoked or terminated by the Commissioner, and in any of the above-described events the **Surety** shall remain obligated under the provisions of this bond for future payments of workers' compensation liabilities incurred by the **Principal** prior to termination or revocation. However, the **Surety** shall be released from its liability if the **Principal** provides replacement surety acceptable to the **Department of Workers' Claims** for payment of the liabilities covered by this bond.

4. This bond may be terminated by the **Surety** by filing a written notice of intent to terminate the bond in the Office of the Commissioner of the **Department of Workers' Claims** and mailing a copy of the notice to the **Principal** on or before the date of filing, in which event the **Surety's** obligation for new workers' compensation liabilities shall terminate sixty (60) days from the date of such filing with the Commissioner. If the **Principal** fails to file substitute security that is acceptable to the Commissioner within thirty (30) days of the filing of the **Surety's** notice, the **Principal** shall be in default and this bond may be called. Substitution of surety may be allowed only by novation whereby the new surety or other security assumes all liabilities of the **Principal** past, present, future and potential, under the Kentucky Workers' Compensation Act.

5. The Commissioner of the **Department of Workers' Claims** may make written demand personally or by mail upon the **Principal** and **Surety**, at the addresses indicated on the face of this bond, for any portion of the bond amount from time to time or for the full amount of the bond upon a default by the **Principal** in the performance of any of its obligations as a self-insured employer or upon the insolvency, bankruptcy, or receivership of either the **Principal** or the **Surety**. Payment shall be made within fifteen (15) business days after delivery of such demand to the **Surety**.

6. The amount of this bond may be increased or decreased by an agreement stating the effective date of the increase or decrease, executed by the **Principal** and **Surety** on the form specified by the **Department of Workers' Claims**, and approved by the Commissioner of the **Department of Workers' Claims**.

7. If the Surety makes payment to the Commissioner of the **Department of Workers' Claims** pursuant to the provisions of this bond, any unused balance may be released to the **Surety** by the Commissioner upon proof of payment and a lapse of time adequate to assure that the **Principal's** liabilities under the Kentucky Workers' Compensation Act have been fully satisfied and that each has been paid or lapsed under the Act.

8. The insolvency, bankruptcy or receivership of the **Principal** shall not relieve the **Surety** of its obligations under this bond.

9. Nothing stated herein shall be deemed to relieve the **Principal** of any liabilities arising under the Kentucky Workers' Compensation Act.

IN WITNESS WHEREOF, the **Principal** and **Surety** herein have caused this bond to be signed and executed in their names and on their behalf this _____ day of _____, 20_____.

ATTEST:

_____

PRINCIPAL

BY:_____(seal)

ATTEST:

_____

SURETY

BY:_____(seal)

NOTE: Please type name and title below signatures.
Power of attorney must be attached.

COMMONWEALTH OF KENTUCKY
DEPARTMENT OF WORKERS' CLAIMS
FRANKFORT, KENTUCKY 40601

ATTACHMENT TO
FORM NO. SI-03, 1/2004

SURETY RIDER

TO BE ATTACHED TO AND FORM A PART OF BOND NUMBER _____

EXECUTED BY _____, AS PRINCIPAL,

AND BY _____, AS SURETY,

IN FAVOR OF THE COMMONWEALTH OF KENTUCKY, DEPARTMENT OF WORKERS' CLAIMS;

(INCREASE/DECREASE) THE AMOUNT OF SAID BOND

FROM: _____

TO: _____

The Surety agrees that the obligation of this endorsement and the above -referenced bond shall cover and extend to all past, present, future and potential Kentucky workers' compensation liabilities of Principal, as a self-insured employer, to the sum herein named.

Nothing herein contained shall vary, alter or extend any provision or condition of the original bond except as herein expressly stated.

This rider is effective _____

Signed and sealed this _____ day of _____, 20_____.

_____
PRINCIPAL

BY: _____

_____
SURETY

BY: _____

Form SI-04
Rev. 1/04

Name of company must not appear in the body of this document. If it does, it will be returned.

Commonwealth of Kentucky
Department of Workers' Claims
Prevention Park
657 Chamberlin Ave.
Frankfort, KY 40601

Gentlemen:

We hereby issue our Irrevocable Letter of Credit No. _____ in your favor, for drawings up to the aggregate amount of U.S. $_____ effective immediately and expiring at this office with our close of business on _____ and available upon presentation of your sight draft(s) drawn on us, each draft, for all or any part of this Credit, to be marked "Drawn under _____ Bank, N.A. Letter of Credit No. _____." Drafts drawn under and in compliance with the terms of this Letter of Credit will be duly honored if presented at this office on or before the expiry date or any automatically extended date.

Except as stated herein, this undertaking is not subject to any condition or qualification. The obligation of the Bank under this Letter of Credit shall be the individual obligation of the Bank, in no way contingent upon reimbursement with respect thereto.

This Letter of Credit shall be deemed automatically extended without amendment for one year from the expiry date hereof, or any future expiration date, unless sixty (60) days prior to an expiration date we shall notify you by certified mail that we elect not to renew this Letter of Credit for any such additional period. Upon receipt of a sixty-day (60) election not to renew, the Department of Workers' Claims is hereby vested with the authority to call in the funds in their entirety represented by this Letter of Credit.

It is a further condition of this Letter of Credit that if this Letter of Credit expires during any interruptions of the Bank's conduct of business caused by an act of God, riot, civil commotion, insurrection, war or other cause beyond the Bank's control, or by any strike or lockout, the expiry date hereof shall be automatically extended by the period of the interruption.

Should you have occasion to communicate with us regarding the Credit, kindly direct your communication to the attention of our Letter of Credit Department making specific reference to our Credit No. _____.

This Letter of Credit is subject to and governed by the Uniform Customs and Practice for Documentary Credits (1993 Revision) of the International Chamber of Commerce (Publication No. 500).

If any proceedings are initiated with respect to payment of this Letter of Credit, it is agreed that such proceedings shall be subject to Kentucky courts of Law.

MANAGED-CARE/UTILIZATION REVIEW

Has your organization contracted with an approved Managed Care Organization to provide medical services to injured employees? KRS 342.020(3)
If so, please provide the following information:

Name: _____

Address: _____

Phone No.: _____

E-Mail Address: _____

If your organization has not contracted with an approved Managed Care Organization to provide medical services to injured employees, who provides Utilization Review and Medical Bill Audit for medical treatment rendered to injured workers? 803 KAR 25:190 § 3(3)(5)

Name: _____

Address: _____

Phone No.: _____

Fax No.: _____

E-Mail Address: _____

Please Note: It is the self-insured employer's responsibility to inform the Kentucky Department of Workers' Claims when policy changes relating to the administration of claims, managed-care and utilization review have been implemented within a respective employer's self-insurance program.

This is to verify that the service contract between _____
(Employer)

and _____meets the requirements set forth in
(Service Company)

administrative regulation 803 KAR 25:021 § 3(4) and therefore contains one of the two following provisions:

(A) The service organization shall adjust to a final conclusion any and all claims that result from an occurrence during the period for which the contract is effective unless a substitute service organization has been procured; OR

(B) The service organization shall adjust any and all claims for a period of sixty (60) days following an order from the Commissioner finding the self-insured employer in default unless a substitute service organization has been procured.

_____
Signature of authorized Service Company Representative

Date _____

_____
Signature of authorized Self-Insured Employer Representative

Date _____

FORM SI-01
rev. 11/05

COMMONWEALTH OF KENTUCKY
DEPARTMENT OF WORKERS' CLAIMS
FRANKFORT, KENTUCKY 40601
SELF-INSURERS' GUARANTEE AGREEMENT

I. Guarantee: That _____ (hereinafter "Guarantor") a corporation, organized and existing under and by virtue of the laws of the _____ do hereby agree to assume and guarantee to pay or otherwise discharge promptly, all the liabilities and obligations of the following business entity (entities) (hereinafter "Employer(s)"):

_____
_____
_____
_____
_____
_____
_____
_____
_____

which are provided for under the provisions of the Workers' Compensation Act of the Commonwealth of Kentucky per KRS Chapter 342 (hereinafter "Act"). In the event that said Employer(s) fails to pay or cause to be paid their Workers' Compensation liabilities as they become due under said Act, then the Guarantor covenants and agrees that it will pay same.

II. Guarantor's Obligation upon Employer's Default: If the Employer(s) fails to pay any of their obligations as a self-insurer under the Act, the Guarantor will, upon demand and without delay, pay each such unpaid amount as required by the Act to or on behalf of the employee whose injury or disease resulted in that obligation or the representative or beneficiary of that employee, if appropriate, (hereinafter collectively called the "Employee"). Guarantor enters this agreement with the express understanding as a condition precedent to the execution and acceptance of this agreement, that it is for the benefit of unknown and unnamed employees and said employees may maintain direct action on this Agreement to enforce the Guarantor's obligations . In addition, the Commissioner of the Department of Workers' Claims or his representatives, successors or assigns (hereinafter "Department of Workers Claims") may maintain direct action on this Agreement to enforce the performance of the Guarantor's obligations hereunder. In any such actions, the employees and Department of Workers' Claims may recover costs and reasonable attorneys' fees incurred. Notwithstanding the foregoing, Guarantor shall be entitled to contest its liability in any actions brought against it pursuant to this agreement on the same grounds on which the Employer(s) could do so.

III. Guarantor's Waiver of Defenses and Subrogation Rights: In no event shall the Guarantor demand or require as a condition of performing its obligations hereunder that the Department of Workers' Claims (a) obtain judgment or exercise any remedies against an Employer(s), (b) exhaust any rights with respect to any security that an Employer(s) may have posted with the Commissioner, or (c) notify the Guarantor of any information concerning amendment(s) to the Act after the date hereof or concerning Employer(s) that may be relevant to the obligations guaranteed hereunder. The Guarantor hereby agrees not to assert any subrogation rights that it may have as a result of any payments made hereunder against any security that Employer(s) has posted or may post with the Commissioner unless and until the Commissioner returns or releases the security. In addition, the Guarantor agrees to make the payments provided for in this Agreement without regard to whether any obligation of the Employer(s) has been discharged under federal bankruptcy laws or any similar laws.

IV. Termination of Guarantee: This agreement may be terminated at any time by Guarantor giving the Commissioner of the Department of Workers Claims written notice stating when, not less than sixty (60) days from receipt of notice, such termination shall be effective. It is expressly understood and agreed by Guarantor that such cancellation, however, is not to affect liabilities incurred prior to the date of cancellation, or any liabilities or obligations it has under Kentucky Revised Statute Chapter 342. Furthermore, Guarantor understands and agrees that the sale or change in ownership of the Employer(s) it guarantees under this agreement does not terminate this agreement.

V. Reaffirmation of the Guarantee: In his or her sole discretion, the Executive Director may, from time to time, require the Guarantor to reaffirm its obligations under this Agreement by re-executing the form of this Agreement as it may subsequently be revised by the Department of Workers Claims. The Guarantor shall
comply with the Commissioner's demand for such a reaffirmation within fifteen (15) days of its receipt. Notwithstanding the foregoing, the Guarantor shall remain liable under the terms of this Agreement in the absence of any such reaffirmation.

VI. Choice of Venue; Consent to Jurisdiction; Waiver of Personal Service: All actions, suits or proceedings commenced by any person in connection with this Agreement shall solely and exclusively be brought in a state or federal court located in Franklin County, Commonwealth of Kentucky. The Guarantor hereby consents to the jurisdiction of said court in any action or proceeding commenced in connection with this agreement and waives any objection to venue in connection therewith. The Guarantor hereby waives personal service of process or papers to be served in connection with the foregoing and agrees that service may be made by service upon its registered agent in the Commonwealth of Kentucky or upon an official of the Employer(s) that the Guarantor has agreed to guarantee under this agreement.

In the event any provision of this Agreement is deemed to be in violation of law, such provision shall not impair the validity of any other provision.

This agreement shall be effective as of _____, 20____ .

Signed, sealed and delivered this day of ,_____ 20____ .

_____
Company

_____
Title

_____
Signature

Attest:

_____
(CORPORATE SEAL)

* Attach hereto a Resolution of the Board of Directors or a certified copy of the corporate by-laws authorizing the signature(s) displayed on this document