

**Item 6 Revised**

**Application for a Public Entity  
Certificate of Consent to Self Insure**



Our File: \_\_\_\_\_

## APPLICATION FOR A PUBLIC ENTITY CERTIFICATE OF CONSENT TO SELF INSURE

**NOTE:** All questions must be answered. If not applicable, enter "N/A".  
Workers' compensation insurance must be maintained until certificate is effective.

### APPLICANT INFORMATION

Legal Name of Applicant (show exactly as on Charter or other official documents):

San Mateo County Harbor District

Street Address of Main Headquarters:

504 Alhambra Ave, Second Floor, El Granada, CA 94018

Mailing Address (if different from above):

PO Box 1449

Federal Tax ID No.: \_\_\_\_\_

City:

El Granada

State:

CA

Zip + 4:

94018 - 1449

**TO WHOM DO YOU WANT CORRESPONDENCE REGARDING THIS APPLICATION ADDRESSED?**

Name: Stephen McGrath

Title: General Manager

Company Name: San Mateo County Harbor District

Mailing Address: PO Box 1449

City: El Granada

State: CA

Zip + 4: 94018-1449

**Type of Public Entity (check one):**

City and/or County     School District     Police and/or Fire District     Hospital District     Joint Powers Authority

Other (describe): Special District Harbor District

**Type of Application (check one):**

New Application     Reapplication due to Merger or Unification     Reapplication due to Name Change Only

Other (specify): \_\_\_\_\_

**Date Self Insurance Program will begin:** \_\_\_\_\_

**CURRENT PROGRAM FOR WORKERS' COMPENSATION LIABILITIES**

Currently Insured with State Compensation Insurance Fund, Policy Number: \_\_\_\_\_

Policy Expiration Date: \_\_\_\_\_ Yearly Premium: \$ \_\_\_\_\_

Current Yearly Incurred (paid & unpaid) Losses: \$ \_\_\_\_\_ (FY or CY)

Currently Self Insured, Certificate Number: \_\_\_\_\_

Name of Current Certificate Holder: \_\_\_\_\_

Other (describe): Travelers Insurance

**JOINT POWERS AUTHORITY**

Will the applicant be a member of a workers' compensation Joint Powers Authority for the purpose of pooling workers' compensation liabilities?

Yes  No If yes, then complete the following:

Effective date of JPA Membership: \_\_\_\_\_ JPA Certificate No.: 5806

Name and Title of JPA Executive Officer:

Gregory S. Hall, CEO

Name of Joint Powers Authority Agency:

Special District Risk Management Authority

Mailing Address of JPA:

1112 "I" Street, Suite 300

City: Sacramento State: CA Zip + 4: 95814-2865

Telephone Number: ( 800 ) 537-7790

**PROPOSED CLAIMS ADMINISTRATOR**

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

JPA will administer, JPA Certificate No.: \_\_\_\_\_

Third party agency will administer, TPA Certificate No.: 132

Public entity will self administer  Insurance carrier will administer

Name of Individual Claims Administrator:

York Risk Services Group, Inc. Dorianne Zumwalt

Name of Administrative Agency:

York Risk Services Group, Inc.

Mailing Address:

Post Office Box 619058

City: Roseville State: CA Zip + 4: 95661

Telephone Number: ( 916 ) 960-0900 FAX Number: ( 916 ) 783-0338

Number of claims reporting locations to be used to handle the agency's claims: 1

Will all agency claims be handled by the administrator listed on previous page?  Yes  No

**AGENCY EMPLOYMENT**

Current Number of Agency Employees: \_\_\_\_\_

Number of Public Safety Officers (law enforcement, police or fire): 0

If a school district, number of certificated employees: 0

Will all agency employees be included in this self insurance program?  Yes  No

If no, explain who is not included and how workers' compensation coverage is to be provided to the excluded agency employees:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**INJURY AND ILLNESS PREVENTION PROGRAM**

Does the agency have a written Injury and Illness Prevention Program?  Yes  No

Individual responsible for agency Injury and Illness Prevention Program:

Name and Title:

Steve McGrath

Company or Agency Name:

San Mateo County Harbor District

Mailing Address:

PO Box 1449

City:

El Granada

State:

CA

Zip + 4:

94018-1449

Telephone Number: 650-583-4400

**SUPPLEMENTAL COVERAGE**

Will your self insurance program be supplemented by any insurance or pooled coverage under a standard workers' compensation insurance policy?  Yes  No

If yes, then complete the following:

Name of Carrier or Excess Pool: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_

Will your self insurance program be supplemented by any insurance or pooled coverage under a specific excess workers' compensation insurance policy?  Yes  No

If yes, then complete the following:

Name of Carrier or Excess Pool: California States Association of Counties - Excess Insurance Authority

Policy Number: EIA-PE 08 EWC-30

Effective Date of Coverage: July 1, 2015 through June 30, 2016

Retention Limits: \$ 4,500,000

Will your self insurance program be supplemented by any insurance or pooled coverage under an aggregate excess (stop loss) workers' compensation insurance policy?  Yes  No

If yes, then complete the following:

Name of Carrier or Excess Pool: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_

Retention Limits: \_\_\_\_\_

**RESOLUTION OF GOVERNING BOARD**

See Attached Resolution—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.**

Signature of Authorized Official:

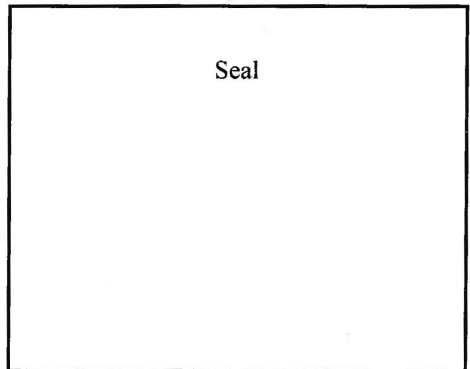
Date:

\_\_\_\_\_  
Typed Name:

\_\_\_\_\_  
Title:

\_\_\_\_\_  
Agency Name:

\_\_\_\_\_



(Emboss seal above or Notarize signature)

RESOLUTION NO.: 14-16 DATED: May 4, 2016

**A RESOLUTION AUTHORIZING APPLICATION  
TO THE DIRECTOR OF INDUSTRIAL RELATIONS, STATE OF CALIFORNIA  
FOR A CERTIFICATE OF CONSENT TO SELF INSURE  
WORKERS' COMPENSATION LIABILITIES**

At a meeting of the Board of Commissioners  
(enter title)

of the San Mateo County Harbor District,  
(enter name of public agency, district)

a Special District organized and existing under the laws of the State of California,  
(enter type of agency)

held on the Fourth day of May, 2016, the following resolution  
was adopted:

**RESOLVED, that the** President of Harbor Board of Commissioners  
(enter position titles)

**be and they are hereby severally authorized and empowered to make application to the Director of Industrial  
Relations, State of California, for a Certificate of Consent to Self Insure workers' compensation liabilities  
on behalf of the**

San Mateo Harbor District  
(enter name of district)

**and to execute any and all documents required for such application.**

I, Tom Mattusch, the undersigned President  
(enter name) (enter title)

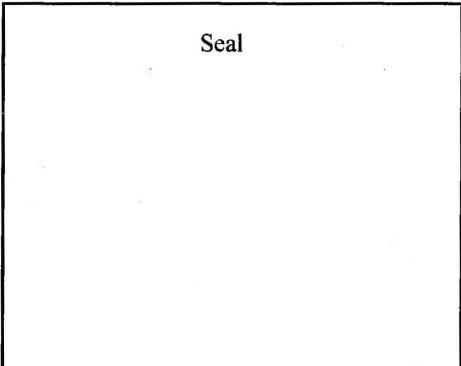
of the Board of the said San Mateo County Harbor District,  
(enter name of agency)

a Special District, hereby certify that I am the President  
(enter type of agency) (enter title)

of said Special District, that the foregoing is a full, true and correct copy of the  
(enter type of agency)

resolution duly passed by the Board at the meeting of said Board held on the day and at the place therein specified  
and that said resolution has never been revoked, rescinded, or set aside and is now in full force and effect.

**IN WITNESS WHEREOF: I HAVE SIGNED MY NAME AND AFFIXED THE SEAL OF THIS**



Special District,  
(enter type of agency)

THIS Fourth DAY OF May, 2016.

\_\_\_\_\_  
(Signature)