State of California
Department of Industrial Relations
Office of Self Insurance Plans
11050 Olson Drive, Suite 230
Rancho Cordova, CA 95670
Phone (916) 464-7000
FAX (916) 464-7007

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):

Cabazon Water District

Street Address of Main Headquarters:

14618 Broadway St

Mailing Address (if different from above):

P.O. Box 297

Federal Tax ID No.:

33-0088107

City, State, Zip Code

Cabazon, CA 92230

TO WHOM DO YOU WANT CORRESPONDENCE REGARDING THIS APPLICATION ADDRESSED?

Name: Jim Byerrum/Myra Evangelista Title: President/Assistant Secretary

Company Name: California Association of Mutual Water Companies Joint Powers Risk and Insurance Management Authority

Mailing Address: C/O California Domestic Water Company
15505 Whittier Blvd.

City: Whittier State: CA Zip + 4: 90603

Telephone Number: (562) 947-3811 Email: jbyerrum@caldomestic.com
mevangelista@caldomestic.com

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

Type of Application (check one):

☒ New Application ☐ Reapplication due to Merger or Unification ☐ Reapplication due to Name Change

☐ Other (describe) _____

Date Self Insurance Program will begin: November 15, 2016

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): Liberty Mutual Insurance; Expiration Date of 11/15/16; Yearly Premium of $8,249

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: November 15, 2016 JPA Certificate No.: 5820

Name and Title of JPA Executive Officer:

Adan Ortega

Name of Joint Powers Authority Agency:

California Association of Mutual Water Companies Joint Powers Risk and Insurance Management Authority

Mailing Address of JPA:

1400 N. Harbor Boulevard, Suite 510

City:	State:	Zip + 4:
Fullerton	CA	92835-4122

Telephone Number: (714) 449-8403

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.: _____

☐ Public entity will self administer ☒ Insurance carrier will self administer

Name of Individual Claims Administrator:

Louise Levine

Name of Administrative Agency:

Zenith Insurance Company

Mailing Address:

21255 Califa Street

City:	State:	Zip + 4:
Woodland Hills	CA	91367-5005

Telephone Number: (818) 713-1000 FAX Number: _____

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: 6

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

If a school district, number of certificated employees: N/A

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:

Company or Agency Name:

Mailing Address:

City: State: Zip + 4:

Telephone Number:

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: _____

Policy Number: _____

Effective Date of Coverage: _____

Retention Limits: _____

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: Zenith Insurance Company

Policy Number: J133354601

Effective Date of Coverage: November 15, 2016

Retention Limits: 0

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: Robert Lynk

Date: 12/20/2016

Typed Name: Robert Lynk

Title: Board Chair

Agency Name: Cabazon Water District

Seal

(Emboss seal above or Notarize signature)

RESOLUTION NO.: 06-2016 DATED: December 20, 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 Directors
(enter title)

of the Cabazon Water District
(enter name of public agency, district)

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

the State of California, held on the 20th day of December , 20 16 , the

following resolution was adopted:

RESOLVED, that the Board Chair
(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

Cabazon Water District
(enter name of district)

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

I, Robert Lynk , the undersigned Board Chair
(enter name) (enter title)

of the Board of the said Cabazon Water District
(enter name of agency)

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

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

passed by the Board at the meeting of said Board held on the day and at the place herein 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

Seal

Special District
(enter type of agency)

THIS 20th DAY OF December , 2016

Robert Lynk
(Signature)