

OKLAHOMA WORKERS' COMPENSATION COMMISSION

1915 NORTH STILES AVENUE
OKLAHOMA CITY, OK 73105
(405) 522-3222 or In-State Toll Free (855) 291-3612

APPLICATION FOR THIRD PARTY ADMINISTRATOR PERMIT

Date _____

The undersigned, a company providing Third-Party Administrative Services to Own Risk employers and/or Group Self-Insurance Associations, hereby applies for permission to act as an approved Third-Party Administrator. To enable the Workers' Compensation Commission to determine the applicant's ability to provide these services, said applicant hereby states the following:

1. TPA Name _____
2. Desired effective date (application should be submitted 30 days in advance) _____
3. TPA # (if a renewal applicant) _____
4. Name of Parent Company, if applicable _____
5. Home office address, phone number & e-mail address _____

6. Oklahoma office address, phone number & e-mail address _____

7. Years in business: Nationally _____ In Oklahoma _____
8. Please include the following items with the application:
 - a. A nonrefundable \$1,000 application fee, payable to the Oklahoma Workers' Compensation Commission.
 - b. Audited financial statements for the most recent fiscal year, including a balance sheet, statement of income, statement of cash flows, and notes. Financial statements may be submitted via email to InsuranceDepartment@wcc.ok.gov or via a cd delivered with the application.
 - c. A list of all claims adjusters on staff. Please include a photocopy of the current Oklahoma license for each adjuster.
 - d. A list of all claims managers or equivalent supervisory personnel. Please include a brief resume for each manager.
 - e. A description of how service fees are determined.
 - f. Services performed by the applicant. If services are provided other than claims adjusting, such as safety consulting, marketing or accounting functions, please provide a brief resume of the principal employee(s) providing these services.
 - g. A description of how client funds are handled for payment of claims.
 - h. A copy of the most recent triennial independent audit performed on the applicant.
 - i. A copy of the Service Organization Controls (SOC) 1 report pursuant to the statement on standards for attestation engagements (SSAE) No. 16, resulting from the most recent independent audit.
 - j. A description of the applicant's policy for setting reserves.

- k. A list of all Own Risk employers, Group Self Insurance associations, and other companies the applicant provides services for.
 - l. A copy of the applicant's Errors and Omissions policy and fidelity bond.
9. In consideration of the approval of this application, the applicant hereby:
- a. Expressly agrees to comply with all applicable statutes, and with the Rules of the Workers' Compensation Commission; and
 - b. Certifies that the TPA:
 - 1) Has adequate personnel on staff to handle the volume and type of work;
 - 2) Establishes claims at the most likely outcome, rather than best case;
 - 3) Retains independence when setting claim reserves; and
 - 4) Maintains adequate computerized records and paper claims files on each claim.

Administrative Workers' Compensation Act, 85A O.S., §6(A)(1)(a): "Any person or entity who makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who employs any device, scheme, or artifice, or who aids and abets any person for the purpose of: (1) obtaining any benefit or payment ... shall be guilty of a felony."

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony punishable by imprisonment, a fine or both.

I declare under penalty of perjury that I have examined this application and all statements contained herein, and to the best of my knowledge and belief, they are true, correct and complete.

Signed this _____ day of _____, 20_____.

Signature of Authorized Representative

(Note: Person signing should have authority to bind the applicant to the agreements contained herein)

Print Name of Authorized Representative

Title of Authorized Representative

Mailing Address

City

State

Zip Code

Street Address, if different from Mailing Address

City

State

Zip Code

E-mail Address of Authorized Representative

Telephone Number of Authorized Representative

Send application to:
OKLAHOMA WORKERS' COMPENSATION COMMISSION
 INSURANCE SERVICES DIVISION
 1915 NORTH STILES AVENUE, SUITE 231
 OKLAHOMA CITY, OK 73105