
RULES AND REGULATIONS

TITLE 34. LABOR AND INDUSTRY**PART VIII. BUREAU OF WORKERS' COMPENSATION****CHAPTER 125. WORKERS' COMPENSATION SELF-INSURANCE****SUBCHAPTER A. INDIVIDUAL SELF-INSURANCE****§ 125.1. Purpose**

This subchapter is promulgated under section 435 of the act (77 P. S. § 991) to provide regulatory guidelines for uniform and orderly administration of self-insurance for individual employers. This subchapter ensures full payment of compensation when due to employees of self-insured employers and to their dependents under the act and the Occupational Disease Act.

§ 125.2. Definitions

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise:

Act — The Workers' Compensation Act (77 P. S. §§ 1 — 1041.4, 2501 – 2506 and 2701 – 2708).

Active self-insurer — A self-insurer that is not a runoff self-insurer.

Actuary — A member in good standing of the Casualty Actuarial Society or a member in good standing of the American Academy of Actuaries.

Adequate accident and illness prevention program — A determination by the Bureau under Chapter 129 (relating to workers' compensation health and safety) that a self-insured employer's accident and illness prevention services fulfill the program and service requirements as stated in that chapter.

Affiliates — Employers which are closely related through common ownership or control.

Aggregate excess insurance — Insurance under which the insurer pays on behalf of or reimburses a self-insurer for its payment of benefits on claims incurred during a policy period in excess of the retention amount to the insurer's liability limit.

Applicant — An employer requesting permission to initiate or to renew self-insurance, an employer requesting permission for it and its affiliates or subsidiaries to initiate or to renew self-insurance, or a parent company requesting permission for its subsidiaries to initiate or to renew self-insurance.

Authorized retention amount — A retention amount that is equal to or is less than a self-insurer's maximum quick assets exposure amount or the current standard retention amount, whichever is less, or the special retention amount approved by the Bureau.

Bureau — The Bureau of Workers' Compensation of the Department.

Cash flow protection amount — The maximum amount of benefits a self-insurer pays over a 2-year period on an occurrence without reimbursement from an insurer under a specific excess insurance policy with a per year per occurrence cash protection plan.

RULES AND REGULATIONS

Catastrophic loss estimation—The greater of the following:

- (i) The largest number of employees anticipated to work at one time during a work day at the largest location in this Commonwealth in terms of the applicant's employment, or the employment of any of its affiliates or subsidiaries under a consolidated permit under §125.4 (relating to application for affiliates and subsidiaries), multiplied by the current Statewide average weekly wage multiplied by 500.
- (ii) The current Statewide average weekly wage multiplied by 5,000.

Claims service company — An individual, corporation, partnership or association engaged in the business of servicing a self-insurer's claims, including the adjusting and handling of claims, the payment of benefits and the provision of required reports.

Commonwealth – The term includes the following:

- (i) The government of the Commonwealth, including the following:
 - (A) The courts and other officers or agencies of the unified judicial system.
 - (B) The General Assembly, and its officers and agencies.
 - (C) The Governor, and the departments, boards, commissions, authorities and officers and agencies of the Commonwealth.
- (ii) An employer, politic and corporate, exercising an essential government function under the laws of the Commonwealth that is not a political subdivision.

Dedicated asset account — An account or fund, such as a bank, checking or trust account or an internal services fund, holding cash or investments solely to finance or hold reserves for the payment of a public employer's workers' compensation liability and related expenses.

Department — The Department of Labor and Industry of the Commonwealth.

Employer — An employer as defined in section 103 of the act (77 P. S. § 21) or under section 103 of the Occupational Disease Act (77 P. S. § 1203), or both.

Excess indemnity insurance — Aggregate excess insurance or specific excess insurance that meets the requirements in §125.11(b)(1) (relating to excess insurance).

Excess insurance—Excess indemnity insurance or workers' compensation excess insurance.

Financial ability to self-insure — Possession of adequate financial capacity and adequate financial health, as specified in §125.6(a) (relating to decision on application).

Guarantor — The affiliate or parent company that has guaranteed a self-insurer's liability by executing an agreement under §125.4(b) (relating to application for affiliates and subsidiaries) that is on file with the Bureau.

Investment grade long-term credit or debt rating — A long-term credit or debt rating identified as investment grade by the NRSRO that issued it.

Liability limit — The maximum amount of benefits for which an insurer indemnifies a self-insurer under an excess insurance policy.

RULES AND REGULATIONS

Long-term credit or debt rating — A measurement by an NRSRO of an applicant's willingness and intrinsic capacity to meet its long-term financial commitments as the commitments become due, exclusive of the effects of any guaranties, insurance or other forms of credit enhancements or legal priorities on any of the applicant's financial obligations.

Loss development — The tendency of the cost of a group of claims to increase as they mature.

Maximum quick assets exposure amount — Five percent of an applicant's average year-end quick assets amount for its last 2 completed fiscal years.

Minimum funding amount — The lower of the following:

- (i) The current Statewide average weekly wage multiplied by 500.
- (ii) The retention amount of the applicant's current or any proposed excess insurance, if applicable.

Minimum security amount — The lower of the following:

- (i) The current Statewide average weekly wage multiplied by 1,000.
- (ii) The retention amount of the applicant's current or any proposed excess insurance, if applicable.

NRSRO — A designated Nationally-recognized statistical rating organization of the United States Securities and Exchange Commission or its successor.

Occupational Disease Act — The Pennsylvania Occupational Disease Act (77 P.S. §§1201 – 1603).

Parent company — An entity which directly or indirectly owns a majority of the voting stock of an employer or controls a majority of the employer's board of directors appointments if the employer has no voting stock.

Permit — The document issued by the Bureau to an employer which authorizes the employer to operate as a self-insurer.

Political subdivision — A county, city, borough, incorporated town, township, school district, vocational school district and county institution district, municipal authority, or other entity created by a political subdivision under law.

Private employer — An employer who is not a public employer as defined in this section.

Public employer — The Commonwealth or a political subdivision.

Quick assets — The sum of an applicant's cash, cash equivalents, current receivables and marketable securities or, if the applicant is a public employer who uses fund accounting, the total of the applicant's general fund assets.

Retention amount —

- (i) The maximum amount of benefits a self-insurer pays without reimbursement from the insurer under an aggregate excess insurance policy or under a specific excess insurance policy which does not include an annual cash flow protection plan.
- (ii) The term also includes the lower of the maximum amount of benefits a self-insurer pays on each occurrence without reimbursement from the insurer or the cash flow protection amount under a specific excess insurance policy which includes an annual cash flow protection plan.

RULES AND REGULATIONS

Runoff self-insurer — An employer that had been a self-insurer but no longer maintains a current permit.

Security — Surety bonds, letters of credit or cash or negotiable government securities held in trust to be used for the payment of a self-insurer's workers' compensation liability upon order of the Bureau if the self-insurer fails to pay its liability due to its financial inability or due to the self-insurer filing for bankruptcy or being declared bankrupt or insolvent.

Self-insurance — The privilege granted to an employer which has been exempted by the Bureau from insuring its liability under section 305(a) of the act (77 P.S. § 501(a)) and section 305 of the Occupational Disease Act (77 P.S. § 1405).

Self-insurance loss portfolio transfer policy — A policy of insurance accepted by the Bureau as meeting the requirements of § 125.21 (relating to self-insurance loss portfolio transfer policy) under which a self-insurer transfers liability incurred as a self-insurer to a workers' compensation insurer.

Self-insurer —

- (i) An employer which has been granted the privilege to self-insure its liability and to maintain direct responsibility for the payment of this liability under the act and the Occupational Disease Act.
- (ii) The term includes a parent company or affiliate which has assumed a subsidiary's or an affiliate's liability upon the termination of the parent-subsiary or affiliate relationship.

Special retention amount —

- (i) A retention amount that exceeds the applicant's maximum quick assets exposure amount or the standard retention amount requested by the applicant and approved by the Bureau based on a determination that the applicant has sufficient quick assets to easily liquidate all losses at the requested greater retention amount.
- (ii) Additionally, an applicant whose self-insurance status began before September 11, 2010, may use a special retention amount that is equal to the retention amount of the applicant's excess insurance in effect on September 11, 2010.

Specific excess insurance — Insurance under which the insurer pays on behalf of or reimburses a self-insurer for its payment of benefits on each occurrence in excess of the retention amount to the insurer's liability limit.

Standard retention amount —

- (i) The current Statewide average weekly wage multiplied by 500.
- (ii) Rounded upward to the nearest hundred thousand.

Statewide average weekly wage — The amount calculated and reported by the Bureau under section 105.1 of the act (77 P. S. § 25.1).

Subsidiary — An employer whose voting stock or board of directors appointments are directly or indirectly controlled by a parent company.

Workers' compensation excess insurance — Aggregate excess insurance or specific excess insurance that meets the requirements in §125.11(b)(2) (relating to excess insurance).

RULES AND REGULATIONS

Workers' compensation excess insurance recoveries — Payments made to a self-insurer under a policy of workers' compensation excess insurance or payments receivable under a policy of workers' compensation excess insurance that the insurer has agreed in writing that it is liable to pay.

Workers' compensation insurer — An insurance company authorized to transact the class of insurance listed in section 202(c)(14) of The Insurance Company Law of 1921 (40 P.S. §382(c)(14)).

§ 125.3. Application

- (a) An applicant shall file an application on a form prescribed by and available upon request from the Bureau. All questions on the application shall be answered completely and accurately with the most recent information available. A rider may be attached if more space is necessary. The application shall be signed by the applicant, or if a corporation, an officer of the corporation. The application, including any attached riders and applicable forms, shall be verified as set forth on the application, subject to the penalties of 18 Pa.C.S. §4904 (relating to unsworn falsification to authorities).
- (b) Initial applications shall be filed with the Bureau no later than 3 months prior to the requested effective date of self-insurance. Renewal applications shall be filed with the Bureau no later than 3 months prior to the expiration of the current permit.
- (c) With the application, the applicant shall include:
 - (1) The nonrefundable statutory fee in the amount of \$500 for initial applicants or \$100 for renewal applicants required under section 305(a) of the act (77 P. S. § 501(a)), payable to the "Commonwealth of Pennsylvania." A statutory fee is required in the amount of \$500 for each affiliate or subsidiary being initially added or in the amount of \$100 for each affiliate or subsidiary renewing under a consolidated application under § 125.4 (relating to application for affiliates and subsidiaries).
 - (2) Its Security and Exchange Commission (SEC) Form 10-K, or equivalent form filed by a foreign corporation with the SEC or the governing body of an internationally recognized public securities exchange for an application being processed under the conditions of §125.4(e) (relating to application for affiliates and subsidiaries), for the last complete fiscal year, if applicable. The filing of these forms does not serve as a substitute for the full completion of the application form.
 - (3) Its latest audited financial statement issued by a licensed certified public accountant or accounting firm. For a private employer, the audited financial statements must cover the last complete fiscal-year period immediately prior to the date of application. The audited financial statements must meet the following criteria:
 - (i) They must be presented in conformance with applicable generally accepted accounting principles as promulgated by the Financial Accounting Standards Board or the Government Accounting Standards Board or with international financial reporting standards promulgated by the International Accounting Standards Board. The text of the financial statements and their accompanying notes must be in the English language. If the currency used in the financial statements is not in United States dollars, the applicant shall cooperate and assist the Bureau in converting the currency to United States dollars.

RULES AND REGULATIONS

- (ii) They must be audited in accordance with generally accepted auditing standards in the United States or in accordance with the standards of the Public Company Accounting Oversight Board (United States) or the International Standards on Auditing. An unqualified or qualified opinion shall be stated on the most recent audited financial statements.
 - (iii) If the most current audited period precedes the application date by more than 6 months, the applicant's latest SEC Form 10-Q, or similar form filed by a foreign corporation with the SEC or the governing body of an internationally recognized public securities exchange for an application being processed under the conditions of §125.4(e), or unaudited interim financial statements must be submitted.
- (4) Audited financial statements covering the applicant's second and third most recent complete fiscal-year periods prior to the date of the application, if an initial application. If audited financial statements covering those periods are not available, financial statements reviewed by a certified public accountant in accordance with standards established by the American Institute of Certified Public Accountants or the International Auditing and Assurance Standards Board covering the second and third most recent complete fiscal year periods prior to the date of the application will be accepted.
- (5) A report of the paid and incurred workers' compensation loss experience in this Commonwealth under each of the 3 completed policy years prior to the application of each employer requesting self-insurance, if an initial application. The loss information for each policy year shall be valued within 3 months prior to the date of the submission of the application.
- (6) A report on a form prescribed by the Bureau and provided to each employer requesting self-insurance status stating the costs of claims incurred by the employer by annual periods and projecting the total value of its outstanding liability under the act and the Occupational Disease Act, if a renewal application. A renewal applicant that has retained the services of an actuary to project the total value of its outstanding liability may submit the actuary's report with its application.
- (7) A report for each employer requesting self-insurance on a form prescribed by the Bureau and provided to each employer requesting self-insurance summarizing the existence of the accident and illness prevention program required under section 1001(b) of the act (77 P. S. § 1038.1) and regulations promulgated thereunder.
- (8) A listing for each employer requesting self-insurance, in a Bureau-prescribed electronic format provided to each employer requesting self-insurance, of the employer's Pennsylvania workers' compensation claims incurred as a self-insurer, including claims currently in litigation, and information such as payments and reserves on each claim. The listing must include:
 - (i) All open claims at the time of submission.
 - (ii) All claims closed on or after September 11, 2010.
 - (iii) Case reserves provided in the listing must be established according to instructions on forms prescribed by the Bureau and provided to each employer requesting self-insurance.
- (9) Written verification of the applicant's current long-term credit or debt ratings, if any.

RULES AND REGULATIONS

- (d) The applicant shall provide additional data, information and explanation that the Bureau deems pertinent to its review of the application based on the factors enumerated under § 125.6(a) (relating to decision on application), and shall make any corrections determined necessary by the Bureau, and provide any items under subsection (c) determined missing or insufficient by the Bureau. The applicant shall provide the data, information, explanation, corrections or missing items within 21 days of its receipt of written notification from the Bureau of its need to do so, or by a later date if requested by the applicant and approved by the Bureau. If the applicant does not provide the data, information, explanation, corrections or missing items within the prescribed time period, the application will be deemed withdrawn. A renewal applicant that does not provide the data, information, explanation, corrections or missing items within the prescribed time period shall obtain workers' compensation insurance coverage effective the expiration of that time period and shall provide evidence of the coverage, such as a certificate of insurance, to the Bureau no later than the coverage's effective date.
- (e) The Bureau will not issue a decision on the application under §125.6 (relating to decision on application) until the application, including all items required under subsection (c) and all additional data, information, explanation and corrections under subsection (d), have been submitted.
- (f) An initial applicant's requested self-insurance effective date is subject to the approval of the Bureau. An initial applicant which fails to insure its liability pending review of its application will be subject to prosecution under the act and the Occupational Disease Act.

§ 125.4. Application for affiliates and subsidiaries

- (a) An affiliate or subsidiary may be included under an application submitted by another affiliate or its parent company. The related entities will be included under one consolidated permit if the application is approved. A written notification shall be provided by the applicant to delete an affiliate or a subsidiary from a consolidated permit after its issuance.
- (b) An applicant shall provide a written agreement adopted by its board of directors on a form prescribed by the Bureau which states that the applicant guarantees the payment of all claims incurred by the affiliates or subsidiaries. The applicant shall further assume liability for the payment of an affiliate's or subsidiary's claims incurred during its period of self-insurance upon termination of the affiliate or parent-subsidiary relationship unless the applicant is relieved of this liability by the Bureau. In determining whether to relieve an applicant of a subsidiary's or affiliate's liability, the Bureau will consider, among other things, the financial ability of the new owner of the subsidiary or affiliate to pay the liabilities, the new owner's credit worthiness and the adequacy of security held by the Bureau covering the liability.
- (c) The guarantor may not terminate the agreement under any circumstances without first giving the Bureau and the affected affiliate or subsidiary 45 days written notice. The affiliate's or subsidiary's self-insurance status automatically terminates upon expiration of the 45-day notice period.
- (d) Except as provided in § 125.4(e), if an affiliate or subsidiary not included under a consolidated application as outlined in subsection (a) wishes to self-insure, it shall submit an application in its own name and provide its own audited financial statements in the manner indicated in § 125.3 (relating to application). The Bureau may require the parent company to furnish appropriate financial information within 21 days of its receipt of written notification from the Bureau of its need to do so, or by a later date if requested by the applicant and approved by the Bureau.

RULES AND REGULATIONS

- (e) If the applicant is a subsidiary of a parent company that is not incorporated or organized under the laws of a state of the United States, the applicant may submit its parent company's consolidated audited financial statements and an unaudited consolidated balance sheet of the applicant's financial condition, or other financial information on the applicant that the Bureau deems pertinent to its review of the application, to satisfy the financial reporting requirements of §125.3(c), provided the parent company's audited financial statements comply with §125.3(c)(3)(i) and (ii).

§ 125.5. Preliminary requirements

- (a) An applicant shall have been in business for at least 3 consecutive years prior to application.
- (b) An applicant shall be incorporated or organized under the laws of a state of the United States.
- (c) Each employer requesting self-insurance shall have an adequate accident and illness prevention program.

§ 125.6. Decision on application

- (a) The application of an applicant which meets the requirements of § 125.5 (relating to preliminary requirements) will be approved if the Bureau determines that the applicant has demonstrated that it possesses the financial ability to self-insure.
 - (1) An applicant shall demonstrate that it has adequate financial capacity by showing one of the following:
 - (i) The retention amount of the applicant's current or proposed excess insurance equals or is less than its authorized retention amount.
 - (ii) The applicant's catastrophic loss estimation is equal to or is less than its maximum quick assets exposure amount
 - (2) An applicant shall demonstrate that it has adequate financial health, as follows:
 - (i) If a public employer, the applicant satisfies or will satisfy the requirements established for it under §125.10 (relating to funding by public employers).
 - (ii) If a private employer, the applicant's level of financial stability, solvency and liquidity is such that it satisfies one of the following:
 - (A) The applicant, or its parent company for an application being processed under the conditions of §125.4(e) (relating to application for affiliates and subsidiaries), possesses an investment-grade long-term credit or debt rating, or such a rating that is one generic rating classification below investment grade.
 - (B) For an applicant who does not receive a long-term credit or debt rating by an NRSRO, or whose parent company does not receive a long-term credit or debt rating by an NRSRO for an application being processed under the conditions of §125.4(e), the Bureau estimates that the applicant, or its parent company for an application being processed under the conditions of §125.4(e), would merit an investment grade long-term credit or debt rating, or a rating that is one generic rating classification below investment grade, if it were rated.

RULES AND REGULATIONS

- (C) An applicant that was approved to self-insure as of September 11, 2010, that possesses an actual or Bureau-estimated long-term credit or debt rating more than one generic rating classification below investment grade shall be deemed to possess adequate financial health if its generic rating does not decline further. This clause will no longer apply if the applicant's actual or Bureau-estimated long-term credit or debt rating subsequently increases to one generic rating classification below investment grade or higher.
- (b) The Bureau will consider the following information in assessing an applicant's financial ability to self-insure:
- (1) The applicant's level of financial health, or its parent company's level of financial health for an application being processed under the conditions of §125.4(e), based upon the applicant's or its parent's long-term credit or debt rating, if any, or upon an evaluation by the Bureau of one or more of the following:
 - (i) The applicant's financial statements, or its parent company's financial statements for an application being processed under the conditions of §125.4(e), which may include comparisons of the applicant's or its parent company's financial ratios to general or to industry ratios and cash flow analysis.
 - (ii) Public documents and reports filed with other state and Federal agencies including the United States Securities and Exchange Commission.
 - (iii) Other financial analysis information provided to or considered by the Bureau, including financial analysis comparison databases and evaluation models.
 - (2) The amount of the applicant's quick assets at the end of its last 2 completed fiscal years as shown on the financial statements provided to the Bureau under §125.3(c) (relating to application) or under §125.4(e).
 - (3) The terms, conditions and limits of the applicant's existing or proposed excess insurance.
 - (4) For a public employer, its ability to satisfy or its past history in satisfying the requirements established under §125.10.
- (c) If the Bureau finds under subsection (a) that the applicant possesses the financial ability to self-insure, it will send to the applicant an initial decision approving the application and a list of conditions as set forth under subsection (c)(2) that must be met before the applicant will be issued a permit. The Bureau will issue a permit to a renewal applicant at the time of the initial decision when the renewal applicant is currently in compliance with the conditions set forth by the Bureau.
- (1) An applicant has 45 days from the receipt of the initial decision approving the application to comply with the conditions set forth by the Bureau.
 - (i) The applicant may toll the 45-day compliance period by filing a request for a conference or notification of its intent to submit additional written information under subsection (e).
 - (ii) An applicant may be granted a 30-day extension to meet the conditions if the applicant requests an extension in writing. The Bureau must receive the extension request within the initial 45-day compliance period.

RULES AND REGULATIONS

- (iii) Unless a timely reconsideration is initiated under subsection (e), when the applicant does not meet the conditions within this compliance period, the application will be deemed denied.
 - (iv) A renewal applicant that does not meet the conditions within this compliance period and that has not timely initiated the procedures outlined in subsection (e) shall obtain workers' compensation insurance coverage effective the expiration date of the compliance period and provide evidence of the coverage, such as a certificate of insurance, to the Bureau no later than the coverage's effective date.
- (2) The applicant will be issued a permit after all of the following have been filed with the Bureau:
- (i) Security in an amount as set forth in §125.9 (relating to security requirements) or funding as set forth in §125.10.
 - (ii) A certificate providing evidence that the applicant has obtained excess insurance coverage with limits set forth under §125.11(a) (relating to excess insurance), if required.
 - (iii) A guarantee agreement executed by its parent company or an affiliate as set forth in §125.4 (relating to application for affiliates and subsidiaries), if required.
 - (iv) Contact information on the claims service company or in-house staff that will be handling the applicant's claims.
 - (v) Documents relating to any other requirement set by the Bureau to protect the compensation rights of employees.
- (d) If an applicant does not meet the requirements of §125.5 or if upon review under subsection (a) the Bureau finds that the applicant has not demonstrated that it possesses the financial ability to self-insure, the Bureau will send to the applicant an initial decision denying the application. The initial decision will state the documents, data, information, explanation and corrections received from the applicant or otherwise reviewed or considered by the Bureau in rendering its initial decision. A renewal applicant shall obtain workers' compensation insurance coverage effective no later than 30 days after its receipt of an initial decision denying the renewal application and shall provide evidence of the coverage, such as a certificate of insurance, to the Bureau no later than the coverage's effective date, unless the applicant has timely initiated the procedures outlined in subsection (e).
- (e) The applicant may request a conference with the Bureau to submit additional materials to support its application or the alteration of the conditions required in the initial decision, or to challenge the accuracy of underlying calculations made or data considered by the Bureau in its decision or conditions. The applicant may also notify the Bureau of its intention to submit these materials directly in writing without a conference. The Bureau must receive a request or notification within 20 days of the date of the Bureau's initial decision.
- (1) Upon its receipt of the request or notification, the Bureau will schedule a conference. If a conference is not requested, the applicant shall provide the additional materials within 21 days of its receipt of written notification from the Bureau of its need to do so, or by a later date if requested by the applicant and approved by the Bureau.
 - (2) The prior permit of a renewal applicant that has filed a timely request for a conference or notification of intent to submit additional materials will be automatically extended beyond the

RULES AND REGULATIONS

permit's original expiration date until the Bureau issues a reconsideration decision on the renewal application under subsection (f). During the time the permit is extended, the prior conditions established by the Bureau, as set forth under subsection (c)(2), shall continue to apply.

- (f) After a conference or the receipt of additional materials, the Chief of the Self-Insurance Division of the Bureau will review the entire record of the application and will issue a reconsideration decision on the application.
 - (1) The applicant shall have 30 days from its receipt of a reconsideration decision approving an application to comply with any conditions set forth by the Bureau in that decision.
 - (i) Unless a timely appeal is filed under subsection (g), when the applicant does not meet the conditions within this 30-day period, the application will be deemed denied.
 - (ii) A renewal applicant that does not meet the conditions within this 30-day period shall obtain workers' compensation insurance coverage effective the expiration of the compliance period and shall provide evidence of the coverage, such as a certificate of insurance, to the Bureau no later than the coverage's effective date, unless the applicant has timely initiated the procedures outlined in subsection (g).
 - (2) Upon the issuance of a reconsideration decision denying a renewal application, the renewal applicant shall obtain workers' compensation insurance coverage effective no later than 30 days after its receipt of the reconsideration decision and provide evidence of the coverage, such as a certificate of insurance, to the Bureau no later than the coverage's effective date unless the applicant has timely initiated the procedures outlined in subsection (g).
- (g) An applicant shall have the right to appeal a reconsideration decision issued under subsection (f). The Bureau must receive the appeal within 30 days of the date of the reconsideration decision. The prior permit of a renewal applicant that filed a timely appeal shall be automatically extended beyond the permit's original expiration date, until a presiding officer issues a written decision on the appeal. During the time the permit is extended, the prior conditions established by the Bureau, as set forth under subsection (c)(2), shall continue to apply. Untimely appeals will be dismissed without further action by the Bureau.
 - (1) The Director of the Bureau will assign the appeal to a presiding officer who will schedule a hearing on the appeal from the reconsideration decision. The presiding officer will provide notice to the parties of the hearing date, time and place.
 - (2) The hearing will be conducted under this subsection and 1 Pa.Code Part II (relating to General Rules of Administrative Practice and Procedure) to the extent not superseded in paragraph (6). The presiding officer will not be bound by strict rules of evidence.
 - (3) Hearings will be stenographically-recorded. The transcript of the proceedings will be part of the record.
 - (4) The presiding officer will issue a written decision and order under 1 Pa.Code Chapter 35, Subchapters G and H (relating to proposed reports; and agency action) to the extent not superseded in paragraph (6). The presiding officer will determine whether the Bureau abused its discretion or acted arbitrarily in the reconsideration decision. The applicant has the burden to prove that the Bureau abused its discretion or acted arbitrarily in the reconsideration decision.
 - (5) A party aggrieved by a decision rendered by the presiding officer may appeal the decision to Commonwealth Court.

RULES AND REGULATIONS

- (6) This subsection supersedes 1 Pa.Code §§35.131, 35.190, 35.201, 35.211—35.214 and 35.221.
- (h) An applicant which has been denied self-insurance may reapply after audited financial statements are published subsequent to the latest ones submitted with the denied application.

§ 125.7. Permit

- (a) A permit is issued for 1 year, except that the Bureau may shorten or extend the effective period of a permit by not more than 6 months to facilitate the filing of timely financial statements or other data and information required with the next renewal application.
- (b) If the Bureau fails to issue an initial decision with respect to a renewal application under §125.6 (relating to decision on application) prior to the expiration of the permit for the prior year, the prior permit will be automatically extended under the prior conditions as set forth under §125.6(c)(2) beyond the permit's original expiration date, until a decision on the renewal application is issued by the Bureau. This automatic extension applies only in cases when the renewal application has been timely filed under § 125.3 (relating to application) and the applicant has submitted or is submitting all data, information, explanation, corrections and missing items, or has corrected or is correcting inaccurate data, within the time period prescribed in writing by the Bureau.

§ 125.8. (Reserved)**§ 125.9. Security requirements**

- (a) A private employer shall provide security in an amount as set forth in subsection (d). The security required in this section is not a substitute for the applicant demonstrating its financial ability to self-insure. A self-insurer's security may be adjusted annually or more frequently as determined by the Bureau.
- (b) The following forms of security are acceptable:
 - (1) A surety bond on a form prescribed by and available upon request from the Bureau issued by a company authorized to transact surety business in this Commonwealth by the Insurance Department.
 - (i) At the time of the issuance of the bond, the surety company shall possess a current A. M. Best Rating of A- or better or a Standard & Poor's insurer's financial strength rating of A or better or a comparable rating by another NRSRO.
 - (ii) The self-insurer shall replace the bond with a new bond issued by a surety company with an acceptable rating or with another acceptable form of security if the surety company's highest rating falls below an A. M. Best Rating of B+, a Standard & Poor's insurer's financial strength rating of A- or a comparable rating by another NRSRO after the bond is issued. If the bond is not replaced within 45 days of the self-insurer's receipt of written notification of the rating decline from the Bureau, the Bureau will have discretion to draw on the surety bond and deposit the proceeds with the State Treasurer to secure the self-insurer's liability and to revoke the current permit if the bond exclusively secures claims currently being incurred against the self-insurer.
 - (iii) An active self-insurer that does not post another bond or another acceptable form of security to cover claims currently being incurred against the self-insurer, after the surety of a bond that exclusively secures the claims provides notification of its intention to terminate the bond, shall obtain workers' compensation insurance coverage effective the bond's termination date. The self-insurer shall provide evidence of the coverage, such as a certificate of insurance, to the Bureau no later than the coverage's effective date.

RULES AND REGULATIONS

- (2) A security deposit held under a trust agreement prescribed by and available upon request from the Bureau and maintained for the benefit of employees of the self-insurer:
 - (i) The deposit must consist of cash; bonds or other evidence of indebtedness issued, assumed or guaranteed by the United States of America, or by an agency or instrumentality of the United States; investments in common funds or regulated investment companies which invest primarily in United States Government or Government agency obligations; or bonds or other security issued by the Commonwealth and backed by the Commonwealth's full faith and credit.
 - (ii) The securities must be held in a Commonwealth chartered bank and trust company or trust company as defined in section 102 of the Banking Code of 1965 (7 P. S. § 102) or a Federally-chartered bank or foreign bank with a branch office and trust powers in this Commonwealth.
- (3) An irrevocable letter of credit using language required by the Bureau issued by and payable at a branch office of a commercial bank located in the continental United States. The letter of credit must state that the terms of the letter of credit automatically renew annually unless the letter of credit is specifically nonrenewed by the issuing bank 60 days or more prior to the anniversary date of its issuance.
 - (i) At the time of issuance of the letter of credit, the issuing bank or its holding company shall have a B/C or better rating or 2.5 or better credit evaluation score by Fitch Ratings, as successor to the rating services of Thomson BankWatch, or the issuing bank shall have a CD or long-term issuer credit rating of BBB or better or a short-term issuer credit rating of A-2 or better by Standard & Poor's or a comparable rating by another NRSRO.
 - (ii) The self-insurer shall replace the letter of credit with a new letter of credit issued by a bank with an acceptable credit rating or with another acceptable form of security if the issuing bank's highest rating falls below the acceptable rating outlined in subparagraph (i) after the letter of credit is issued. If the letter of credit is not replaced within 45 days, the Bureau will draw on the letter of credit and will deposit the proceeds to secure the self-insurer's liability.
- (c) Affiliates included under a consolidated permit under § 125.4(a) (relating to application for affiliates and subsidiaries) must be included together under the forms of security provided. For purposes of this section, affiliates that are runoff self-insurers are considered to be active self-insurers if they were included under a consolidated permit with affiliates that remain active self-insurers.
- (d) The amount of security required of private employers is determined as set forth in paragraphs (1) — (6).
 - (1) For a new self-insurer, the Bureau will determine the initial amount of security to be calculated as follows:
 - (i) An amount no less than two times the amount of the applicant's total greatest annual insured incurred workers' compensation losses in this Commonwealth during the last 3 completed policy years prior to its application, or the minimum security amount, whichever is greater.
 - (ii) Discounted by the percentage outlined under subsection (l) for the applicant's highest current long-term credit or debt rating, if any.
 - (iii) Rounded upward to the nearest hundred thousand.

RULES AND REGULATIONS

- (2) For those active self-insurers who have been approved to self-insure for more than 1 year but less than 3 years, the amount of security is calculated as follows:
 - (i) The greater of:
 - (A) The amount outlined in paragraph (1).
 - (B) One hundred percent of the Bureau's calculation of the self-insurer's undiscounted outstanding liability based on loss development, net of workers' compensation excess insurance recoveries.
 - (ii) Discounted by the percentage outlined under subsection (1) for the applicant's highest current long-term credit or debt rating, if any.
 - (iii) Rounded upward to the nearest hundred thousand.
- (3) For those active self-insurers who have been approved to self-insure for 3 or more years, the amount of security is calculated as follows:
 - (i) One hundred percent of the Bureau's calculation of the self-insurer's undiscounted outstanding liability based on loss development, net of workers' compensation excess insurance recoveries, or the minimum security amount, whichever is greater.
 - (ii) Discounted by the percentage outlined under subsection (1) for the applicant's highest current long-term credit or debt rating, if any.
 - (iii) Rounded upward to the nearest hundred thousand.
- (4) When multiple affiliates are included under a consolidated permit, the required amount of security for the consolidated program is calculated as follows:
 - (i) The sum of each individual affiliate's required amount of security as calculated under the applicable paragraphs above but excluding the effects of any rounding or minimum applicable to the individual affiliates, or the minimum security amount, whichever is greater.
 - (ii) Discounted by the percentage outlined under subsection (1) for the applicant's highest current long-term credit or debt rating, if any.
 - (iii) Rounded upward to the nearest hundred thousand.
- (5) For runoff self-insurers, the amount of security is calculated as follows:
 - (i) One hundred percent of the Bureau's calculation of the runoff self-insurer's undiscounted outstanding liability based on loss development, net of workers' compensation excess insurance recoveries.
 - (ii) Discounted by the percentage outlined under subsection (1) for the runoff self-insurer's or its guarantor's highest current long-term credit or debt rating, if any.
 - (iii) Rounded upward to either:
 - (A) The nearest ten thousand if the Bureau's calculated undiscounted outstanding liability, net of workers' compensation excess insurance recoveries, discounted by the percentage outlined under subsection (1) for the runoff self-insurer's or its guarantor's highest current long-term credit or debt rating, if any, is \$50,000 or less.
 - (B) The nearest hundred thousand.

RULES AND REGULATIONS

- (6) When multiple runoff self-insurers are included under one security instrument, the required amount of security is calculated as follows:
 - (i) The sum of each individual runoff self-insurer's required amount of security as calculated under paragraph (5) but excluding the effects of any rounding applicable to the individual runoff self-insurers.
 - (ii) Discounted by the percentage outlined under subsection (l) for the runoff self-insurers' or their guarantor's highest current long-term credit or debt rating, if any.
 - (iii) Rounded upward to either:
 - (A) The nearest ten thousand if the Bureau's calculated undiscounted outstanding liability, net of workers' compensation excess insurance recoveries, discounted by the percentage outlined under subsection (l) for the runoff self-insurers' or their guarantor's highest current long-term credit or debt rating, if any, is \$50,000 or less.
 - (B) The nearest hundred thousand.
- (e) A self-insurer wishing to refute the Bureau's adjustment of its outstanding liability by its history of loss development may do so by providing a report prepared by an actuary.
- (f) The Bureau will incorporate the overall Pennsylvania workers' compensation experience of insured or self-insured employers in the self-insurer's industry or of all insured or self-insured employers in its selection of loss development factors under subsection (d) if the claim volume or experience of the self-insurer is not sufficient to be considered fully credible based on generally accepted actuarial procedures. The loss development factors selected by the Bureau and its other judgments in its calculation of a self-insurer's outstanding liability will be sufficiently conservative to ensure the adequate provision of security.
- (g) The Bureau will make adjustments to the loss development procedures under subsection (d) it deems appropriate under the circumstances if the Bureau believes that a self-insurer has changed its reserving methodology in such a way as to invalidate loss development factors based on past experience.
- (h) The Bureau may reduce the amount of security required of a self-insurer under subsection (d) if the self-insurer confirms that liabilities under the act and the Occupational Disease Act are funded through a Black Lung Benefits Trust established under section 501(c)(21) of the Internal Revenue Code of 1986 (26 U.S.C.A. § 501(c)(21)).
- (i) The Bureau may reduce the amount of security required of a self-insurer under subsection (d) to no less than the minimum security amount rounded upward to the nearest hundred thousand if the self-insurer establishes a funding trust to provide a source of funds for the payment of its liability. A self-insurer may elect to establish a funding trust or it may be required by the Bureau to establish a funding trust where the Bureau determines that a dedicated source of funds is needed to further ensure the timely payment of the self-insurer's liability. In either case, the following conditions shall be met:
 - (1) The trust agreement must be in a form prescribed by the Bureau.
 - (2) The trust assets must be held in a Commonwealth chartered bank and trust company or trust company as defined in section 102 of the Banking Code of 1965 or a Federally chartered bank or foreign bank with a branch office and trust powers in this Commonwealth.

RULES AND REGULATIONS

- (3) The value of the trust fund must be adjusted at least annually to the required funding level as determined by the Bureau.
- (j) A self-insurer with security which is less than the level of security required under subsection (d) may be permitted to phase in the level of required security over a maximum of 2 years. The Bureau will determine the terms of the phase-in period, including the length of time and the annual phase-in amounts.
- (k) The Bureau may release a runoff self-insurer of its obligation to provide security if either of the following occurs:
- (1) The runoff self-insurer provides evidence that its liability was assumed under a self-insurance loss portfolio transfer policy.
 - (2) If the runoff self-insurer made no payments on its liability over the past 2 years and all claims against the runoff self-insurer are closed.
- (l) The following discount percentages shall be applied in calculating a self-insurer's required amount of security under subsection (d) based on the highest current long-term credit or debt rating of the self-insurer or of its guarantor:

Security Discount Table

Moody's Investors Service	Standar & Poor's, Fitch Ratings, or Dominion Bond Rating Service	Security Discount
Aaa	AAA	75%
Aa1	AA+	65%
Aa2	AA	60%
Aa3	AA-	55%
A1	A+	45%
A2	A	40%
A3	A-	35%
Baa1	BBB+	25%
Baa2	BBB	20%
Baa3	BBB-	15%
Ba1 and lower	BB+ and lower	0%

- (m) The Bureau may revise the table in subsection (l) through publication of a notice in the *Pennsylvania Bulletin* to assign security discount rates for any organization receiving designation as a NRSRO after September 11, 2010.

§ 125.10. Funding by public employers

- (a) A self-insured public employer shall establish and maintain a dedicated asset account to provide a source of funds for the payment of benefits and other obligations and expenses relating to its self-insurance program. This section does not apply to a runoff self-insured public employer whose average annual payout of benefits on self-insurance claims over its last 3 completed fiscal years, net of workers' compensation excess insurance recoveries, is less than the current Statewide average weekly wage multiplied by 100.

RULES AND REGULATIONS

- (b) For a new self-insured public employer and for an active self-insured public employer that has been self-insured for less than 3 consecutive years, the required asset level of the dedicated asset account established under subsection (a) is calculated as follows:
- (1) An amount greater than or equal to 20% of the public employer's modified manual premium calculated in accordance with §125.202 (relating to definitions) or the minimum funding amount, whichever is greater.
 - (2) Discounted by the percentage outlined under §125.9(1) (relating to security requirements) for the self-insurer's highest current long-term credit or debt rating, if any.
 - (3) The dedicated asset account must equal the above prescribed asset level no later than 30 days before the effective date of the public employer's initial permit and may not be reduced below this asset level for the first 3 years of self-insurance.
- (c) For an active self-insured public employer that has been self-insured for more than 3 consecutive years but less than 7 consecutive years, the required asset level of the dedicated asset account established under subsection (a) is calculated as follows:
- (1) An amount greater than or equal to the greater of the following:
 - (i) The self-insurer's greatest annual fiscal year payout of benefits since its initial approval to self-insure, net of workers' compensation excess insurance recoveries, plus 20% of that annual payment amount.
 - (ii) The minimum funding amount.
 - (2) Discounted by the percentage outlined under §125.9(1) for the self-insurer's highest current long-term credit or debt rating, if any.
 - (3) The dedicated asset account must be equal to or exceed the prescribed asset level 120 days before the beginning of the self-insurer's next fiscal year or by a later date if requested by the applicant and approved by the Bureau.
 - (4) Prior to issuing a permit under §125.6(c), the Bureau will require that the asset level of a self-insurer's dedicated asset account under paragraphs (1) and (2) be based on an adjustment to the self-insurer's greatest annual benefit payout amount to correct any material underpayment of benefits the Bureau believes is the result of the self-insurer's failure to pay compensation for which it is liable during the evaluation period.
- (d) For an active self-insured public employer that has been self-insured for 7 or more consecutive years, the required asset level of the dedicated asset account established under subsection (a) is calculated as follows:
- (1) An amount greater than or equal to the greater of the following:
 - (i) The self-insurer's average annual payout of benefits over its three most recent completed fiscal years, net of workers' compensation excess insurance recoveries, plus 20% of that average payment amount.
 - (ii) The minimum funding amount.
 - (2) Discounted by the percentage outlined under §125.9(1) for the self-insurer's highest current long-term credit or debt rating, if any.

RULES AND REGULATIONS

- (3) If the asset level of the self-insurer's dedicated asset account is below the required level under paragraphs (1) and (2) as of September 11, 2010, the required asset level of the account established under subsection (a) is calculated as follows:
 - (A) The amount required to be in the dedicated asset account under paragraphs (1) and (2) for the current year.
 - (B) Minus the difference between the amount required to be in the dedicated asset account under paragraphs (1) and (2) as of September 11, 2010, and the actual asset value of the dedicated asset account as of September 11, 2010.
- (4) The dedicated asset account must equal or exceed the prescribed asset level 120 days before the beginning of the self-insurer's next fiscal year or by a later date if requested by the applicant and approved by the Bureau.
- (5) Prior to issuing a permit under §125.6(c), the Bureau will require that the asset level of a self-insurer's dedicated asset account under paragraphs (1) and (2) be based on an adjustment to the self-insurer's average annual payout of benefits to correct any material underpayment of benefits the Bureau believes is the result of the self-insurer's failure to pay compensation for which it is liable during the evaluation period.
- (e) For a runoff self-insured public employer, the asset level of the dedicated asset account established under subsection (a) is that outlined under subsection (d), except that the minimum funding amount does not apply.
- (f) If a self-insured public employer does not possess an investment grade long-term credit or debt rating, the Bureau may require that the asset level of its dedicated asset account established under subsection (a) be greater than that outlined under subsection (b), (c) or (d), in any amount which the Bureau determines will guaranty that the self-insurer will have sufficient funding to meet its claims payments and other obligations and expenses relating to its self-insurance program as they come due over the self-insurer's next fiscal year.

§ 125.11. Excess insurance

- (a) An applicant whose catastrophic loss estimation is greater than its maximum quick assets exposure amount shall obtain aggregate excess insurance or specific excess insurance with a retention amount that is no more than its authorized retention amount and a liability limit acceptable to the Bureau to provide an adequate level of protection to cover the losses from a catastrophic event. The Bureau will consider the financial capacity of the applicant and the amount of the catastrophic loss estimation in determining the adequacy of the applicant's proposed liability limit.
- (b) A contract or policy of excess insurance must comply with the following:
 - (1) For excess indemnity insurance:
 - (i) It must state that it is not cancelable or nonrenewable unless written notice by registered or certified mail is given to the other party to the policy and to the Bureau at least 45 days before termination by the party desiring to cancel or not renew the policy.
 - (ii) It must state that it applies to any losses of a self-insurer under the act or the Occupational Disease Act.
 - (iii) It may not exclude coverage for any categories of injuries or diseases compensable under the act and the Occupational Disease Act.

RULES AND REGULATIONS

- (iv) It must be issued by an insurer that possesses an A.M. Best rating of A- or better, or a Standard & Poor's insurer financial strength rating of A or better, or a comparable rating by another NRSRO.
- (2) For workers' compensation excess insurance:
 - (i) It must meet the requirements of paragraph (1)(i)—(iii).
 - (ii) It must state that if a self-insurer is unable to make benefit payments under the act and the Occupational Disease Act due to insolvency or bankruptcy, the excess carrier shall make payments to other parties involved in the paying of the self-insurer's liability, as directed by the Bureau, subject to the policy's retentions and limits.
 - (iii) It must state that the following apply toward reaching the retention amount in the excess contract:
 - (A) Payments made by the employer.
 - (B) Payments made on behalf of the employer under a surety bond or other forms of security as required under this subchapter.
 - (C) Payments made by the Self-Insurance Guaranty Fund.
 - (iv) It must be issued by a workers' compensation insurer that includes the premium collected for the insurance in data used by the Workers' Compensation Security Fund set forth in the Workers' Compensation Security Fund Act (77 P.S. §§1051—1066) to calculate assessments against workers' compensation insurers to finance the operations of that fund.
- (c) A certificate of the excess insurance obtained by the self-insurer must be filed with the Bureau together with a certification that the policy fully complies with subsection (b).

§ 125.12. Payment, handling and adjusting of claims

- (a) A self-insurer and its claims service company are responsible for the prompt payment of compensation in accordance with the act, the Occupational Disease Act and this part.
- (b) A self-insurer shall have ample facilities and competent personnel within its organization to service its program of claims handling and adjusting or shall contract with a registered claims service company to provide these services.
- (c) A self-insurer shall immediately notify the Bureau when it changes arrangements for the handling or adjusting of its claims, including the initiation, modification or termination of self-administration arrangements or the initiation, termination, expiration or modification of services with a registered claims services company. The self-insurer shall file with the Bureau a summary of data on its claims, such as cumulative payments sorted by year of loss, in a format prescribed by the Bureau and provided to the self-insurer within 21 days of its receipt of written notification from the Bureau of its need to do so.

§ 125.13. Special funds assessments

- (a) A self-insurer is responsible for the payment of assessments to maintain funds under the act, including:
 - (1) The Workmen's Compensation Administration Fund.
 - (2) The Subsequent Injury Fund.

RULES AND REGULATIONS

- (3) The Workmen's Compensation Supersedeas Fund.
 - (4) The Self-Insurance Guaranty Fund.
 - (5) The Uninsured Employers Guaranty Fund.
- (b) A runoff self-insurer is liable for the payment of any assessments made after the termination or revocation of its self-insurance status until it has discharged the obligations to pay compensation which arose during the period of time it was self-insured. The assessments of a runoff self-insurer shall be based on the payment of claims that arose during the period of its self-insurance status.
- (c) A self-insurer shall keep accurate records of compensation paid on a calendar year basis, including payment for disability of all types, death benefits, medical benefits and funeral expenses, for the purposes of assessments under the act and the Occupational Disease Act. The records must be available for audit or physical inspection by Bureau employees or other designated persons, whether in the possession of the self-insurer or a service company. If the Bureau has a reasonable basis to question the annual compensation payments reported by the self-insurer, it may require the self-insurer to retain the services of the self-insurer's licensed certified public accounting firm to audit the data reported to provide confirmation or make necessary adjustments.

§ 125.14. Change in legal status, ownership or financial condition

- (a) A self-insurer shall submit promptly a renewal application to continue its self-insurance status under this subchapter in the event of a change in its or its parent's controlling interest, by sale or otherwise. Failure to comply with this subsection may result in the revocation of the self-insurer's permit.
- (b) A self-insurer which amends its articles, charter or agreement of incorporation, association, partnership or sole proprietorship to change its identity or business structure shall promptly notify the Bureau in writing of that action. The Bureau may request copies of documents or information deemed necessary to determine whether the transaction has affected the ability of the employer to self-insure.
- (c) A self-insurer shall promptly notify the Bureau in writing of any material adverse changes to its financial condition which occur after the date of the most recent financial statements submitted with its last application.

§ 125.15. Workers' compensation liability

- (a) Notwithstanding the terms of a guarantee and assumption agreement executed under § 125.4(b)(relating to application for affiliates and subsidiaries), a self-insurer or a runoff self-insurer remains liable for workers' compensation on injuries or disease exposures occurring during its period of self-insurance. With application to and permission from the Bureau, liability can be transferred to another employer. Liability also may be transferred through a self-insurance loss portfolio transfer policy.
- (b) A self-insurer which liquidates or dissolves shall transfer its liability to a third party, subject to the approval of the Bureau, or shall obtain a self-insurance loss portfolio transfer policy covering the liability.
- (c) If a self-insurer sells or divests a part of itself, self-insurance coverage ends for the separated parts on the date of separation. The self-insurer remains responsible for claims incurred against the separated part occurring up to the date of separation unless the Bureau approves a request to transfer the self-insurer's liability to another entity.

RULES AND REGULATIONS

§ 125.16. Reporting by runoff self-insurer

- (a) A runoff self-insurer shall file an annual report with the Bureau by a date prescribed by the Bureau on a prescribed form provided by the Bureau until all cases incurred during its period of self-insurance have been closed for at least 2 years.
- (b) The runoff report must include a listing in a Bureau-prescribed electronic format provided by the Bureau to the runoff self-insurer of the runoff self-insurer's Pennsylvania workers' compensation claims, including all claims currently in litigation, and information such as payments and reserves on each claim. The listing must include:
 - (i) All open claims at the time of submission.
 - (ii) All claims closed on or after September 11, 2010.
 - (iii) Case reserves provided in the listing must be established according to the instructions on forms prescribed by the Bureau and provided to the runoff self-insurer.
- (c) A runoff self-insurer that is a private employer shall make any request for the adjustment of its amount of security in writing when it submits its runoff report. If the runoff self-insurer disagrees with the Bureau's decision on the request, it may request reconsideration of this decision under §125.6(e) (relating to decision on application).

§ 125.17. Claims service companies

- (a) A claims service company desiring to engage in the business of adjusting and handling claims for an approved self-insurer shall register with the Bureau as provided under section 441(c) of the act (77 P. S. § 997(c)) and regulations thereunder on a prescribed form before entering into a contract to provide these services. The claims service company shall answer the questions on the registration form and swear to the information provided on the form.
- (b) A claims service company shall have adequate facilities and employ competent staff to provide claims services in a manner which fulfills a self-insurer's obligations under the act, the Occupational Disease Act and this part. A claims service company which repeatedly or unreasonably fails to provide claims adjusting or services promptly with the result that compensation is not paid as required under the act or the Occupational Disease Act may have its privilege of conducting this business revoked or suspended under the procedures of section 441(c) of the act.
- (c) The claims service company shall employ at least one person on a full-time basis who has the knowledge and experience necessary to service claims properly under the act and the Occupational Disease Act. A resume covering that person's background must be attached to the registration form of the claims service company.
- (d) A claims service company whose engagement to handle or adjust the claims of a self-insurer is terminating or expiring, or has terminated or expired, shall provide reasonable assistance to the self-insurer and the Bureau in providing data and information on the claims serviced to maintain the integrity of past data on the claims filed with the Bureau, to rectify or explain discrepancies or questions on the claims data raised by the Bureau, or to address other related issues identified by the Bureau.

RULES AND REGULATIONS

§ 125.18. Contact person

A self-insurer shall provide the Bureau with the name, title, address and phone number of a contact person who will be the liaison with the Bureau regarding all self-insurance matters, including the processing of applications, the provision of information and the payment of assessments, and to whom self-insurance correspondence will be sent. The self-insurer shall give written notice of a change in contact person or change in address or telephone number within 10 days of this change.

§ 125.19. Additional powers of Bureau and orders to show cause

- (a) If the Bureau has reason to question whether a self-insurer continues to maintain the financial ability to self-insure during the pendency of a permit, authorized under section 305(a)(3) of the act (77 P.S. §501(a)(3)) and under section 305 of the Occupational Disease Act (77 P.S. §1405), it will issue a letter to the self-insurer noting the reasons for its concerns and outlining the documents, data and information upon which the Bureau's concerns are based. The following also apply:
- (1) The Bureau's letter is treated for procedural purposes as if it were an initial decision denying a renewal application under §125.6(d) (relating to decision on application).
 - (2) When the Bureau determines that the self-insurer no longer possesses the financial ability to self-insure, the self-insurer's current permit will be revoked, unless the self-insurer timely initiates the procedures outlined under §125.6(e)—(g).
 - (3) The self-insurer shall obtain workers' compensation insurance coverage effective no later than 30 days after its receipt of a notice of revocation by the Bureau and provide evidence of the coverage, such as a certificate of insurance, to the Bureau no later than the coverage's effective date.
- (b) The Department may serve upon a self-insurer an order to show cause why its self-insurance status should not be suspended or revoked under section 441(b) of the act (77 P.S. §997(b)) for unreasonably failing to pay compensation for which it is liable, or for failing to submit any report or to pay any assessment made under the act.
- (1) The order to show cause proceedings are governed by provisions in Chapter 121 (relating to general provisions), found in §121.27 (relating to orders to show cause).
 - (2) The self-insurer shall obtain workers' compensation insurance coverage effective no later than 30 days after its receipt of an order revoking or suspending its self-insurance status and provide evidence of the coverage, such as a certificate of insurance, to the Department no later than the coverage's effective date.

§ 125.20. Computation of time

Except as otherwise provided by law, in computing a period of time prescribed or allowed by this chapter, the day of the act, event or default after which the designated period of time begins to run may not be included. The last day of the period so computed shall be included, unless it is Saturday, Sunday or a legal holiday in this Commonwealth, in which event the period shall run until the end of the next day which is neither a Saturday, Sunday nor a holiday. A part-day holiday shall be considered as other days and not as a holiday. Intermediate Saturdays, Sundays and holidays shall be included in the computation.

§125.21. Self-insurance loss portfolio transfer policy.

A self-insurance loss portfolio transfer policy must comply with all of the following:

RULES AND REGULATIONS

- (1) The insurance carrier must be a workers' compensation insurer.
- (2) The policy must provide statutory coverage limits and state that the insurer is responsible to defend, adjust and handle all open, reopened and incurred but not reported claims against the self-insurer for the period of time covered by the policy.
- (3) The policy must be retrospective, providing coverage for a consecutive period of time of self-insurance.
- (4) The policy must be noncancelable by either the insurance carrier or the self-insurer for any reason.
- (5) The amount of annual compensation paid by the insurance carrier on any claims assumed under the policy must be included as compensation paid on the data reports filed with the Insurance Department.
- (6) The insurance carrier must include the premium received on the policy in the amount of net written workers' compensation premium it annually reports to the Insurance Department or to the National Association of Insurance Commissioners.
- (7) The insurance carrier must notify existing claimants with injuries or diseases covered by the policy that it has assumed liability for the payment and handling of their claims.
- (8) The insurance carrier must file the policy with a rating organization approved by the Insurance Commissioner and identify it as a special self-insurance loss portfolio transfer policy. The insurance carrier should not report statistical information on claims assumed under the policy to the rating organization.
- (9) The insurance carrier must enter an appearance with the appropriate workers' compensation judge, the Workers' Compensation Appeal Board and any appellate court on each pending claim in adjudication against the self-insurer for injuries or disease exposures occurring during the time period covered by the policy.

SUBCHAPTER B. GROUP SELF-INSURANCE**§ 125.101. – 125.123 [Reserved]****§ 125.131. Purpose**

This subchapter is promulgated under sections 435 and 818 of the act (77 P. S. §§ 991 and 1036.18) to provide regulatory guidelines for uniform and orderly administration of group self-insurance funds under Article VIII of the act (77 P.S §§ 1036.1 — 1036.18). This subchapter will ensure full payment of compensation due under the act and the Occupational Disease Act to employees of employers that pool their liabilities through participation in a group self-insurance fund.

§ 125.132. Definitions

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise:

Act — The Workers' Compensation Act (77 P. S. §§ 1 — 1038.2).

Administrator — An administrator as defined in section 801 of the act (77 P. S. § 1036.1).

RULES AND REGULATIONS

Aggregate excess insurance — Insurance which provides that the excess insurer pays on behalf of or reimburses a fund for its payment of benefits on claims incurred during a policy period in excess of the retention amount to the excess insurer's limit of liability.

Applicant — A group of five or more homogeneous employers requesting approval of the Bureau to operate as a fund.

Board of trustees — The governing body of a fund.

Bureau — The Bureau of Workers' Compensation of the Department.

Claims service company — An individual, corporation, partnership or association engaged in the business of servicing a fund's claims, including the adjusting and handling of claims, the payment of benefits and the provision of required reports.

Contributions — The amount of money charged each member to fund the obligations and expenses of a fund. The term includes charges calculated and made known to the members prior to the beginning of each fund year, and adjustments to those charges made during the fund year by the board of trustees.

Department — The Department of Labor and Industry of the Commonwealth.

Dividends — Cash, contribution credits or similar distributions provided to the members from surplus.

Employer — An employer as defined in section 801 of the act.

Excess insurer — An insurance company authorized to transact the class of insurance listed in section 202(c)(14) of The Insurance Company Law of 1921 (40 P. S. § 382(c)(14)).

Fiscal agent — An individual, corporation, partnership or association engaged by a fund to carry out the fiscal policies of the fund and to invest, manage, hold and disburse fund assets. The board of trustees may delegate the duties of fiscal agent to the administrator.

Fund — A fund as defined in section 801 of the act. The fund shall assume the liabilities and obligations of its members under the act and the Occupational Disease Act.

Fund year — The fiscal year and annual reporting period of a fund, which shall consist of 12 calendar months, except for the first year, which may consist of fewer or more than 12 months as established by the Bureau.

Homogeneity — Homogeneity exists where a fund is comprised of homogeneous employers.

Homogeneous employers — Employers who have been assigned to the same classification series for at least 1 year or are engaged in the same or similar types of business, including political subdivisions.

Independent actuary — An independent actuary as defined in section 801 of the act.

Loss costs — The dollar amounts per unit of exposure attributable to the payment of losses under the act and the Occupational Disease Act, filed by a rating organization based on aggregate experience of all members of that rating organization and approved by the Insurance Commissioner under Article VII of the act (77 P. S. §§ 1035.1 — 1035.22).

Loss-cost multiplier — A factor approved by the Bureau for each fund which is multiplied against the loss costs to recoup the fund's administrative and operating costs and expenses, including:

- (i) The fund's costs in connection with the examination, investigation, handling, adjusting and litigation of claims.

RULES AND REGULATIONS

- (ii) The cost of excess insurance, loss control services, underwriting services, assessments and taxes.
- (iii) The fees and commissions for accountants, attorneys, actuaries, investment advisors and other specialists whose services are necessary for the operation and administration of the fund.

Member — An employer participating in a fund.

Occupational Disease Act — The Pennsylvania Occupational Disease Act (77 P. S. §§ 1201 — 1603).

Permit — A permit as defined in section 801 of the act.

Plan committee — A plan committee as defined in section 801 of the act.

Political subdivision — A political subdivision as defined in section 801 of the act.

Retention amount — The maximum amount of benefits a fund would be required to pay without reimbursement from the excess insurer under an aggregate or specific excess insurance policy.

Runoff fund — A fund which voluntarily terminated its permit or a fund whose permit was revoked by the Bureau.

Security — Security as defined in section 801 of the act.

Service company — A claims service company and all other individuals, corporations, partnerships or associations engaged by a fund to provide the fund with services such as legal assistance, underwriting, safety engineering, loss control, medical management, information analysis, statistics compilation, loss and expense report preparation and contribution development.

Specific excess insurance — Insurance which provides that the excess insurer pays on behalf of or reimburses a fund for its payment of benefits on each occurrence in excess of the retention amount to the excess insurer's limit of liability.

Surplus — Surplus as defined in section 801 of the act. In determining surplus, incurred but not reported claims shall be included in the calculation of incurred losses.

Trust agreement — A trust as defined in section 801 of the act.

Trustee — Each person serving as a member of the board of trustees.

§ 125.133. Application

- (a) An applicant shall file an application on a form prescribed by the Bureau. Questions on the application shall be answered thoroughly and completely with the most recent information available. A rider may be attached if more space is necessary. The application shall be signed by a representative of the applicant and attested to as set forth on the application. Any attached rider and applicable form enclosed with the application shall be verified to in the sworn affidavit requested on the application.
- (b) Applications shall be filed with the Bureau no later than 90 days prior to the requested effective date of the fund.
- (c) With the application, the applicant shall include:
 - (1) The nonrefundable fee in the amount of \$1,000 required by section 802(c) of the act (77 P. S. § 1036.2(c)).

RULES AND REGULATIONS

- (2) The audited financial statements presented in conformity with generally accepted accounting principles of one prospective member with a net worth of at least \$1 million or of more than one prospective member with aggregate net worth of at least \$1 million, or an amount as may be promulgated annually by the Bureau and published in the Pennsylvania Bulletin to take effect on January 1 of each year. This paragraph does not apply to applicants composed of political subdivisions.
- (3) The prior fiscal year's audited or reviewed financial statements of each prospective member whose annual contribution to the fund would make up more than 10% of the total annual contributions to the fund.
- (4) An explanation of the same classification series, as described under § 125.155(a) (relating to homogeneity), common to all prospective members with the amount of each member's contributions derived from the classification codes within the common series, or an explanation of how the prospective members are engaged in the same or similar types of business, as described under § 125.155(b). The Bureau may request additional information to determine the homogeneity of the applicant.
- (5) If the applicant is eligible under § 125.135 (relating to classification system; experience rating; contributions rates) and is requesting to deviate from the loss costs of a rating organization as defined under section 703 of the act (77 P. S. § 1035.3), a report prepared by an independent actuary projecting the workers' compensation incurred loss experience of the applicant during its first fund year by various levels of actuarial confidence and rendering an opinion that the rates requested for use will be adequate to satisfy the applicant's obligations and expenses.
- (6) A schedule of the projected annual contributions which will be paid by each prospective member and in total during the first fund year and worksheets showing the calculation of each prospective member's annual contributions.
- (7) A schedule of projected administrative expenses in dollar amounts and as a percentage of the estimated total member contributions for the first fund year.
- (8) The applicant's proposed trust agreement and bylaws, which shall include:
 - (i) A pledge that each member will be jointly and severally liable for the expenses and other obligations of the fund and for each other member's workers' compensation liability which is incurred while it is a member, including liability for assessments on claims incurred during a member's membership but not issued until after it has terminated membership.
 - (ii) A pledge that the applicant will remain liable to pay and administer the claims incurred by members while they participated in the fund.
 - (iii) The powers, duties and responsibilities of the board of trustees.
 - (iv) The structure of the board of trustees.
 - (v) The method of appointing, removing and replacing trustees by the plan committee.
 - (vi) The persons or committee responsible for the acquisitions, management, investment and disposition of real and personal property of the fund.
 - (vii) The rights, privileges and obligations of the members.

RULES AND REGULATIONS

- (viii) Procedures for amending the trust agreement and the bylaws, which shall require the approval of the plan committee.
 - (ix) Requirements for membership.
 - (x) Procedures for the withdrawal or expulsion of members.
 - (xi) Rules on payment and collection of contributions and assessments.
 - (xii) Procedures for resolving disputes between members and the fund.
 - (xiii) The powers and responsibilities of the plan committee.
 - (xiv) Procedures for calling special meetings of the board of trustees and the plan committee.
 - (xv) Delineation of authority granted to the administrator, the fiscal agent and the service companies.
- (9) Policy statements on the following subjects:
- (i) Underwriting standards.
 - (ii) Asset investment policies and strategy based on permitted investments of capital or surplus of stock casualty insurance companies in section 602 or 603 of The Insurance Company Law of 1921 (40 P. S. §§ 722 and 723) (Repealed). For the purpose of this subparagraph, permitted investments of capital or surplus of stock casualty insurance companies in section 602 or 603 of The Insurance Company Law of 1921 shall include investments permitted for domestic stock casualty insurance companies under section 602.1 of The Insurance Company Law of 1921 (40 P. S. § 722.1).
 - (iii) The timing, frequency and calculation of supplemental assessments needed to maintain actuarially appropriate reserves.
 - (iv) The payment of dividends and the maintenance of surplus.
 - (v) Procedures and policies on member payroll audits and the adjustment of contributions based on the results of the audits.
- (10) Membership applications executed by each prospective member and approved by the applicant on a form prescribed by the Bureau. The membership application will also serve the purpose of the letter of intent required under section 802(b)(12) of the act.
- (11) A report on a form prescribed by the Bureau summarizing the scope, function and operation of the proposed loss prevention and safety program required under sections 802(b)(13) and 1001(b) of the act (77 P. S. §§ 1036.2(b)(13) and 1038.1(b)) and regulations thereunder.
- (12) The applicant's proposed loss-cost multiplier on a form prescribed by the Bureau.
- (d) The Bureau will not begin its review of the application until the application and the required supporting materials as outlined in this section have been submitted.
- (e) The applicant shall provide additional data and information that the Bureau deems pertinent to its review of the application based on the factors enumerated under § 125.134 (relating to decision on application). The applicant shall provide data and information within the time prescribed by the Bureau, which will be reasonable based on the extent and the availability of the data and information required.

RULES AND REGULATIONS

§ 125.134. Decision on application

- (a) The application of an applicant which meets the requirements of the act relating to matters such as the number of homogeneous employers, aggregate net worth and aggregate premium will be approved if the Bureau determines that the applicant has demonstrated, with reasonable certainty, that it will meet the liabilities incurred by its members under the act and the Occupational Disease Act. The Bureau will include the following factors in assessing the applicant's ability to meet those liabilities:
- (1) The adequacy of member contributions.
 - (2) The applicant's plans for the establishment of surpluses to absorb matters such as unexpected losses and uncollected contributions.
 - (3) The applicant's plans for member assessments needed to maintain actuarially appropriate loss reserves.
 - (4) Restrictions on the payment of dividends on surplus.
 - (5) The overall financial ability of the members to satisfy their obligations to the applicant.
 - (6) The applicant's ability to control losses through the safety and loss control program proposed.
 - (7) The excess insurance coverage obtained by the fund, if any.
 - (8) The validity of the actuarial assumptions used to predict the likely loss levels, if any.
 - (9) The liquidity and safety of the fund's assets.
 - (10) The likely stability of membership in the fund.
 - (11) The adequacy of the trust agreement, bylaws and written policies.
 - (12) The degree to which the total risk of the fund is spread among the members.
- (b) If the Bureau's assessment under subsection (a) is that the applicant can meet its obligations, it will send to the applicant a preliminary approval notice of the application and a list of conditions under subsection (d) that shall be met before the applicant may operate as a fund.
- (c) An applicant has 60 days from the receipt of the preliminary approval notice to comply with the conditions set forth by the Bureau. The applicant may toll the 60-day compliance period by filing a request for a conference under subsection (f). An applicant may be granted a 30-day extension to meet the conditions if the applicant requests an extension in writing to the Bureau within the initial 60-day compliance period. The application of an applicant which does not meet the conditions within the compliance period will be deemed withdrawn.
- (d) The applicant will be issued a permit which is effective no sooner than 15 days after the following has been filed with the Bureau:
- (1) The trust agreement and bylaws as approved by the Bureau and executed by the members.
 - (2) Security in an amount as determined by the Bureau, if any. This requirement does not apply to funds comprised exclusively of political subdivisions.
 - (3) A certificate providing evidence of excess insurance as required by the Bureau.
 - (4) Confirmation of the name and address of the administrator, fiscal agent and of service companies the applicant will use.

RULES AND REGULATIONS

- (5) Certification by the administrator that each member has paid 25% of its annual contribution to the fund.
 - (6) One or more fidelity bonds to protect the fund against misappropriation or misuse of assets on a form and in an amount approved by the Bureau. The fidelity bonds shall cover the individuals and contractors who will handle fund assets or who will have authority to gain access to fund assets, including trustees, the administrator, the fiscal agent and the claims service company. The fiscal agent need not be covered by a bond if it is a duly chartered commercial bank or trust company.
 - (7) Documents relating to other requirements set by the Bureau to protect the compensation rights of employees of members.
- (e) If upon review of the pertinent data the Bureau finds that the applicant does not meet the requirements of subsection (a), it will send to the applicant a written preliminary denial notice of the application. The notice will state the documents, evidence and other data received from the applicant or otherwise reviewed or considered by the Bureau in reaching its preliminary determination.
 - (f) The applicant may request a conference with the Bureau upon receipt of the Bureau's preliminary approval notice or denial notice. A conference request shall be made in writing within 20 days after the receipt of the preliminary notice. At the conference, the applicant may present additional evidence or data to support its application or the alteration of the conditions required in the preliminary approval notice. The applicant may present that information to the Bureau in writing, or in person, or both.
 - (g) After a conference and the receipt of written submissions, the Chief of the Self-Insurance Division of the Bureau will promptly review the entire record of the applicant and will issue a reconsideration decision on the application.
 - (h) An applicant shall have a right to appeal a reconsideration decision issued under subsection (g) with the Bureau within 30 days of the receipt of the reconsideration decision. Untimely appeals will be dismissed without further action by the Bureau. A hearing will be conducted on the appeal as specified in § 125.154 (relating to hearings).

§ 125.135. Classification system; experience rating; contribution rates

- (a) A fund shall adhere to the uniform classification system and uniform experience rating plan filed with the Commissioner of the Insurance Department by a rating organization under Article VII of the act (77 P. S. §§ 1035.1 — 1035.22).
- (b) A fund shall base its member contribution rates on no less than the current effective loss costs plus the fund's approved loss-cost multiplier. A fund may also reduce a member's contribution rates for up to 5 years by 5% if the member establishes a workplace safety committee which received certification by the Department and continues to meet certification requirements under section 1002 of the act (77 P. S. § 1038.2) and regulations thereunder.
- (c) No later than 45 days prior to the beginning of a fund year, a fund may request the Bureau's permission to change its loss-cost multiplier for member contributions payable during that next fund year. The request to change a fund's loss-cost multiplier shall be on a form prescribed by the Bureau. The fund may support its loss-cost multiplier request with a report prepared by an independent actuary but an actuarial report is not required.
- (d) If the Bureau determines that the loss-cost multiplier requested under subsection (c) is unreasonably low, so that it impairs the fund's ability to meet its expenses, the Bureau will notify the fund that the loss-cost multiplier request is denied. The notification will be sent to the fund no later than 30 days after the filing of the request. Use of a loss-cost multiplier which has not been approved by the Bureau shall result in the revocation of the fund's permit under section 805(a) of the act (77 P. S. § 1036.5).

RULES AND REGULATIONS

- (e) No later than 45 days prior to the beginning of a fund year following its third year of operation, a fund may request permission of the Bureau to deviate from the uniform classification system, uniform experience rating plan, loss costs and discounts outlined in subsections (a) and (b), including the use of retrospectively rated and deductible plans. An applicant comprised of a majority of prospective members who are participants in a group insurance purchase cooperative/safety group for at least 3 years prior to the submission of its application or comprised of a majority of prospective members who are political subdivisions approved as self-insurers under section 305 of the act (77 P. S. § 501) may also request permission of the Bureau to deviate from the requirements of subsections (a) and (b).
- (f) A deviation request under subsection (e) shall be supported by a report prepared by an independent actuary projecting the incurred loss experience of the fund for its next fund year by various levels of actuarial confidence and rendering an opinion that the total contributions received if the deviation is permitted will be adequate to satisfy the applicant's obligations and expenses. A request for deviation from the loss costs of a rating organization shall include a schedule of the loss costs proposed for the fund year.
- (g) If the Bureau determines that the deviation requested under subsection (e) may impair the fund's ability to meet its obligations, it will notify the fund that the deviation request is denied. The notification will be sent to the fund no later than 30 days after the filing of the request. Use of loss costs which have not been approved by the Bureau will result in the revocation of the fund's permit under section 805(a) of the act (77 P. S. § 1036.5).

§ 125.136. Addition of members

- (a) The addition of a new member to a fund shall be approved on an application form prescribed by the Bureau. The approval shall be granted by the plan committee or the board of trustees or by the administrator if the board of trustees has delegated this authority to the administrator.
- (b) The approved application form for fund membership shall be filed with the Bureau no more than 15 days after the effective date of the employer's membership in the fund.
- (c) With the approved application, the fund shall submit to the Bureau:
 - (1) Evidence of the prospective member's execution of the trust agreement and the bylaws.
 - (2) A schedule of the prospective member's annual contributions to the fund.
 - (3) The prospective member's prior year's audited or reviewed financial statement if its annual contributions will make up more than 10% of total annual contributions to the fund.
- (d) The fund shall provide to the Bureau financial information requested by the Bureau to determine whether the addition of a member will affect the fund's continuing ability to satisfy its obligations, such as special financial statements or projections.
- (e) The Bureau will notify the fund and the new member if it finds that the new member will disturb the homogeneity of the fund. The new member's participation in the fund shall terminate 15 days after the issuance of the notice.

§ 125.137. Withdrawal or expulsion of members

- (a) A fund shall notify the Bureau in writing of the withdrawal or expulsion of a member no less than 15 days prior to the effective date of the withdrawal or expulsion.

RULES AND REGULATIONS

- (b) Each member which withdraws or is expelled from a fund shall provide to the Bureau a certificate providing evidence of its workers' compensation coverage by the effective date of its withdrawal or expulsion.
- (c) The fund shall provide to the Bureau any financial information requested by the Bureau to determine whether the withdrawal or expulsion of a member will affect the fund's continuing ability to satisfy its obligations, such as special financial statements or projections.

§ 125.138. Change in legal status, ownership, financial condition, name and address of member

- (a) A member shall promptly notify the fund in writing in the event of a change in its or its parent's controlling interest, by sale or otherwise.
- (b) A member which amends its articles, charter or agreement of incorporation, association, partnership or sole proprietorship to change its identity or business structure shall promptly notify the fund in writing of that action.
- (c) A member shall promptly notify the fund in writing of any material adverse changes to its financial condition.
- (d) A member shall promptly notify the fund in writing of any changes in its name or address.
- (e) The fund shall promptly notify the Bureau in writing of changes reported by members under subsections (a) — (d).

§ 125.139. Change of administrator, fiscal agent or service companies

A fund shall promptly notify the Bureau in writing of a change in its administrator, fiscal agent or its service companies.

§ 125.140. Change of trust agreement, bylaws or written policies; notification of insufficient assets

- (a) A fund shall promptly file with the Bureau amendments to its trust agreement or bylaws or amendments to its written policies which could materially affect the operation of the fund.
- (b) A fund which knows, or should know, that it has insufficient assets to maintain actuarially appropriate loss reserves as defined under section 801 of the act (77 P. S. § 1036.1) shall immediately notify the Bureau in writing of this condition. With the notification, the fund shall inform the Bureau of its plan to correct the deficiency.

§ 125.141. Annual report

- (a) No more than 5 months following the end of each fund year, a fund shall file a report with the Bureau as required by section 815 of the act (77 P. S. § 1036.15). Failure to file an annual report in the time prescribed may result in the revocation of the fund's permit.
- (b) The fund shall submit with its annual report:
 - (1) The evaluation fee in the amount of \$1,000 required by section 815(c) of the act.
 - (2) The fund's audited financial statements for its prior fund year as prepared by a certified public accountant in accordance with generally accepted accounting principles.
 - (3) A report prepared by an independent actuary projecting the value of the fund's incurred and outstanding liability by fund year.

RULES AND REGULATIONS

- (4) The prior fiscal year's audited or reviewed financial statements of each member whose annual contribution to the fund makes up more than 10% of the total annual contributions to the fund.
 - (5) A schedule of the projected administrative expenses in dollar amounts and as a percentage of the total member contributions for the current fund year.
 - (6) A schedule of the annual contributions which will be paid by each member and in total during the current fund year and worksheets showing the calculation of each member's annual contributions.
 - (7) A certificate providing evidence of excess insurance as required by the Bureau.
 - (8) A schedule of member dividends paid during the prior fund year and the fund year from which the dividends were paid.
 - (9) A schedule of the dividends the fund plans to return to its members during the current year. The schedule shall include a recommendation from an independent actuary that the dividends proposed will not impair the fund's ability to meet its obligations and that the dividends will comply with the other requirements of section 809 of the act (77 P. S. § 1036.9).
 - (10) Confirmation of the existence of the fidelity bonds required under § 125.134(d)(6) (relating to decision on application).
- (c) A fund shall provide to the Bureau other information required by the Bureau to determine whether the fund has the ability to continue to satisfy its obligations and expenses.
 - (d) The Bureau may require a fund to file interim reports during its fund year of its financial condition, claims experience and other items the Bureau may require.
 - (e) Extensions of the filing date under subsection (a) may be granted by the Bureau for 30-day periods upon good cause shown by the fund in stating its reasons for requesting the extension. The request for extension shall be submitted in writing no less than 10 days prior to the due date in sufficient detail to permit the Bureau to make an informed decision with respect to the requested extension.

§ 125.142. Maintenance of fund permit

Following the submission of a fund's annual report or at other times determined by the Bureau, the Bureau may revise the conditions previously set for the issuance of the fund's permit. The fund's permit may be revoked if the revised conditions are not met in the time prescribed by the Bureau, subject to the right of a hearing under § 125.154 (relating to hearings).

§ 125.143. Restriction on the use of assets

- (a) A fund, its board of trustees, fiscal agent or administrator may not use member contributions for a purpose unrelated to the satisfaction of the workers' compensation obligation of the fund and expenses related to those obligations.
- (b) The board of trustees, administrator or fiscal agent of the fund may not borrow money from the fund or in the name of the fund, including the issuance of loan guarantees or other forms of encumbrances.
- (c) A fund may not extend credit to a member for payment of contributions. This subsection does not prohibit the payment of annual contributions based on an installment plan as presented in the schedule submitted to the Bureau in § 125.133(c)(6) or § 125.141(b)(6) (relating to application; and annual report).

RULES AND REGULATIONS

§ 125.144. Revocation and voluntary termination of permit

- (a) Upon the revocation or voluntary termination of a permit under sections 805(a) or 808(c) of the act (77 P. S. §§ 1036.5 and 1036.8), members shall insure their liabilities to pay compensation as required by the act.
- (b) Upon the approval of the Bureau, a revoked or terminated fund may be allowed to operate as a runoff fund to pay claims incurred during the effective period of its permit from assets currently on hand or from assessments of its members. Absent this approval, a revoked or terminated fund shall make its best efforts to insure the workers' compensation liability incurred prior to the revocation or termination of its permit with a carrier licensed to write workers' compensation in this Commonwealth. The revoked or terminated fund shall pay insurance premiums from its assets and from assessments of its members, if necessary.
- (c) Upon proof provided to the Bureau that a revoked or terminated fund is unable to obtain insurance coverage for the workers' compensation liability incurred prior to the revocation or termination of its permit, the revoked or terminated fund shall operate as a runoff fund and shall pay claims on the liability from its assets and from assessments of its members.

§ 125.145. Merger of funds

- (a) Subject to the prior written approval of the Bureau, a fund may merge with another fund with the same homogeneous characteristics if the resulting fund assumes in full all obligations of the merging funds.
- (b) The resulting fund may be a continuing fund under the name of one or more of the merged funds or a new fund whose name shall be subject to the Bureau's approval. In all respects, the continuing fund or the new fund shall be subject to this subchapter. Funds merging under this section shall enter into a written agreement for the merger prescribing the merger's terms and conditions. The agreement shall be the following:
 - (1) Assented to by a majority of the plan committee and the board of trustees of each fund.
 - (2) Executed in duplicate by a majority of the board of trustees of each fund.
 - (3) Accompanied by copies of the resolutions authorizing the merger and the execution of the agreement attested by the recording officer of each fund.
 - (4) Submitted to the Bureau, with the records of the fund pertaining thereto.
- (c) If the requirements of subsections (a) and (b) have been complied with, the Bureau will issue a new permit to the merged fund with the powers retained and specified in the agreement.
- (d) Upon merger, the rights and properties of the several funds shall accrue to and become the property of the merged fund, which shall succeed to all the obligations and liabilities of the merged funds, in the same manner as if they had been incurred or contracted by it. The members of the merged fund shall continue to be subject to all the liabilities, claims and demands existing against them at or before the merger.
- (e) No action or proceeding pending at the time of the merger in which any or all of the funds merged may be a party will abate or be discontinued by reason of the merger, but the same may be prosecuted to final judgment in the same manner as if the merger had not taken place, or the continuing fund or the new fund may be substituted in place of a fund so merged by order of the court in which the action or proceeding may be pending.
- (f) Members of either merging fund who do not wish to belong to the merged fund may withdraw their membership at the time of the merger without penalty. They will remain jointly and severally liable for the claims, expenses and other obligations incurred by the fund during the period of their membership and prior to the merger.

RULES AND REGULATIONS

§ 125.146. Payment of dividends

- (a) Payment of dividends to members as permitted in section 809 of the act (77 P. S. § 1036.9) may not be made sooner than 60 days following a fund's filing of its annual report as required by § 125.141 (relating to annual report). A runoff fund may not pay dividends sooner than 60 days following its filing of the report required by § 125.150 (relating to runoff fund).
- (b) If the Bureau determines that the payment of proposed dividends may impair the fund's ability to meet its obligations or may violate other provisions of section 809 of the act, it will notify the fund that the dividend payment is prohibited. The notification will be sent to the fund no later than 45 days after the filing of the annual report. Payment of dividends which have not been approved by the Bureau will result in the revocation of the fund's permit under section 805(a) of the act (77 P. S. § 1036.5(a)).

§ 125.147. Special funds assessments

- (a) A fund is responsible for the payment of assessments to maintain funds under the act, including:
 - (1) The Workmen's Compensation Administration Fund.
 - (2) The Subsequent Injury Fund.
 - (3) The Workmen's Compensation Supersedeas Fund.
 - (4) The Self-Insurance Guaranty Fund.
- (b) A runoff fund is liable for the payment of any assessments made after the termination or revocation of its permit until it has discharged the obligations to pay compensation which arose during the effective period of its permit. The assessments of a runoff fund shall be based on the payment of claims that arose during the effective period of the fund's permit.
- (c) A fund shall keep accurate records of compensation paid on a calendar year basis, including payment for disability of all types, death benefits, medical benefits and funeral expenses, for the purposes of assessments under the act. The records shall be available for audit or physical inspection by Bureau employees or other designated persons, whether in the possession of the fund or a service company.

§ 125.148. Security

The security required in § 125.134(d)(2) (relating to decision on application) shall be in one of the following forms:

- (1) A surety bond on a form prescribed by the Bureau issued by a company authorized to transact surety business in this Commonwealth by the Insurance Department.
 - (i) The surety company shall possess a current A.M. Best Rating of B+ or better or a Standard and Poor's rating of claims paying ability of A or better.
 - (ii) The fund shall replace the bond with a new bond issued by a surety company with an acceptable rating or with another acceptable form of security if the surety company's rating falls below the acceptable rating after the bond is issued. If the bond is not replaced within 60 days, the Bureau will have discretion to draw on the surety bond and deposit the proceeds with the State Treasurer to secure the fund's obligation.
- (2) A security deposit held under a trust agreement prescribed by the Bureau.
 - (i) The deposit shall consist of cash; bonds or other evidence of indebtedness issued, assumed or guaranteed by the United States, or by an agency or instrumentality of the United States;

RULES AND REGULATIONS

investments in common funds or regulated investment companies which invest primarily in United States Government or Government agency obligations; or bonds or other security issued by the Commonwealth and backed by the Commonwealth's full faith and credit.

- (ii) The securities shall be held in a Commonwealth chartered bank and trust company or trust company as defined in section 102 of the Banking Code of 1965 (7 P. S. § 102) or a Federally chartered bank or foreign bank with a branch office and trust powers in this Commonwealth.
- (3) An irrevocable letter of credit using language required by the Bureau issued by and payable at a branch office of a commercial bank located in the continental United States, Alaska or Hawaii. The letter of credit shall state that the terms of the letter of credit automatically renew annually unless the letter of credit is specifically nonrenewed by the issuing bank 60 days or more prior to the anniversary date of its issuance.
- (i) At the time of issuance of the letter of credit, the issuing bank or its holding company shall have a B/C or better rating or 2.5 or better score by Thomson BankWatch or the issuing bank shall have a CD rating of BBB or better by Standard & Poor's Corporation.
 - (ii) The fund shall replace the letter of credit with a new letter of credit issued by a bank with an acceptable credit rating, or with another acceptable form of security, if the bank's rating falls below the acceptable rating after the letter of credit is issued. If the letter of credit is not replaced within 60 days, the Bureau will draw on the letter of credit and will deposit the proceeds to secure the fund's obligations.
 - (iii) The fund shall execute a standby trust agreement on a form prescribed by the Bureau with a Commonwealth chartered bank and trust company or trust company as defined in section 102 of the Banking Code of 1965 or a Federally chartered bank or foreign bank with a branch office and trust powers in this Commonwealth. The trust agreement will accommodate proceeds from a letter of credit drawn on by the Bureau.

§ 125.149. Specific excess insurance and aggregate excess insurance

- (a) A fund shall obtain specific excess insurance with a retention amount and liability limit acceptable to the Bureau. The Bureau may waive this requirement upon written request if the fund demonstrates that it has sufficient financial strength and liquidity to assure that all obligations under the act and the Occupational Disease Act will be promptly met without the protection of an excess insurance policy.
- (b) Aggregate excess insurance may be obtained by a fund. The Bureau will not recognize a contract or policy of aggregate excess insurance in considering the ability of a fund to fulfill its financial obligations unless the contract or policy complies with subsection (c).
- (c) The contract or policy of aggregate excess insurance or specific excess insurance, or both, shall comply with the following:
 - (1) It shall be issued by an excess insurer which possesses an A. M. Best Rating of B+ or better or a Standard and Poor's rating of claims paying ability of A or better.
 - (2) It shall state that it is not cancelable or nonrenewable unless written notice by registered or certified mail is given to the other party to the policy and to the Bureau at least 45 days before termination by the party desiring to cancel or not renew the policy.
 - (3) It shall state that if the fund is unable to make benefit payments under the act and the Occupational Disease Act due to insolvency or bankruptcy, the excess carrier shall make the payments to other parties involved in the paying of the fund's obligations, as directed by the Bureau, subject to the policy's retentions and limits.

RULES AND REGULATIONS

- (4) It shall state that the following apply toward reaching the retention amount in the excess contract:
 - (i) Payments made by the fund.
 - (ii) Payments made on behalf of the fund under a surety bond or other forms of security as required under this subchapter.
 - (iii) Payments made by the Self-Insurance Guaranty Fund.
- (5) It shall state that it applies to any losses of a fund under the act and the Occupational Disease Act; it may not exclude coverage for any categories of injuries or diseases compensable under the act or the Occupational Disease Act.
- (d) A certificate of the excess insurance obtained by the fund shall be filed with the Bureau together with a certification that the policy fully complies with subsection (c).

§ 125.150. Runoff fund

- (a) A runoff fund shall pay any obligations, prepare reports and administer transactions associated with the period when it was an approved fund. A runoff fund shall continue to comply with appropriate provisions of this subchapter as determined by the Bureau.
- (b) A runoff fund shall file an annual report with the Bureau by a date prescribed by the Bureau on a prescribed form. This report shall be filed until all cases incurred by the runoff fund when it was a permittee are closed. The report shall include the information outlined in section 815(b) of the act (77 P.S. § 1036.15(b)).

§ 125.151. Claims service companies

- (a) A claims service company desiring to engage in the business of handling and adjusting claims for a fund shall register with the Bureau as provided under section 441(c) of the act (77 P. S. § 997(c)), and regulations thereunder, on a prescribed form before entering into any contract to provide these services. The service company shall answer the questions on the registration form and shall swear to the information provided on the form.
- (b) A claims service company shall have adequate facilities and employ competent staff to provide claims services in a manner which fulfills a fund's obligations under the act, the Occupational Disease Act and this part. A claims service company which reportedly or unreasonably fails to provide claims adjusting or services promptly with the results that compensation is not paid as required under the act or the Occupational Disease Act may have the privilege of conducting the business revoked or suspended under section 441(c) of the act.
- (c) The claims service company shall employ at least one person on a full-time basis who has the knowledge and experience necessary to service claims under the act and the Occupational Disease Act. A resume covering that person's background shall be attached to the registration form of the claims service company

§ 125.152. Board of trustees

- (a) The board of trustees of a fund shall establish the fund's policies, ensure its fiscal stability and engage and delegate functions to its administrator, fiscal agent and service companies on behalf of the plan committee.
- (b) Trustees shall be appointed by a fund's plan committee in accordance with the trust agreement and the bylaws.
- (c) At least 2/3 of a fund's trustees shall be members of its plan committee. A member may not be represented by more than one trustee on the board of trustees. A fund's administrator, service companies or an officer, owner, employe of or another person or corporation affiliated with the administrator or

RULES AND REGULATIONS

service companies may not serve as a voting trustee, unless the administrator or service company is an organization consisting of political subdivisions, the income of which is not subject to Federal income taxation. An administrator or service company may serve as a nonvoting trustee.

- (d) Each trustee shall act as a fiduciary for the benefit of employees of members and shall carry out his powers and responsibilities under the trust agreement independent of any powers and responsibilities he may possess or exercise as an employee, officer or director of a member.
- (e) If an association of employers assist in the establishment of more than one fund, the plan committees of the several funds may decide to participate in a single board of trustees to oversee the operations of the several funds. The following restrictions and requirements apply to that single board of trustees:
 - (1) Each of the several funds shall be equally represented on the board of trustees.
 - (2) The pledge of joint and several liability of a member of a fund applies only to the liabilities and obligations of that member's fund; it does not apply to the other funds participating in the single board of trustees.
 - (3) Only the trustee-representatives of a specific fund shall vote on matters relating to the amendment of that fund's trust agreement or bylaws.
 - (4) Only the trustee-representatives of a specific fund shall set policies and make determinations governing the admission of members and the requirements for membership in that fund.
 - (5) At least 2/3 of the single board of trustees shall be members of the plan committees of the several funds. Other restrictions on the makeup of the board outlined under subsection (c) also apply to the single board of trustees.

§ 125.153. Additional powers of Bureau

In addition to the powers enumerated elsewhere in this subchapter and the act, the Bureau will have the authority, after notice and opportunity for hearing, to suspend a fund's operation, to issue cease and desist orders and to order corrective actions if a fund, its administrator or service companies are in violation of this subchapter or the act.

§ 125.154. Hearings

- (a) The Director of the Bureau will assign appeals to decisions or orders issued under this subchapter and Article VIII of the act (77 P.S §§ 1036.1 — 1036.18) to a hearing officer who will schedule a de novo hearing on the appeal from the initial decision or order. The applicant or the fund will receive reasonable notice of the hearing date, time and place.
- (b) The hearing will be conducted in a manner to provide the applicant or the fund and the Bureau the opportunity to be heard. The hearing officer will not be bound by strict rules of evidence. Relevant evidence of reasonably probative value may be received into evidence. Reasonable examination and cross-examination of witnesses will be permitted.
- (c) Testimony will be recorded and a full record kept of the proceeding. The Bureau and the applicant or the fund will be provided the opportunity to submit briefs addressing issues raised.
- (d) Following the close of the record, the hearing officer will promptly issue a written decision and order. The decision and order will include relevant findings and conclusions, and state the rationale of the decision. The decision will be served upon the applicant or the fund, the Bureau and counsel of record.
- (e) An applicant, fund or the Bureau, aggrieved by a decision rendered under subsection (d), may appeal the decision to Commonwealth Court.

RULES AND REGULATIONS

§ 125.155. Homogeneity

- (a) The definition of “homogeneous employer” under section 801 of the act (77 P. S. § 1036.1) and under § 125.132 (relating to definitions) is deemed satisfied as to employers who have been assigned to the same classification series if the members derive a majority of their contributions from codes within the same classification group listed in a manual of risk classes approved by the Commissioner of the Insurance Department under Article VII of the act (77 P. S. §§ 1035.1 — 1035.22).
- (b) The definition of “homogeneous employer” under section 801 of the act and under § 125.132 is deemed satisfied as to employers engaged in the same or similar types of business if the members have been assigned to the same two-digit major group of the four-digit Standard Industrial Classification system published by the Federal Office of Management and Budget or if the members have been assigned to three-digit industry groups outside of the primary two-digit major group which the Bureau has determined share substantial common aspects of production or services with the industries within the primary two-digit major group.
- (c) Prospective members affiliated through common ownership or control shall be considered one employer for the purpose of calculating the number of homogeneous employers participating in a fund.
- (d) Political subdivisions are homogeneous employers. Political subdivisions may not participate in funds which include employers who are not political subdivisions.

§ 125.156. Computation of time

Unless otherwise provided, reference to “days” in this subchapter shall mean calendar days. For purposes of determining timeliness of filing and receipt of documents transmitted by mail, 3 days shall be presumed added to the prescribed period. If the last day for filing a document is a Saturday, Sunday, legal holiday or a day on which the Bureau’s offices are closed, the time for filing shall be extended to the next business day. Transmittal by mail shall mean by first-class mail.

SUBCHAPTER C. SELF-INSURING GUARANTY FUND

§ 125.201. Purpose

This subchapter is promulgated under sections 435 and 908 of the act (77 P. S. §§ 991 and 1037.8) to provide regulatory guidelines for uniform and orderly administration of the guaranty fund.

§ 125.202. Definitions

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise:

Act — The Workers’ Compensation Act (77 P. S. §§ 1 — 1038.2).

Basis of premium — The basis for the computation of an employer’s workers’ compensation insurance premium, such as employe remuneration paid by the employer.

Bureau — The Bureau of Workers’ Compensation of the Department.

Compensation — Compensation as defined in section 901 of the act (77 P. S. § 1037.1).

Custodial accounts — The two distinct and separate accounts of the guaranty fund established under section 902(c) of the act (77 P. S. § 1037.2(c)). One account is to be used exclusively to pay benefits

RULES AND REGULATIONS

arising from defaulting individual self-insurers and one account is to be used exclusively to pay benefits arising from defaulting group self-insurance funds.

Default — The failure of a self-insurer to pay compensation due to the self-insurer's financial inability or the self-insurer filing for bankruptcy or being declared bankrupt or insolvent.

Department — The Department of Labor and Industry of the Commonwealth.

Employer — An employer as defined in section 901 of the act.

Guaranty fund — The guaranty fund as defined in section 901 of the act.

Manual premium — The sum of an employer's basis of premium for each classification for the 12-month period immediately prior to the effective date of its individual self-insurance status under section 305 of the act (77 P. S. § 501) or of its membership in a group self-insurance fund under Article VIII of the act (77 P. S. §§ 1036.1 — 1036.18) multiplied by the applicable SWIF rate in effect at the time of the issuance of the insurance policy immediately prior to the employer's individual self-insurance status or its membership in a group self-insurance fund.

Modified manual premium — An employer's manual premium multiplied by its experience modification factor for the insurance policy immediately prior to the employer's individual self-insurance status or its membership in a group self-insurance fund, before adjustments or discounts.

New individual self-insurer — An employer operating as a self-insurer under its first permit, including an employer operating as a self-insurer under its first permit following the lapse of a previous period of self-insurance.

New group self-insurance fund — A group self-insurance fund initiating operation under the act.

Occupational Disease Act — The Pennsylvania Occupational Disease Act (77 P. S. §§ 1201 — 1603).

Runoff group self-insurance fund — A group self-insurance fund which voluntarily terminated the permit issued to it under Article VIII of the act or a group self-insurance fund whose permit was revoked by the Bureau.

Runoff individual self-insurer — An employer that had been a self-insurer under section 305 of the act (77 P. S. § 501) and section 305 of the Occupational Disease Act (77 P. S. § 1405) but no longer maintains a current permit.

Security — Security as defined in section 901 of the act.

Self-insurer — A self-insurer as defined in section 901 of the act, including a runoff individual self-insurer and a runoff group self-insurance fund.

Self-insurer accounts — Individual segregated subaccounts of the custodial accounts for the deposit of funds received from security demanded under section 904(d)(2)(ii) of the act (77 P. S. § 1037.4(d)(2)(ii)).

SWIF — The State Workers' Insurance Fund.

SWIF rate — The amount per unit of exposure which SWIF charges for insurance, calculated by multiplying the lost cost charge for a classification by the SWIF lost cost multiplier.

§ 125.203. Default

- (a) Upon receipt of information that a self-insurer has failed to pay compensation due under the act or the Occupational Disease Act, the Bureau will investigate whether the failure to pay compensation has occurred and, if it has, determine the reason for that failure.

RULES AND REGULATIONS

- (b) If the Bureau determines that the failure to pay compensation may be due to the self-insurer's financial inability to pay compensation, the Bureau will notify the self-insurer of its determination and direct the compensation to be paid within 15 days of the receipt of the notice.
- (c) If the self-insurer fails to pay the compensation as directed within 15 days, the Bureau will declare the self-insurer in default. The Bureau also may at any time declare a self-insurer to be in default if the self-insurer fails to pay compensation due to a filing for bankruptcy or being declared bankrupt or insolvent.

§ 125.204. Procedures following default

- (a) After the Bureau declares a default, it will determine whether the liabilities of the self-insurer exceed or are less than the self-insurer's security.
- (b) If the defaulting self-insurer's liabilities are less than the security, the Bureau will notify the custodian of the security that it shall utilize the security to cure the default. The Bureau will monitor payments made by the custodian of the security to ensure that compensation is paid as due under the act or the Occupational Disease Act.
- (c) If at any time the defaulting self-insurer's liabilities exceed or can reasonably be expected to exceed the security, the Bureau will order payment of the security into a self-insurer account within the appropriate custodial account. The funds deposited into each self-insurer account and the interest thereon will be used solely for the payment of compensation or costs associated therewith to employees of the defaulting self-insurer providing the security.
- (d) After the assets of a self-insurer account have been exhausted, compensation shall be paid from funds obtained through assessments made and collected under section 907 of the act (77 P. S. § 1037.7) and related provisions of this subchapter and interest thereon.

§ 125.205. Allocation of security

When a security instrument posted by a self-insurer applies to claims resulting from injuries and exposures occurring both prior to and on or after the establishment of the guaranty fund, the Bureau may order payment of a portion of the security into a self-insurer account under section 904 (d)(2)(ii) of the act (77 P. S. § 1037.4(d)(2)(ii)) for the payment of compensation on claims resulting from injuries and exposures occurring on or after the establishment of the guaranty fund. The portion of the security retained by the custodian of the security shall be used for the payment of compensation on claims resulting from injuries and exposures occurring prior to the establishment of the guaranty fund.

§ 125.206. Payments to claimants

When payment of compensation is ordered by the Bureau from the guaranty fund relating to a defaulting self-insurer, compensation in arrears to the claimants will be paid within 15 days of the issuance of the order. After the initial payment of compensation, compensation will be paid in the same manner as the defaulting self-insurer would be required to make those payments under the act or the Occupational Disease Act.

§ 125.207. Assessment of new individual self-insurer

As a condition for the issuance of a permit to operate as an individual self-insurer under section 305 of the act (77 P. S. § 501), an applicant shall submit to the Bureau the calculation of its modified manual premium on a form prescribed by the Bureau. Following the receipt of the calculation form and the commencement of the applicant's self-insurance status, the Bureau will issue a notice to the new self-insurer assessing it for the guaranty fund based on 1/2% of its modified manual premium. The new self-insurer shall pay the assessment in the time prescribed by the Bureau.

RULES AND REGULATIONS

§ 125.208. Assessment of new group self-insurance fund

As a condition for the issuance of a permit to operate as a group self-insurance fund under Article VIII of the act (77 P. S. §§ 1036.1 — 1036.18), an applicant shall submit to the Bureau the calculation of each member's modified manual premium on a form prescribed by the Bureau. Following the receipt of the calculation forms and the commencement of the applicant's group self-insurance status, the Bureau will issue a notice to the new group self-insurance fund assessing it for the guaranty fund based on 1/2% of the total of its members' modified manual premiums. The new group self-insurance fund shall pay the assessment within 30 days of the receipt of the assessment.

§ 125.209. Assessment of new members of group self-insurance fund

As an existing group self-insurance fund adds new members, it shall submit the form prescribed by the Bureau calculating each new member's modified manual premium. Following the receipt of the calculation form, the Bureau will issue to the group self-insurance fund a notice assessing it for the guaranty fund based on 1/2% centum of the total of its new members' modified manual premiums. The group self-insurance fund shall pay the assessment within 30 days of the receipt of the assessment.

§ 125.210. Assessment of existing self-insurer

- (a) If the liabilities of the guaranty fund exceed its assets, including funds deposited into the guaranty fund under section 906(a)(1) of the act (77 P. S. § 1037.6(a)(1)), the Bureau may assess self-insurers for the additional amount needed to satisfy the liabilities under section 907(b)(1) of the act (77 P. S. § 1037.7(b)(1)).
- (b) The Bureau will give notice to each self-insurer of the amount assessed against the self-insurer under this section. Payment of the assessment shall be made within 30 days of the receipt of the assessment.
- (c) Assessment of a self-insurer under section 907 (b)(1) of the act shall be determined as follows: the amount of compensation paid by the self-insurer during the preceding calendar year multiplied by the quotient resulting from dividing the amount determined by the Bureau to carry out the requirements of Article IX of the act (77 P. S. §§ 1037.1 — 1037.8) by the total amount of compensation paid by all self-insurers during the preceding calendar year. The amount of compensation paid by the self-insurer and the total amount of compensation paid by self-insurers shall be obtained from the annual reports filed with the Bureau under sections 445 and 446(e) of the act (77 P. S. §§ 1000.1 and 1000.2(e)).
- (d) A self-insurer will not be assessed in any one calendar year more than 1% of the compensation paid by that self-insurer during the previous calendar year.

§ 125.211. Objections to assessment

Within 15 days after the receipt of an assessment notice issued against a self-insurer under Article IX of the act (77 P. S. §§ 1037.1 — 1037.8), the self-insurer may file objections with the Bureau if it believes the assessment is excessive, erroneous, unlawful or invalid. The objector shall state in detail the grounds for the objections. The Bureau, after notice to the objector, will hold a hearing upon the objections. After the hearing, the Bureau will record its findings on the objections and will transmit to the objector, by registered mail, notice of the amount, if any, charged against it in accordance with the findings. That amount shall be paid by the objector within 10 days after receipt of notice of the findings unless the objector initiates an action in the appropriate court within 10 days after receipt of the Bureau's notice to restrain the collection or payment of the assessment.

§ 125.212. Calculation of outstanding liability

The Bureau may retain the services of a casualty actuary to project the outstanding liability of the guaranty fund. Fees for actuarial services shall be an expense of the guaranty fund.