State of California
Department of Industrial Relations
Office of Self-Insurance Plans
1750 Howe Avenue, Suite 215
Sacramento,Ca. 95825
Phone (916) 464-7000
Fax (916) 464-7007

**State of California**
**Department of Industrial Relations**
**OFFICE OF SELF-INSURANCE PLANS**

# APPLICATION FOR CERTIFICATE OF CONSENT TO SELF-INSURE AS A PUBLIC AGENCY EMPLOYER SELF-INSURER

**All questions must be answered. If not applicable, enter "N/A".**

**To the Director of the Department of Industrial Relations:** The public agency employer identified below submits the following information to obtain a Certificate of Consent to Self-Insure the payment of workers' compensation under California Labor Code Section 3700.

**LEGAL NAME OF APPLICANT** (Show exactly as on Charter or other official documents):

Central Fire District of Santa Cruz County

Address: 930 17th Avenue

City: Santa Cruz State: CA Zip + 4: 95062 -

Federal Tax ID # of Group: 86-1542674

**CONTACT** - Who Should Correspondence Regarding This Applicant Be Addressed To:

Name: Jason Nee Title: Fire Chief

Company Name: Central Fire District of Santa Cruz County

Address: Central Fire District of Santa Cruz County

City: Santa Cruz State: CA Zip + 4: 95062 -

Phone: (831) 479-6842 E-Mail: jason.nee@centralfiresc.org

**TYPE OF PUBLIC ENTITY (Check one):**

☐ City and/or County ☐ School District ☑ Police and/or Fire District ☐ Hospital District
☐ Joint Powers Authority ☐ Other (describe): _____

**TYPE OF APPLICATION (Check one):**

☑ New Application ☐ Reapplication (Merger/Unification) ☐ Reapplication (Name Change)
☐ Other (describe): _____

Date Self-Insurance Program will begin: 07/01/2025

## CURRENT WORKERS' COMPENSATION PROGRAM

☐ Currently Insured with State Fund Policy # _____ Expiration Date: _____

☑ Currently Self Insured, Certificate # 5021-032

☐ Other (describe): _____

## CLAIMS ADMINISTRATION

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

☐ JPA will administer

☑ Third Party Administrator, TPA Certificate # 152

☐ Public entity will self-administer ☐ Insurance Carrier will administer

Name of Third Party Administrator:

Name: Amber Davis Title: Director of Claims - Public Entities

Company Name: LWP Claims Solutions

Address: PO Box 340916

City: Sacramento State: CA Zip + 4: 95834 - _____

Phone: (916) 609-3654 E-Mail: a_davis@lwpclaims.com

# of claims reporting locations to be used to handle Agency's claims: 1

Does applicant currently have a California Certificate of Consent to Self-Insure? ☐ Yes ☑ No

If yes, what is the current Certificate Number: _____

Total Number of Affiliate's California employees to be covered by Group: _____

## AGENCY EMPLOYER

Current # of Agency Employees: 128 # of Public Safety Employees (police//fire): 110

If school District, # of certificated employees: _____

Will all Agency employees be covered by this self-insurance plan? ☑ Yes ☐ No

If 'No', explain who is not covered and how workers' compensation coverage will be provided to the excluded employees:

## JOINT POWERS AUTHORITY

Will applicant be a member of a JPA for workers' compensation ?

☑ Yes ☐ No (If 'yes', complete the following)

Effective date of JPA Membership: 07/01/2025 JPA Certificate # 5017

Name of JPA: California Intergovernmental Risk Authority

## AGENCY SAFETY PROGRAM

Does the Agency have a written Injury and Illness Prevention Program (IIPP)? ☑ Yes ☐ No

Individual responsible for Agency workplace safety and IIPP program:

Name: Jason Nee Title: Fire Chief

Company Name: Central Fire District of Santa Cruz County

Address: 930 17th Street

City: Santa Cruz State: CA Zip + 4: 95602 -

Phone: (831) 479-6842 E-Mail: jason.nee@centralfiresc.org

## SUPPLEMENTAL COVERAGE

**1.)** Will your program be supplemented by any insurance or pooled coverage under a **STANDARD** workers' compensation insurance policy? ☐ Yes ☑ No (If 'Yes', complete the following):

Name of Excess Pool/Carrier:

Policy #: Effective Date of Coverage:

**2.)** Will your program be supplemented by any insurance or pooled coverage under a **SPECIFIC EXCESS** workers' compensation insurance policy? ☑ Yes ☐ No (If 'Yes', complete the following):

Name of Excess Pool/Carrier: Safety National

Policy #: SP 4066628 Effective Date of Coverage: 07/01/2025

Retention Limits: 25,000

**3.)** Will your program be supplemented by any insurance or pooled coverage under an **AGGREGATE EXCESS** (stop loss) specific excess workers' compensation insurance policy? ☐ Yes ☑ No (If 'Yes', complete the following):

Name of Excess Pool/Carrier:

Policy #: Effective Date of Coverage:

Retention Limits:

## RESOLUTION FROM GOVERNING BOARD

Attach a properly executed Governing Board Resolution. See attached sample resolution on page 5.

## CERTIFICATION

**The undersigned on behalf of the applicant hereby applies for a Certificate of Consent to Self-Insure the payment of workers' compensation liabilities pursuant to Labor Code Section 3700. The above information is submitted for the purpose of procuring said Certificate from the Director of Industrial Relations, State of California. If the Certificate is issued, the applicant agrees to comply with applicable California statutes and regulations pertaining to the payment of compensation that may become due to the applicant's employees covered by the Certificate.**

X _____ DATE: 08/14/2025

SIGNED: Authorized Official / Representative

Jason Nee

Printed Name

Fire Chief

Title

Central Fire District of Santa Cruz County

Agency Name

RESOLUTION NO.: 2025.12 DATED: 08/14/2025

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

At a meeting of the Central Fire District of Santa Cruz County Board of Directors
(Enter Name of the Board)

of the Central Fire District of Santa Cruz County
(Enter Name of Public Agency, District, Etc.)

a Independent Special Fire District organized and existing under the
(Enter Type of Agency, i.e., County, City, School District, etc.)

laws of the State of California, held on the 14 day of August, 2025,

the following resolution was adopted:

**RESOLVED, that the above named public agency is authorized and empowered to make application to the Director of Industrial Relations, State of California, for a Certificate of Consent to Self-Insure workers' compensation liabilities and representatives of Agency are authorized to execute any and all documents required for such application.**

IN WITNESS WHEREOF: I HAVE SIGNED AND AFFIXED THE AGENCY SEAL.

X _____ DATE: 08/14/2025
SIGNED: Board Secretary or Chair

Jason Nee
Printed Name

Fire Chief/Board Secretary
Title

Central Fire District of Santa Cruz County
Agency Name

Affix Seal Here

MW
Notary Public
See Attached
8/14/25

# ACKNOWLEDGMENT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California
County of Santa Cruz )

On August 14th ,2025 before me, Mike Nielsen ,Notary Public
(insert name and title of the officer)

personally appeared Jason Nee ,
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

MIKE NIELSEN
COMM. # 2484796
NOTARY PUBLIC - CALIFORNIA
SANTA CRUZ COUNTY
COMM. EXPIRES MAR. 19, 2028

Signature _____ **(Seal)**