STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION
Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

INSTRUCTION SHEET FOR FORM HC-61
HEALTH CARE APPLICATION FOR SELF-INSURANCE AUTHORIZATION

Instructions

Please completely fill out the HC-61 HEALTH CARE APPLICATION FOR SELF-INSURANCE AUTHORIZATION FORM.

The **Delivery Information** section below lists various delivery options. Please select the most convenient method, and submit the completed form accordingly.

Please remember to sign and date the form before submitting it.

Delivery Information

Delivery by U.S. Mail
Department of Labor and Industrial Relations, Disability Compensation Division
P.O. Box 3769, Honolulu, Hawaii 96812-3769

Delivery In-Person
Department of Labor and Industrial Relations, Disability Compensation Division
Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

Visit our Website at www.labor.hawaii.gov/dcd for forms.

(Rev. 03/2025)

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FORM HC-61
HEALTH CARE APPLICATION FOR SELF-INSURANCE AUTHORIZATION

To the Director of the Department of Labor and Industrial Relations (DLIR):

The undersigned, an employer, hereby makes application for permission to operate as a self-insurer pursuant to Chapter 393, Hawaii Revised Statutes, as amended, and in support of such application provides the following information:

1. Name of Applicant (List the name of the entity exactly as registered with the Department of Labor and Industrial Relations.)	
DOL No. - -	Please Check: ☐Corporation ☐Sole Proprietorship ☐Partnership ☐Other_____
2. (a) Mailing Address in Hawaii	
(b) Street Address in Hawaii (if different from above)	
(c) Telephone No. in Hawaii ( )	(d) Fax No. ( )
3. Other Business Locations in Hawaii	
4. Nature of Business	
5. (a) Number of employees **in Hawaii** to be covered under health care plan	
(b) Total number of employees (including those of Hawaii, parent and subsidiary companies)	

6. If a Subsidiary Company:

(a) Name of Parent Company
(b) Address
(c) Parent Company's Percentage of Stock Ownership

7. Will applicant conduct business under any other name than that shown in item 1 or item 6(a)? ☐Yes ☐No If yes,

(a) Name
(b) Address
(c) Nature of Business

8. Date Business Commenced in Hawaii

9. Enter below net profit or loss after taxes for the last five years

Year					
Amount	$	$	$	$	$

Equal Opportunity Employer/Program
Auxiliary aids and services are available upon request to individuals with disabilities.
TDD/TTY Dial 711 then ask for (808) 586-9188

(Rev. (03/2025)

10. Individual responsible for submitting Self-Insurer's audited financial statements annually

Name (Print)	Title
Address	
Telephone No. ( )	Fax No. ( )

11. Applicant's Current Hawaii Health Care Contractor(s)

12. Has an application for health care insurance ever been rejected or a policy cancelled? ☐Yes ☐No If yes,

(a) On What Date	(b) Name of Contractor
(c) Reason for Rejection/Cancellation	

13. Individual in your organization that will be responsible for your self-insurance program

Name (Print)	Title
Address	
Telephone No. ( )	Fax No. ( )

14. Claim administration/functions (claims adjusting, etc.) will be performed by

(a) If by Self-Insurer's own organization:	
Name of Administrator	Title
Address	
Telephone No. ( )	Fax No. ( )
(b) If by an outside organization:	
Name of Organization	
Name of Administrator	Title
Address	
Telephone No. ( )	Fax No. ( )
(c) Other	

(d) Will the administrator have the authority to promptly provide all benefits due?
☐Yes ☐No

If no, please explain limitations

15. Will the administration of claims be performed at more than one location?
☐Yes ☐No

If yes, at the end of the form (page 4 of 4), please provide all information requested in item 14 above for each adjusting location.

16. Will applicant's health care self-insurance program be supplemented by an insurance (stop-loss) policy? (Refer to NOTE below) ☐ Yes ☐ No

If yes, please attach a copy of the policy. (Any subsequent change in coverage should be promptly filed with the Director.)

NOTE: Employers with less than 1,500 total employees must obtain and maintain an excess of loss reinsurance protection for at least the first three (3) years from date that the self-insured plan is approved by the DLIR. The coverage must include a specific deductible not to exceed $100 per member multiplied by the number of members covered by the Company's health plan. Employers with more than 1,500 employees need not obtain a policy. **By signing this Application for Self-Insurance Authorization, the employer agrees to obtain and maintain the reinsurance policy.**

17. At the date of this application, is there any litigation or proceeding pending or threatened, the result of which might substantially adversely affect the financial condition, business or operations of the applicant or any of its subsidiaries? ☐ Yes ☐ No

If yes, please explain

18. REQUIRED ATTACHMENTS:

(a) A current copy of the applicant's Independent Auditor's Report, audited financial statements, complete with all schedules and notes. The current audited financial statements shall be dated within (12) twelve months of this application.

(b) If a Corporation:
Please provide a copy of the resolution of the applicant corporation's Board of Directors authorizing the filing of an application for a certificate of consent to self-insurance and execution of the instrument of undertaking in furnishing security, if required.

(c) A copy of applicant's self-insured health care plan. (If the plan is a preferred provider type of plan, a directory of the plan's network providers IN HAWAII is also required.)

(d) A copy of the applicant's supplemental insurance policy per item 16.

19. The employer agrees to the following:
(a) on a monthly basis deposit to an account that will be used for medical expense reimbursements (minimum monthly funding) of at least $150 per member and
(b) submit annually a copy of its independently audited financial statements with applicable DOL numbers **and the supplemental reinsurance policy, if required,** within three (3) months following its year end to:

State of Hawaii, Department of Labor and Industrial Relations
Disability Compensation Division
P.O. Box 3769
Honolulu, Hawaii 96812-3769

(c) provide the following information if the financial statements being submitted are other than the applicant's own financial statement:

Name of company whose financial statements will be used to determine financial solvency
Relationship of Company to Applicant
Percentage of Company's Ownership in Applicant

Note: By agreeing to provide the audited financial statements for the applicant employer, the related company shall submit a letter of guarantee, upon request by the DLIR, guaranteeing payment on all obligations or liabilities for which the applicant becomes legally obligated to pay pursuant to Chapter 393, Hawaii Revised Statutes and the attendant administrative rules.

Signature	Date
Name (Print)	Title
Telephone No. ( )	Fax No. ( )