Department of Business and Industry

Nevada Division of Insurance

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SELF-INSURED EMPLOYER'S ACTIVE ANNUAL CLAIMS INFORMATION REPORT
FOR FISCAL YEAR ENDING: JUNE 30, 2017

DUE SEPTEMBER 30, 2017

SECTION A - EMPLOYER INFORMATION

1. Employer Name _____

2. Certification Date _____ No. of Uninterrupted Years Certified _____

3. Employer Contact

   Name: _____

   Title: _____

   Address: _____

   Telephone: _____ Email Address: _____

4. Has there been a change in the nature of the employer's operations, business structure, or ownership in the last year?

   YES* _____ NO _____

   *If YES, please provide details: _____

5. Do you anticipate a change in the nature of operations, business structure or ownership in the next year?

   YES* _____ NO _____

   *If YES, please provide details: _____

   _____

6. Have there been any changes to your business or subsidiary name(s) in the past year? YES*_____ No _____

   Review your current certificate of authority and addendum or visit http://di.nv.gov/sdc/EmployerList.pdf to view your business names as shown on your addendum.

   *If YES, please provide details: _____

   _____

7. *How many business locations did you have in Nevada as of June 30, 2017 ?* _____

8. How many employees did you have in Nevada as of June 30, 2017? _____

9. What is the amount of your current security deposit?

	Number	Amount
Surety Bond		
Time Certificate/CD		
Letter of Credit		
Other		

10. Who is your excess insurance carrier? Insurer: _____

    Policy Number: _____ SIR: _____

SECTION B - ADMINISTRATOR INFORMATION

A **Certification of Claims Administration** must be completed by each Administrator with whom the Employer has contracted for claims handling. Each signed original certification must be submitted with this report. The employer must complete a **Certification of Claims Administration** for any portion of the period of self-insurance that is self-administered.

11. List below each of the Administrators currently responsible for the handling of claims. Also list the dates of the injury assigned to that Administrator.

ALL YEARS THAT THE EMPLOYER HAS BEEN CERTIFIED MUST BE REPRESENTED BELOW.

A **Certification of Claims Activity** for each Administrator listed must be submitted with your report.

Administrator	Dates Handled by Administrator
a.	
b.	
c.	
d.	

SECTION C - CLAIMS ACTIVITY

12.

a. How many claims were filed during the reporting period?_____

b. How many claims were accepted during the reporting period?_____

c. How many accidents were incurred during the current reporting period that involved five or more employees?_____

d. Did you incur any fatalities during the reporting year? YES*_____ NO_____

* Please attach a copy of the OSHA report for each fatality

SECTION D - SIGNATURES & EMPLOYER CERTIFICATION

Pursuant to NAC 616B.460, each report must be signed by an officer or an authorized employee of the self-insured employer. Notarization is not required.

Signed _____

Self-Insured Employer
(Signature Required)

_____

Title Date

PLEASE SUBMIT REPORTS VIA EMAIL TO:

Employers A-L
Shirley Choma
schoma@doi.nv.gov

Employers M-Z
Sherri Abeyta
slabeyta@doi.nv.gov