



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, 2018

DUE SEPTEMBER 30, 2018

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, control or ownership in the last year?
 YES* NO *If YES, please attach an explanation.
5. Do you anticipate a change in the nature of operations, business structure, control or ownership in the next year?
 YES* NO *If YES, please attach an explanation.
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 attach an explanation.
7. How many business locations did you have in Nevada as of June 30, 2018 ? _____
Attach a list of locations. A location for each subsidiary name on the addendum should also be included.
8. How many employees did you have in Nevada as of June 30, 2018? _____
9. What is the amount of your current security deposit?

	Financial Institution	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 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 and the dates of the injury assigned to that Administrator. A **Certification of Claims Activity** for each Administrator listed must be submitted with your report.

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

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 incurred during the current reporting period 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 - SIGNATURE & 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.

Signature of Representative of Self-Insured Employer (Required)	Title
Printed Name of Representative	Date

PLEASE SUBMIT REPORTS VIA EMAIL TO:

Employers A-L Shirley Choma schoma@doi.nv.gov	Employers M-Z Terri Chambers tchambers@doi.nv.gov
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