STATE OF NEVADA
DEPARTMENT OF BUSINESS AND INDUSTRY
DIVISION OF INSURANCE
Self-Insured Workers' Compensation
1818 E. College Parkway, Suite 103
Carson City, NV 89706
(775) 687-0700

INACTIVE
SELF-INSURED EMPLOYER'S ANNUAL CLAIMS INFORMATION REPORT
FOR FISCAL YEAR ENDING: JUNE 30, 2016

DUE SEPTEMBER 30, 2016

A. IDENTIFICATION

1. Employer's Name:_____

2. Date of Certification:_____ Date of Decertification_____

3. Number of Consecutive Years as a Self-Insured Employer (see instructions C2(a)):_____

4. Name of Employer's **Contact Person – (**Mandatory):_____

   Title: _____ E-mail Address (Mandatory):_____

   Address: _____

   Telephone Number:_____ Fax Number (Mandatory):_____

5. **If multiple claims Third-Party Administrators are utilized, you must include contact information and claims dates handled for each Administrator. Attach a separate list if necessary.**

   Claims Administrator:_____ Contact Person:_____

   Mailing Address:_____

   Telephone Number:_____ E-mail address:_____

   Claim Dates Administered:_____

   Location of Records (attach list, if necessary):_____

   Claims Administrator:_____ Contact Person:_____

   Mailing Address:_____

   Telephone Number:_____ E-mail address:_____

   Claim Dates Administered:_____

   Location of Records (attach list, if necessary):_____

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B. SECURITY DEPOSIT (NRS 616B.300) & (NAC 616B.436) – Please note that pursuant to NRS 616B.333 the security deposited must remain on deposit for at least 36 months after termination of status as a self-insured employer. At the expiration of the 36-month period, the Commissioner of Insurance may accept in lieu of any security deposited a policy of paid-up insurance (loss portfolio transfer) in a form approved by the Commissioner of Insurance. **PLEASE ATTACH COPY (OR COPIES) OF CURRENT SECURITY DEPOSIT(S) HELD WITH THE DIVISION OF INSURANCE.**

Form of Security

1. Surety Bond - Bond Number: _____

   Company: _____

   Amount: $ _____

   NOTE: Pursuant to NRS 616B.306: *A company providing a surety bond may terminate liability on its surety bond by giving the commissioner and the employer 90 days' written notice.* ***THE TERMINATION DOES NOT LIMIT LIABILITY WHICH WAS INCURRED UNDER THE SURETY BOND BEFORE THE TERMINATION.***

2. Time Certificate of Deposit (CD) Number (s): _____ Amount(s): $ _____

   Issuing Institution(s): _____ Contact Person: _____

   E-mail Address: _____ Telephone Number: _____

3. Irrevocable Letter of Credit Number (NAC 616B.439): _____ Amount(s): $ _____

   Bank _____ Contact Person: _____

   E-mail Address: _____ Telephone Number: _____

   U. S. Securities: Type: _____ Amount(s): $ _____

4. Issuing Institution(s): _____ Contact Person: _____

   E-mail Address: _____ Telephone Number: _____

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C. CLAIMS INFORMATION (NAC 616B.463) – **PLEASE REFER TO INSTRUCTIONS FOR EACH LINE ITEM**

Each third-party administrator responsible for handling your claims must complete a separate report of claims, which must be included in your complete filing due September 30, 2016.

TPA Name: _____ Dates claims were administered: From _____ To _____

The following claims information must reflect all claims, which have occurred since the employer became self-insured. (Please round to the nearest whole dollar amount.) **Do not include cents. If using the automated version use only positive numbers.)**

1. **Annual Claims Expenditure Average**

	7/01/13 to 6/30/14		7/01/14 to 6/30/15		7/01/15 to 6/30/16		SUBTOTAL	TOTAL
a. Claims Expenditures	$_____	+	$_____	+	$_____	=	$0	
b. Claims Expenditures Three-Year Average (Total of three years divided by 3)						=		$0

2. **Closed Claims Costs**

a. Total Number of Closed Claims at June 30, 2016: _____

	MEDICAL		INDEMNITY		OTHER		SUBTOTAL	TOTAL
b. **Actual** Paid to Date	$_____	+	$_____	+	$_____	=	$0	
c. Multiplied by: Applicable Percentage Used (See instructions)			_____					
d. Equals: Provision for Reopened Claims Costs (See Instructions)	$0	+	$0	+	$0	=		$0

3. **Claims Administration Costs (See Instructions)**

a. Administration Expense $_____

4. **Minimum Security Deposit Required (See Instructions)**
(Rounded Up to the Nearest Thousand) $0

(ANY ADJUSTMENTS TO PRESENT DEPOSIT AMOUNT MUST BE AUTHORIZED IN WRITING BY THE DIVISION OF INSURANCE)

5. **Open Claims Information**

a. Total Number of **Open** Claims at June 30, 2016: _____
(Do Not Include Incident Reports)

	MEDICAL		INDEMNITY		OTHER		TOTAL
b. Total **Anticipated Gross** Costs	$_____	+	$_____	+	$_____	=	$0
c. Less: **Actual** Paid to Date	_____	+	_____	+	_____	=	$0
d. Equals: Reserves	$0	+	$0	+	$0	=	$0

e. Total Number of Claims Expected to be paid from Other Sources
(Please attach back-up – see instructions) _____

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This report was prepared and verified by:

_____
Printed Name

_____
Title Date

Signed_____
Third Party Administrator or Self-Administered Employer Name
(Signature Required)

State of Nevada

County of _____

I hereby certify under penalty of perjury that the foregoing statements are true and correct to the best of my knowledge and belief.

This instrument was acknowledged before me on _____
Date

by _____ as
Name(s) of person(s)

Signed _____
Officer/Owner – Self-Insured Employer
(Signature Required)

_____ of _____
Type of authority, e.g. officer, trustee, etc.

_____
Title Date

_____
Name of party for whom instrument was executed

_____
Signature of Notary

Notary Stamp

_____
Title and Rank (optional)