

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

**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: \_\_\_\_\_

3. Number of Consecutive Years as a Self-Insured Employer (see instructions H2(c): \_\_\_\_\_

4. Name of Employer's Contact Person\* **(Mandatory)**: \_\_\_\_\_

Title: \_\_\_\_\_ E-mail Address **(Mandatory)**: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number **(Mandatory)**: \_\_\_\_\_

5. Name of Employer's Risk Manager: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

6. **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. ADMINISTRATION (NRS 616B.315)

1. Has the nature of operation, business structure, organization or identity of the above named employer changed during the last fiscal year?  
YES \_\_\_\_\_ NO \_\_\_\_\_ If YES, attach a statement of explanation signed by an officer.
2. Does the employer expect a change in the nature of operation, business structure, organization or identity during the next 12 months?  
YES \_\_\_\_\_ NO \_\_\_\_\_ If YES, attach a statement of explanation signed by an officer.

C. SECURITY DEPOSIT (NRS 616B.300) & (NAC 616B.436)

**(Information for current security deposit must be provided). PLEASE ATTACH A COPY (OR COPIES) OF CURRENT SECURITY DEPOSIT(S) HELD WITH THE DIVISION OF INSURANCE.**

**FORM OF SECURITY**

1. **\*Surety Bond - Bond Number:** \_\_\_\_\_ **\*Amount \$** \_\_\_\_\_  
**\*Company:** \_\_\_\_\_ **\*Contact Person:** \_\_\_\_\_  
**Title:** \_\_\_\_\_ **\*Address:** \_\_\_\_\_  
**E-mail Address:** \_\_\_\_\_ **Telephone Number:** \_\_\_\_\_
2. **\*Time Certificate of Deposit (CD) Number (s):** \_\_\_\_\_ **\*Amount(s): \$** \_\_\_\_\_  
**\*Issuing Institution(s):** \_\_\_\_\_ **\*Contact Person:** \_\_\_\_\_  
**Title:** \_\_\_\_\_ **\*Address:** \_\_\_\_\_  
**E-mail Address:** \_\_\_\_\_ **Telephone Number:** \_\_\_\_\_
3. **\*Irrevocable Letter of Credit Number (NAC 616B.439):** \_\_\_\_\_ **\*Amount \$** \_\_\_\_\_  
**\*Bank:** \_\_\_\_\_ **Expiration Date:** \_\_\_\_\_ **\*Contact Person:** \_\_\_\_\_  
**Title:** \_\_\_\_\_ **\*Address:** \_\_\_\_\_  
**E-mail Address:** \_\_\_\_\_ **Telephone Number:** \_\_\_\_\_
4. **\*U. S. Securities: Type:** \_\_\_\_\_ **\*Amount: \$** \_\_\_\_\_  
**\*Issuing Institution(s):** \_\_\_\_\_ **\*Contact Person:** \_\_\_\_\_  
**Title:** \_\_\_\_\_ **\*Address:** \_\_\_\_\_  
**E-mail Address:** \_\_\_\_\_ **Telephone Number:** \_\_\_\_\_

**\*MANDATORY**

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D. EXCESS INSURANCE INFORMATION (NRS 616B.300)

Insurer's Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_ S.I.R.: \$ \_\_\_\_\_

Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

E. BUSINESS NAMES (NAC 616B.451)

List all names of subsidiaries or entities operated in Nevada that are covered under the employer's certificate of self-insurance. All listed entities must be included in the combined audited financial statements of the certificate holder. (Attach a list, if necessary).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

F. PHYSICAL LOCATIONS (NAC 616B.451)

All current self-insured physical locations in Nevada must be listed below (attach a list, if necessary).

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

G. AUDITED FINANCIAL STATEMENTS (NRS 616B.336) & (NAC 616B.433)

Audited financial statements must be submitted within 120 days following the close of the self-insured's latest fiscal year.

What is your fiscal year end date? \_\_\_\_\_

Have you submitted your current audited financial statements? YES \_\_\_\_\_ NO \_\_\_\_\_

Explain, if necessary: \_\_\_\_\_

**NOTE: DO NOT INCLUDE THE AUDITED STATEMENTS WITH THIS REPORT.**

**SELF-INSURED  
2016 ANNUAL CLAIMS INFORMATION REPORT FOR \_\_\_\_\_**

H. 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 \_\_\_\_\_

(Please round to the nearest whole dollar amount. **Do not include cents.**)

**ANNUAL SECURITY DEPOSIT CALCULATION**

**1. Annual Claims Expenditure Average**

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

**2. Closed Claims Costs**

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

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

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

a. Administration Expense \$ \_\_\_\_\_

**4. Minimum Security Deposit Required (See Instructions)**

(Rounded Up to the Nearest Thousand) \$ \_\_\_\_\_

(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)**

	<u>MEDICAL</u>	<u>INDEMNITY</u>	<u>OTHER</u>	<u>TOTAL</u>
b. Total <b>Anticipated Gross</b> Costs	\$ _____	+ \$ _____	+ \$ _____	= \$ _____
c. Less: <b>Actual</b> Paid to Date	\$ _____	+ \$ _____	+ \$ _____	= \$ _____
d. Equals: Reserves	\$ _____	+ \$ _____	+ \$ _____	= \$ _____

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

**2016 ANNUAL CLAIMS INFORMATION REPORT**

The following industrial claims information represents **ONLY** claims data filed during the fiscal year ending June 30, 2016 (July 1, 2015 through June 30, 2016):

- 6. Number of Claims **Filed** for Current Reporting Period \_\_\_\_\_
- 7. Number of Claims **Accepted** for Current Reporting Period \_\_\_\_\_
- 8. Number of Accidents That Affected Five or More Employees \_\_\_\_\_
- 9. Were there any fatalities during Fiscal Year Ending June 30, 2016? YES \_\_\_\_\_ NO \_\_\_\_\_ NUMBER OF FATALITIES \_\_\_\_\_

If yes, attach a complete report for each fatality.

**I. EMPLOYEE INFORMATION (MANDATORY)**

Total Number of Employees in Nevada as of June 30, 2016 \_\_\_\_\_  
 Total Number of Locations in Nevada as of June 30, 2016 \_\_\_\_\_

=====

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 \_\_\_\_\_

This instrument was acknowledged before me on \_\_\_\_\_  
Date

by \_\_\_\_\_ as  
Name(s) of person(s)

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

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)