Department of Business and Industry

Nevada Division of Insurance

1818 E. College Pkwy., Suite 103, Carson City, Nevada 89706 **Phone:** (775) 687-0700 **Fax:** (775) 687-0787 **Web:** doi.nv.gov

SELF-INSURED EMPLOYER'S INACTIVE ANNUAL CLAIMS INFORMATION REPORT FOR FISCAL YEAR ENDING JUNE 30, 2018

DUE SEPTEMBER 30, 2018

SECTION A - EMPLOYER INFORMATION

1. Employer Name _____

2. Certification Dates _____ to _____

3. Employer Contact

   Name _____

   Title _____

   Address _____

   Telephone _____ Email Address _____

4. Has there been a change in control or ownership?

   ☐ YES* ☐ NO *If YES, please attach an explanation.

5. Do you anticipate a change in control or ownership?

   ☐ 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 *If YES, please attach an explanation.

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

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

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.

8. 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 - SIGNATURE & EMPLOYER CERTIFICATION

Pursuant to NAC 616B.460, each report must be signed by an officer or 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