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 ACTIVE ANNUAL CLAIMS INFORMATION REPORT

FOR YEAR ENDING JUNE 30, 2026

DUE SEPTEMBER 30, 2026

SECTION A – EMPLOYER INFORMATION

1. Employer Name_____ Certificate No._____
2. Certification Date _____ No. of Uninterrupted Years Certified_____
3. Employer Regulatory Contact
   Name_____
   Title_____
   Address_____
   Telephone_____ Email Address_____
4. Employer Complaints Contact
   Name_____
   Title_____
   Address_____
   Telephone_____ Email Address_____
5. Has there been a change in operations, business structure, control or ownership in the next year?
   Yes* ☐ No ☐ **If YES, please attach an explanation.*
6. Do you anticipate a change in operations, business structure, control or ownership in the next year?
   Yes* ☐ No ☐ **If YES, please attach an explanation.*
7. Have there been any changes to your business or subsidiary name(s) in the past year?
   Yes* ☐ No ☐ **If YES, please attach an explanation.*
8. How many business locations did you have in Nevada as of June 30, 2026?_____
9. How many employees did you have in Nevada as of June 30, 2026?_____
10. What is the amount of your current security deposit?

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

11. 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 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 and should be listed below.

12. List the **Certification** forms that will be submitted with this report. All years that the Employer has been certified must be represented below.

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

SECTION C – LOCATIONS OF CLAIMS RECORDS

13. Identify the location of all open and closed claims records and the responsible party for each period of claims, including the number of claims at each location and the format(s) in which they are stored.

	No. of Claims	Period of Loss Dates	Responsible Party	Physical Address or Software Name
Paper				
Electronic				

Are all supporting documents available in the electronic record for all loss dates incurred?

Yes ☐ No ☐ **If NO, provide an explanation below.*

SECTION D – 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)** Date

Printed Name of Representative Title

PLEASE SUBMIT REPORTS VIA EMAIL TO:
siemail@doi.nv.gov