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, 2024

DUE SEPTEMBER 30, 2024

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 the nature of the operations, business structure, control or ownership in the last year?

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

6. 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.*

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, 2024? _____

   Attach a list of locations. A location for each subsidiary name on the addendum should also be included.

9. How many employees did you have in Nevada as of June 30, 2024? _____

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

	Financial Institution	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 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** form 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.

	Paper or Electronic	Number of Claims	Period of Loss Dates	Responsible Party	Address/Software
a.					
b.					
c.					
d.					

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:

SIEmail@doi.nv.gov