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 YEAR ENDING JUNE 30, 2026

DUE SEPTEMBER 30, 2026

SECTION A – EMPLOYER INFORMATION

1. Employer Name_____ Certificate No._____
2. Certification Dates _____to_____
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 control or ownership?
   - Yes* ☐ No ☐ **If YES, please attach an explanation.*
6. Do you anticipate a change in control or ownership?
   - 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. What is the amount of your current security deposit?

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

SECTION B – ADMINISTRATOR & CLAIMS RECORDS 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.

9. 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.		

10. 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 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)** Date

Printed Name of Representative Title

PLEASE SUBMIT REPORTS VIA EMAIL TO:

siemail@doi.nv.gov