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, 2020

DUE SEPTEMBER 30, 2020

SECTION A - EMPLOYER INFORMATION

1. Employer Name ______________________ Certificate No. __________

2. Certification Date __________ No. of Uninterrupted Years Certified __________

3. Employer Contact

   Name ______________________

   Title ______________________

   Address ______________________

   Telephone __________ Email Address ______________________

4. 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.*

5. 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.*

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. How many business locations did you have in Nevada as of June 30, 2020 ? __________

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

8. How many employees did you have in Nevada as of June 30, 2020? __________

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

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

10. 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** form for any portion of the period of self-insurance that is self-administered.

11. List below each of the Administrators currently responsible for the handling of claims and the dates of injury assigned to that Administrator. A **Certification** form from each listed 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 - CLAIMS ACTIVITY

12. a. How many claims were filed during the reporting period? ______________

b. How many claims were accepted during the reporting period? ______________

** If a claims status other than open or closed claims is used, please attach a detailed explanation.*

c. How many accidents incurred during the current reporting period involved five or more employees?____________

d. Did you incur any fatalities during the reporting year? ☐ YES* ☐ NO

** Please attach a copy of the OSHA report for each fatality.*

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:

Employers A-L
Shirley Choma
schoma@doi.nv.gov

Employers M-Z
Michael Marsala
marsalam@doi.nv.gov