



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, 2023

DUE SEPTEMBER 30, 2023

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	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.

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.

	Paper or Electronic	Number of Claims	Period of Loss Dates	Responsible Party	Address
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:

SIEmail@doi.nv.gov