Self-Insurer's Annual Update Form
2016

Name of Self-Insured: ______________________________

FEIN #: ______________ Carrier ID # B ______________

Primary Contact

Name of Primary Contact Person at Self-Insured: ______________________________

Title of Contact Person: ______________ Telephone #: ______________

E-Mail Address: ______________ Fax #: ______________

Mailing Address: ______________________________

City: ______________ State: ______________ Zip: ______________

Additional Contact (if applicable)

Name of Contact Person at Self-Insured: ______________________________

Title of Contact Person: ______________ Telephone #: ______________

E-Mail Address: ______________ Fax #: ______________

Mailing Address: ______________________________

City: ______________ State: ______________ Zip: ______________

Additional Contact (if applicable)

Name of Contact Person at Self-Insured: ______________________________

Title of Contact Person: ______________ Telephone #: ______________

E-Mail Address: ______________ Fax #: ______________

Mailing Address: ______________________________

City: ______________ State: ______________ Zip: ______________

Additional Contact (if applicable)

Name of Contact Person at Self-Insured: ______________________________

Title of Contact Person: ______________ Telephone #: ______________

E-Mail Address: ______________ Fax #: ______________

Mailing Address: ______________________________

City: ______________ State: ______________ Zip: ______________

Active Subsidiaries in self-insurance program:

Name: ______________________________ FEIN#: ______________
Name: ______________________________ FEIN#: ______________
Name: ______________________________ FEIN#: ______________
Name: ______________________________ FEIN#: ______________
Name: ______________________________ FEIN#: ______________
Name: ______________________________ FEIN#: ______________
Name: ______________________________ FEIN#: ______________
Name: ______________________________ FEIN#: ______________

- ☐ Claims are self-administered by the Self-Insured Employer
- ☐ Claims are administered by a TPA (please complete back of form with TPA information)

(Attach list if additional entities are included)

Return this form to the WCB Office of Self-Insurance via email to: selfinsurance@wcb.ny.gov

TPA – Claims Administrator Information & History

Claims Administrator: ____________________

Contact Person for your account: ____________________

Title of Contact Person: ____________________ Telephone #: ____________________

E-Mail Address: ____________________ Fax #: ____________________

Mailing Address: ____________________

City: ____________________ State: ____________________ Zip: ____________________

This TPA is handling all cases for our entire period of self-insurance? Yes ☐ No ☐

If no, answer below.

The following is a breakdown of Claims Administrators:

Dates of Accident from ____________________ to ____________________

Claims Administrator: ____________________

Contact Person for your account: ____________________

Title of Contact Person: ____________________ Telephone #: ____________________

E-Mail Address: ____________________ Fax #: ____________________

Mailing Address: ____________________

City: ____________________ State: ____________________ Zip: ____________________

Dates of Accident from ____________________ to ____________________

Claims Administrator: ____________________

Contact Person for your account: ____________________

Title of Contact Person: ____________________ Telephone #: ____________________

E-Mail Address: ____________________ Fax #: ____________________

Mailing Address: ____________________

City: ____________________ State: ____________________ Zip: ____________________

Dates of Accident from ____________________ to ____________________

Claims Administrator: ____________________

Contact Person for your account: ____________________

Title of Contact Person: ____________________ Telephone #: ____________________

E-Mail Address: ____________________ Fax #: ____________________

Mailing Address: ____________________

City: ____________________ State: ____________________ Zip: ____________________

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