Self-Insurer's Annual Update Form 2016

Primary Contact	Name of Self-Insured:				
Name of Primary Contact Person at Self-Insured: Telephone #: Fittle of Contact Person: Telephone #: E-Mail Address: Fax #: Mailing Address: Zip: City: State: Zip: Additional Contact (if applicable) Name of Contact Person at Self-Insured: Telephone #: E-Mail Address: Fax #: Mailing Address: Zip: Additional Contact (if applicable) State: Zip: Name of Contact Person at Self-Insured: Telephone #: E-Mail Address: City: State: Zip: Additional Contact (if applicable) Name of Contact Person at Self-Insured: Telephone #: Title of Contact Person at Self-Insured: Telephone #: E-Mail Address: City: State: Zip: Additional Contact (if applicable) Name: Fax #: Mailing Address: Fax #: City: State: Zip: Active Subsidiaries in self-insurance program: Name: FEIN#: FeIN#: FEIN#:	FEIN #: Carrier ID	Carrier ID # B			
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(Attach list if additional entities are included)

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

<u>TPA – Claims Administrator Information & History</u>

Claims Administrator: ————					
Contact Person for your account:					
Title of Contact Person:		Tel			
E-Mail Address:					
Mailing Address:					
City:	State:		_ Zip:		
This TPA is handling all cases for	-	of self-insurance? answer below.	Yes No		
The following is a breakdown of Cl	aims Administrat	tors:			
Dates of Accident from		to			
Claims Administrator:					
Contact Person for your account:					
Title of Contact Person:		Tel	lephone #:		
E-Mail Address:					
Mailing Address:					
City:	State:		_ Zip:		
Dates of Accident from		to			
Claims Administrator:					
Contact Person for your account:					
Title of Contact Person:			lephone #:		
E-Mail Address:					
Mailing Address:					
City:	State:		_ Zip:		
Dates of Accident from		to			
Claims Administrator:					
Contact Person for your account:					
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E-Mail Address:			<u></u>		
Mailing Address:					
City:	State:		Zin:		

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