Self-Insurer's Annual Update Form
2015

Name of Self-Insured: _____

FEIN #: _____ NYS UI Employer Registration #: _____ Carrier ID # W _____

Primary Contact

Name of Contact Person at Self-Insured: _____

Title of Contact Person: _____ Telephone #: _____

E-Mail Address: _____ Fax #: _____

Mailing Address: _____

City: _____ State: _____ Zip:

Assessment Reporting & Billing Contact

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:

Subsidiaries in self-insurance program:

Name: _____ FEIN#: _____ NYS UI ER#: _____
Name: _____ FEIN#: _____ NYS UI ER#: _____
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(Attach list if additional entities are included.)

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: _____