Self-Insurer's Annual Update Form
2016

Name of Self-Insured: _____

FEIN #: _____ Carrier ID # W _____

Primary Contact _____

Name of Primary 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: _____

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.)

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: _____