2020 ANNUAL REPORT OF CLAIMS INVENTORY

To: State of California, Department of Industrial Relations
Division of Workers' Compensation, Audit & Enforcement Unit ~ Attn: ARI Desk
160 Promenade Circle, Suite 340
Sacramento, CA 95834-2962

COMPANY NAME

COMPANY FEIN

STREET ADDRESS

CITY, STATE, ZIP CODE

MAILING ADDRESS

MAIN COMPANY CONTACT & COMPLAINT CONTACT:

TELEPHONE

E-MAIL

Type of Entity:

- ☐ Self-Administered Insurance Company or Group
- ☐ Third-Party Administrator
- ☐ Self-Insured, Self-Administered Employer (Private Or Public)
- ☐ Self-Administered Joint Powers Authority
- ☐ Combination of any of the following, but only if administered under the same local management. (Check two or more)
  - ☐ Self-Administered Insurance Company or Group
  - ☐ 1 Self-Insured Self-Administered Employer
  - ☐ Third-Party Administrator

Number of California Workers' Compensation Claims Reported at this location during the 2020 Year:

Type of Claim:	**Number:**	**Paid Indemnity:**	**Number:**
Indemnity:		How many of the designated indemnity claims have indemnity payments?	
Denied:			

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PART 2

For each individual underwriting company in an insurance group or client of a third-party administrator (whether a self-insured employer or an insurer), whose claims are administered at the adjusting location, complete the following:

Medical Only: _____

Total: _____

Submitted by: _____

Title: _____

Date: _____

NOTE: Insurer Groups (more than one underwriting company at the same location), third-party administrators, and combinations of the two must complete Part 2. Reports of Claims Inventory for each adjusting location of California workers' compensation claims are due by **April 1, 2021**. Failure to timely submit reports may be subject to penalty assessments of up to $500 per location.

_____
COMPANY NAME

_____
COMPANY FEIN

_____
STREET ADDRESS

_____
CITY, STATE, ZIP CODE

_____
MAILING ADDRESS

_____
MAIN COMPANY CONTACT &
COMPLAINT CONTACT

_____
TELEPHONE

_____

CHECK ONE:

☐ Self-Administered Insurance Company or Group

☐ Self-Insured, Self-Administered Employer (Private Or Public, including Joint Powers Authority)

Type of Claim:	**Number:**
☐ **Indemnity:**	_____
☐ **Denied:**	_____
☐ **Medical-Only:**	_____
☐ **Total**	_____

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PART 2

For each individual underwriting company in an insurance group or client of a third-party administrator (whether a self-insured employer or an insurer), whose claims are administered at the adjusting location, complete the following:

E-MAIL

How many of the designated indemnity claims have indemnity payments?

Complete and attach additional sheets if necessary. The sum of the totals for claims of all entities reported for Part 2 must equal the total of claims reported for Part 1.

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PART 2

For each individual underwriting company in an insurance group or client of a third-party administrator (whether a self-insured employer or an insurer), whose claims are administered at the adjusting location, complete the following:

CHECK ONE:

COMPANY NAME

COMPANY FEIN

STREET ADDRESS

CITY, STATE, ZIP CODE

MAILING ADDRESS

MAIN COMPANY CONTACT AND COMPLAINT CONTACT

TELEPHONE

E-MAIL

☐ Self-Administered Insurance Company or Group

☐ Self-Insured, Self-Administered Employer (Private Or Public, including Joint Powers Authority)

Type of Claim:	**Number:**
☐ **Indemnity:**	
☐ **Denied:**	
☐ **Medical-Only:**	
☐ **Total**	
☐ **How many of the designated indemnity claims have indemnity payments?**	

Complete and attach additional sheets if necessary. The sum of the totals for claims of all entities reported for Part 2 must equal the total of claims reported for Part 1.