NOTE: **Self-Insured Employer**
Complete this page on ALL reports.

State of California
Department of Industrial Relations
Office of Self-Insurance Plans
11050 Olson Drive, Suite 230
Rancho Cordova, CA 95670
Web site https://www.dir.ca.gov/osip/sip.html

E-mail: OSIP@dir.ca.gov

PRIVATE SELF-INSURER'S ANNUAL REPORT

I. GENERAL-To be Completed by the Employer

1. CERTIFICATE NUMBER:

☐ Active ☐ Revoked

2. PERIOD OF REPORT:

☐ Full Year ☐ Interim/Amended Report for the Period of:

mm/dd/yy mm/dd/yy

3. MASTER CERTIFICATE HOLDER:

NAME

ADDRESS

CITY STATE

ZIP CODE +4

State of Incorporation:

Federal Tax Identification No.:

First 5 Digits of Your North American Industry Classification System (NAICS):

4. List names of ALL separate, but affiliated or subsidiary companies covered by this certificate (do not include DBAs or operating divisions):

FULL LEGAL NAME	STATE OF INCORPORATION	SUBSIDIARY/AFFILIATE CERTIFICATE NUMBER

(Continue on reverse side of this page if necessary)

5. During the reporting period of this report, has there been any of the following with respect to the Master Certificate Holder or any subsidiary?

(a) Reincorporating ☐ Yes ☐ No
(b) Merger ☐ Yes ☐ No
(c) Change in Identity ☐ Yes ☐ No
(d) Any additions to Self-Insurance Program ☐ Yes ☐ No

If yes, explain:

(Continue on reverse side of this page if necessary)

6. EMPLOYMENT AND WAGES PAID IN CALENDAR YEAR 2019:

(a) **NUMBER OF EMPLOYEES**

7. (For which a W-2 Tax Form was issued for California employment in Calendar Year 2019)

(b) TOTAL WAGES AND SALARIES PAID $
(As reported on EDD Form DE-6 Line M for all four quarters)

7. TO WHOM SHOULD CORRESPONDENCE BE ADDRESSED FOR SECURITY DEPOSIT AND FINANCIAL MATTERS?

FIRST NAME MI LAST NAME

TITLE

COMPANY NAME:

ADDRESS:

CITY: STATE: ZIP+4:

PHONE: EXT: FAX:

E-MAIL ADDRESS:

SUBMIT ONE (1) COMPLETE REPORT OF ALL PAGES INCLUDING LIST OF OPEN INDEMNITY CLAIMS

REPORT IS DUE MARCH 1, 2020

Calendar Year 2019

Year Ending **December 31, 2019**

NOTE: **Claims Administrator**
Complete a separate Liabilities by Reporting Location for:
1. Each Claims Adjusting Office.
2. Each Self-Insured Company merged into this Certificate within the last 4 years.
3. Each Self-Insured Company posting a separate security deposit.

II. LIABILITIES BY REPORTING LOCATION

Reporting Location Nos.:

Name/Identification of Location:

Name of Master/Subsidiary/Affiliate Certificate Holder:

Type of Report:

☐ Original Report ☐ Amended Year End Report ☐ Amended Due to Audit ☐ Interim Report

A. CASES AND BENEFITS (to nearest dollar) From Date (mm/dd/yy) To Date (mm/dd/yy)

	Number	Incurred Liability		Paid to Date		Future Liability	
		$ Indemnity	$ Medical	$ Indemnity	$ Medical	$ Indemnity	$ Medical
1.Cases open as of 12/31/2019 reported prior to 2014							
2. Open & Closed Cases:							
a. All cases reported in 2015							
2015 Cases open							
b. All cases reported in 2016							
2016 Cases open							
c. All cases reported in 2017							
2017 Cases open							
d. All cases reported in 2018							
2018 Cases open							
e. All cases reported in 2019							
2019 Cases open							

	$ Indemnity	$ Medical
SUBTOTAL		
TOTAL		

3. ESTIMATED FUTURE LIABILITY (Indemnity plus Medical)

$ Indemnity	$ Medical

4.Total Benefits paid during 2019 (including all case expenditures): . . . . . .

5.Number of MEDICAL-ONLY cases reported in 2019: . . . . . .

6.Number of INDEMNITY cases reported in 2019: . . . . . .

7. TOTAL of 5 and 6 (also entered in 2e above): . . . . . .

8. TOTAL number of open indemnity cases (all years): . . . . . .

9.Number of Fatality cases reported in 2019: . . . . . .

10. (a) Number of 2019 claims for which the employer or administrator was notified of representation by an attorney or legal representative in 2019: . . . . . .

10. (b) Number of non-2019 claims for which the employer or administrator was notified of representation by an attorney or legal representative in 2019: . . . . . .

11. Attach a List of *ALL* Open Indemnity Claims (by reporting location and by year) reported and with claims (in alphabetical order)

12. Attach the Specific Excess Insurance Policy page(s).

Calendar Year 2019

Name of Administrator/Administrating Agency Submitting This Report

A. NAME OF ADMINISTRATOR(S)/ADMINISTRATING AGENCY(IES) SUBMITTING THIS REPORT.

1. Name (Person)

Agency Name

Address

City **State** **Zip+4**

Administrative Agency's Certificate No.:

or ☐ Self Administered

B. HAS THERE BEEN A CHANGE IN ADMINISTRATOR/ADMINISTRATIVE AGENCY DURING THE PERIOD OF THIS REPORT PERIOD? ☐ YES ☐ NO

IF YES: DATE OF CHANGE: mm/dd/yy

TYPE OF CHANGE: ☐ **Change in Administrative Agency**

☐ **Change to or from Self Administration**

NAME OF NEW ADMINISTRATOR(S)/ADMINISTRATIVE AGENCY(IES):

Name

Agency Name

Address

City **State** **Zip+4**

CERTIFICATION

I declare under penalty of perjury that I have prepared or caused this report to be prepared and I have examined this liabilities report of this self-insurer's workers' compensation liabilities. To the best of my knowledge and belief this report is true, correct and complete with respect to the workers' compensation liabilities incurred and paid. I further declare under the penalty of perjury that the estimates of future liability of workers'compensation claims made in this eport reflect the administrator's best judgment as to the future liability of claims, using prevailing industry standards, and the signatory intends Self-Insurance Plans to rely upon the representation.

Original Signature of Administrator (Qualified Person) **Date**

Typed Name of Administrator **Title**

Administrator's First Name **M.I.** **Last Name**

Name of Administrative Agency or Employer

Street Address **City**

State **Zip+4**

Phone No. of Administrator **Fax No.**

E-mail Address of Administrator

Calendar Year 2019

NOTE: **Self-Insured Employer**
Complete this page on ALL reports.

Year Ending **December 31, 2019**

CERTIFICATION OF COMPANY OFFICER

NOTE: **Labor Code Section 3701(a) requires every private, self-insuring employer to secure incurred liabilities for the payment of compensation by renewing or making a new deposit of security within 60 days of filing of this annual report, but in no event later than May 1 of each year. Civil penalties of up to $5,000 for every 30 days or portion thereof that there is a failure to post deposit may be assessed by the Director of Industrial Relations pursuant to Labor Code Section 3702.9 for failure to post required deposit when due.**

CERTIFICATION OF AUTHORIZED REPRESENTATIVE

I declare under the penalty of perjury that I have examined this Self-Insurer's Annual Report and to the best of my knowledge and belief it is true, correct and complete. I am also aware of our company's duty to post and maintain the required security deposit that is due as a result of this report.

Signature of Authorized Representative **Date**

Typed Name of Representative **Title**

Name of Company

Street Address

City **State** **Zip+4**

Phone No.

Calendar Year
2019

LIST OF OPEN INDEMNITY CASES
AS OF
(Date)

Reporting Location No.:

All Cases on this Page are

For the Year

Certificate Number:

NAME OF MASTER CERTIFICATE HOLDER:

Name of Insured or Deceased (Last) (First Initial)	Date of Injury	Description of Injury	Paid to Date		Estimated Future Liability	
			$ Indemnity	$ Medical	$ Indemnity	$ Medical
(List Alphabetically within year)						

(List by reporting location and by year reported with claims in alphabetical order)

This is a sample format for the list of Open Indemnity Cases. Several Third Party Administrators use a different application to track this data. You can attach a separate listing to your annual report.

Calendar Year
2019