

2017 ANNUAL REPORT OF ADJUSTING LOCATIONS

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

COMPANY NAME

Self-Administered Insurance Company or Group

COMPANY FEIN

Third-Party Administrator

STREET ADDRESS

Self-Administered Self-Insured Employer (private or public)

CITY/STATE/ZIP

Self-Administered Joint Powers Authority

MAILING ADDRESS

Combination of any of the following, but only if administered under the same local management. (Check two or more):

CITY/STATE/ZIP

Self-Administered Insurance Company or Group

CONTACT NAME

Self-Administered Self-Insured Employer

TELEPHONE

Third-Party Administrator

FACSIMILE

E-MAIL

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.

A claims administrator, whose obligation to submit an Annual Report of Inventory has been waived in accordance with the California Code of Regulations, title 8, section 9701(i), must file an Annual Report of Adjusting locations by April 1 of each calendar year for the previous calendar year.

Failure to timely submit an Annual Report of Adjusting Locations under California Code of Regulations, title 8, section 10104, (d) may be subject to penalty assessment of up to \$500 per location.

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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:

COMPANY NAME

CONTACT NAME

COMPANY FEIN

TELEPHONE

MAILING ADDRESS

FACSIMILE

CITY/STATE/ZIP

E-MAIL

CHECK ONE:

Insurance Company

Self-insured employer (private or public including joint powers authority)

COMPANY NAME

CONTACT NAME

COMPANY FEIN

TELEPHONE

MAILING ADDRESS

FACSIMILE

CITY/STATE/ZIP

E-MAIL

CHECK ONE:

Insurance Company

Self-insured employer (private or public including joint powers authority)

COMPANY NAME

CONTACT NAME

COMPANY FEIN

TELEPHONE

MAILING ADDRESS

FACSIMILE

CITY/STATE/ZIP

E-MAIL

CHECK ONE:

Insurance Company

Self-insured employer (private or public including joint powers authority)