

## REPORT OF TRANSFER OF RECORDS

Report the transfer of records by the effective date to the Office of Self Insurance Plans (OSIP) with this form. File an Interim Annual Report within 30 calendar days at <https://efiling.dir.ca.gov/OSIPO> if the transfer is to a new administrative agency.

Please see [§15402.2. of the California Code of Regulations, Title 8](#) for more information on reporting the transfer of records.

Self Insured Employer \_\_\_\_\_ Effective Date of Transfer \_\_\_\_\_  
Self Insured Certificate Number \_\_\_\_\_ Is this a change to or from self administration? Yes No  
Number of Records to be Transferred \_\_\_\_\_ Full Transfer Partial Transfer

### Records will be transferred from:

TPA/Self-Administered \_\_\_\_\_ Certificate Number, if known \_\_\_\_\_  
Location Contact \_\_\_\_\_ Title \_\_\_\_\_  
Physical Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Phone Number \_\_\_\_\_ E-mail Address \_\_\_\_\_  
Qualified Administrator \_\_\_\_\_ Title \_\_\_\_\_  
Phone Number \_\_\_\_\_ E-mail Address \_\_\_\_\_

### Records will be transferred to (provide administrative or storage location):

TPA/Self-Administered \_\_\_\_\_ Certificate Number, if known \_\_\_\_\_  
Location Contact \_\_\_\_\_ Title \_\_\_\_\_  
Physical Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Phone Number \_\_\_\_\_ E-mail Address \_\_\_\_\_  
Qualified Administrator \_\_\_\_\_ Title \_\_\_\_\_  
Phone Number \_\_\_\_\_ E-mail Address \_\_\_\_\_

Storage Facility \_\_\_\_\_  
Contact Person \_\_\_\_\_ Title \_\_\_\_\_  
Physical Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Phone Number \_\_\_\_\_ E-mail Address \_\_\_\_\_

Attach a list of all open and closed indemnity claim files whose records are being transferred (alphabetically within each reporting year). The list should include the:

- claimant name
- date of injury
- description of injury
- amount of indemnity and medical payments paid to date
- estimated future liability of indemnity and medical payments

Any Comments?

Records are being transferred to a new administrative agency and a copy of this form will be sent to them.

Submitted by \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_  
TPA/Self-Administered \_\_\_\_\_ Phone Number \_\_\_\_\_  
E-mail Address \_\_\_\_\_

Please e-mail or mail this notice along with the list of open and closed indemnity records.