

State of California  
Department of Industrial Relations  
Self Insurance Plans  
2265 Watt Avenue, Suite 1  
Sacramento, CA 95825  
Web site <http://sip.dir.ca.gov>  
E-mail: [sip@dir.ca.gov](mailto:sip@dir.ca.gov)

### PUBLIC SELF INSURER'S ANNUAL REPORT FOR NON-JPA MEMBER

#### I. GENERAL

1. CERTIFICATE NUMBER:

-    -   -

Active       Revoked

2. PERIOD OF REPORT:

Full Year       Interim Report for the Period of:

to        
Month Day Year      to      Month Day Year

3. NAME OF MASTER CERTIFICATE HOLDER:

\_\_\_\_\_

Federal Tax Identification No.: \_\_\_\_\_

Address of Main Headquarters \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP + 4 \_\_\_\_\_

4. TYPE OF PUBLIC AGENCY:

CITY/COUNTY  
 SCHOOL

POLICE/FIRE  
 HOSPITAL

TRANSIT  
 OTHER

5. During the period of this report, has there been any of the following with respect to the master certificate holder, subsidiary or affiliate certificate holder?

A merger or unification?  Yes       No

Change in name or identity?  Yes       No

Any addition to Self Insurance Program?  Yes       No

If yes, explain: \_\_\_\_\_

6. Are there any agency employees NOT included in your Workers' Compensation Self Insurance Program?

Yes       No

If yes, what employees are not included? \_\_\_\_\_

Are these employees covered by an insurance policy?  Yes       No

Are these employees covered by another self insurance cert. or JPA?  Yes       No

7. TO WHOM DO YOU WANT CORRESPONDENCE ADDRESSED?

NAME/TITLE: \_\_\_\_\_

AGENCY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP + 4: \_\_\_\_\_

TELEPHONE: (    ) \_\_\_\_\_ FACSIMILE (FAX): (    ) \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

8. CERTIFICATION BY AGENCY OFFICIAL:

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.

Signature (Original Only): \_\_\_\_\_ Date: \_\_\_\_\_

Typed Name: \_\_\_\_\_

Agency Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip + 4: \_\_\_\_\_

Telephone: (    ) \_\_\_\_\_ Facsimile (FAX): (    ) \_\_\_\_\_

**NOTE: Claims Administrator**

Complete this page for ALL reports except item B  
 Employment/Wages, which is completed by  
 Self insured employer.

**II. CONSOLIDATED LIABILITIES**

Certificate Number:  -  -  -

Name of Master Certificate Holder: \_\_\_\_\_

Type of Report:

**Original Report** (Due October 1 each year)

**Amended Report:**

From  Date: Month Day Year

To  Date: Month Day Year

**A. CASES AND BENEFITS (to nearest dollar)**

	Number	Incurred Liability		Paid to Date		Future Liability	
		\$ Indemnity	\$ Medical	\$ Indemnity	\$ Medical	\$ Indemnity	\$ Medical
1. Cases open as of 6/30/2000 reported prior to FY 1995-96							
<b>2. Open &amp; Closed Cases:</b>							
a. FY 1995-96 Total cases reported							
<input type="checkbox"/> FY 1995-96 Cases open							
b. FY 1996-97 Total cases reported							
<input type="checkbox"/> FY 1996-97 Cases open							
c. FY 1997-98 Total cases reported							
<input type="checkbox"/> FY 1997-98 Cases open							
d. FY 1998-99 Total cases reported							
<input type="checkbox"/> FY 1998-99 Cases open							
e. FY 1999-2000 Total cases reported							
<input type="checkbox"/> FY 1999-2000 Cases open							
						\$ Indemnity	\$ Medical
						<b>SUBTOTAL</b>	
<b>3. ESTIMATED FUTURE LIABILITY (Indemnity plus Medical)</b>						<b>TOTAL</b>	
						\$ Indemnity	\$ Medical

- 4. Total Benefits paid during FY 1999-2000 (include all case expenditures): .....
- 5. Number of MEDICAL-ONLY cases reported in FY 1999-2000: .....
- 6. Number of INDEMNITY cases reported in FY 1999-2000: .....
- 7. TOTAL of 5 and 6 (also enter in 2e above): .....
- 8. TOTAL number of open indemnity cases (all years): .....
- 9. Number of Fatality cases reported in FY 1999-2000: .....
- 10. (a) Number of FY 1999-2000 claims for which the employer or administrator was notified of representation by an attorney or legal representative in FY 1999-2000: ....
- (b) Number of non-FY 1999-2000 claims for which the employer or administrator was notified of representation by an attorney or legal representative in FY 1999-2000: ....

**B. TOTAL EMPLOYMENT AND WAGES PAID IN FISCAL YEAR 1999-2000 FOR THIS SELF INSURER:**

- (a) NUMBER OF EMPLOYEES \_\_\_\_\_  
 (Number of individual employees listed on Form DE-6 for year ending June 30, 2000)
- (b) TOTAL WAGES AND SALARIES PAID \$ \_\_\_\_\_  
 (As reported on EDD Form DE-6 Line M for all four quarters)



**NOTE: Claims Administrator**  
 Complete this page for *each adjusting*  
 location where there are *at least*  
 two adjusting locations.

**III. LIABILITIES BY REPORTING LOCATION**

Reporting Location Nos.:  -  -  -

Name/Identification of Location: \_\_\_\_\_

OR

Name of Affiliate/Subsidiary Certificate Holder: \_\_\_\_\_

Type of Report:

**Original Report** (Due October 1 each year)

**Amended Report:**

From    
 Date: Month Day Year

To    
 Date: Month Day Year

**A. CASES AND BENEFITS** (to nearest dollar)

	Number	Incurred Liability		Paid to Date		Future Liability	
		\$ Indemnity	\$ Medical	\$ Indemnity	\$ Medical	\$ Indemnity	\$ Medical
1. Cases open as of 6/30/2000 reported prior to FY 1995-96							
<b>2. Open &amp; Closed Cases:</b>							
a. FY 1995-96 Total cases reported							
<input checked="" type="checkbox"/> FY 1995-96 Cases open							
b. FY 1996-97 Total cases reported							
<input checked="" type="checkbox"/> FY 1996-97 Cases open							
c. FY 1997-98 Total cases reported							
<input checked="" type="checkbox"/> FY 1997-98 Cases open							
d. FY 1998-99 Total cases reported							
<input checked="" type="checkbox"/> FY 1998-99 Cases open							
e. FY 1999-2000 Total cases reported							
<input checked="" type="checkbox"/> FY 1999-2000 Cases open							
						\$ Indemnity	\$ Medical
<b>SUBTOTAL</b>							
<b>3. ESTIMATED FUTURE LIABILITY (Indemnity plus Medical)</b>						<b>TOTAL</b>	
						\$ Indemnity	\$ Medical

4. Total Benefits paid during FY 1999-2000 (include all case expenditures): . . . . . \_\_\_\_\_

5. Number of MEDICAL-ONLY cases reported in FY 1999-2000: . . . . . \_\_\_\_\_

6. Number of INDEMNITY cases reported in FY 1999-2000: . . . . . \_\_\_\_\_

7. TOTAL of 5 and 6 (also enter in 2e above): . . . . . \_\_\_\_\_

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

9. Number of Fatality cases reported in FY 1999-2000: . . . . . \_\_\_\_\_

10. (a) Number of FY 1999-2000 claims for which the employer or administrator was notified of representation by an attorney or legal representative in FY 1999-2000: . . . . . \_\_\_\_\_

(b) Number of non-FY 1999-2000 claims for which the employer or administrator was notified of representation by an attorney or legal representative in FY 1999-2000: . . . . . \_\_\_\_\_

**IIIA. ADMINISTRATOR**

**A. NAME OF CURRENT ADMINISTRATOR(S)/ADMINISTRATING AGENCY(IES) AT THE TIME OF PREPARING THIS REPORT.**

1. Name (Person) \_\_\_\_\_ Administrative Agency's  
 Agency Name \_\_\_\_\_ Certificate No.:   
 Address \_\_\_\_\_ or  Self Administered  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip+4 \_\_\_\_\_

**B. HAS THERE BEEN A CHANGE IN ADMINISTRATOR/ADMINISTRATIVE AGENCY DURING THE PERIOD OF THIS REPORT PERIOD?  YES  NO IF YES, DATE OF CHANGE:**

Month Day Year

TYPE OF CHANGE:  Change in Administrative Agency  
 Change to or from Self Administration

**C. NAME OF PRIOR 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 consolidated 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 report 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 (Person)

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Typed Name of Administrator

\_\_\_\_\_  
 Name of Administrative Agency or Employer

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Street Address

\_\_\_\_\_  
 City State Zip+4

\_\_\_\_\_  
 Phone No. of Administrator ( )  
 area code

\_\_\_\_\_  
 FAX No. ( )  
 area code

\_\_\_\_\_  
 E-mail Address of Administrator

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**IV. RECORDS STORAGE**

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1. Are claims records stored at any location other than with the current administrator?

Yes  No If yes, Where? \_\_\_\_\_

A. Agency Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_ Zip+4 \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_

C. Agency Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_ Zip+4 \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_

B. Agency Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_ Zip+4 \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_

D. Agency Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_ Zip+4 \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_

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**V. INSURANCE COVERAGE**

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1. Are any of your workers' compensation liabilities in California during the reporting period covered by a standard workers' compensation insurance policy?

Yes  No If Yes:

1. Name of Insurance Company: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Policy Issue Date: \_\_\_\_\_

2. Name of Insurance Company: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Policy Issue Date: \_\_\_\_\_

2. Are any of your workers' compensation liabilities in California during the reporting period covered by a specific excess workers' compensation insurance policy?

Yes  No If Yes:

1. Name of Carrier: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Policy Issue Date: \_\_\_\_\_  
Retention Limit: \_\_\_\_\_

2. Name of Carrier: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Policy Issue Date: \_\_\_\_\_  
Retention Limit: \_\_\_\_\_

3. Do you carry an aggregate (stop loss) workers' compensation insurance policy?

Yes  No If Yes:

1. Name of Carrier: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Policy Issue Date: \_\_\_\_\_  
Retention Limit: \_\_\_\_\_

2. Name of Carrier: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Policy Issue Date: \_\_\_\_\_  
Retention Limit: \_\_\_\_\_

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**VI. OPEN INDEMNITY CLAIMS**

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A. List of ALL Open Indemnity Claims by reporting location and by year reported and with claims in alphabetical order is attached immediately following page 6 of this report.  
(You may use the form attached or a computer-prepared printout organized in the same format.)

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VII. FUNDING OF LIABILITIES

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Certificate Number:  -  -  -

Name of Certificate Holder: \_\_\_\_\_  
\_\_\_\_\_

1. Which of the following best describes the method your agency uses to fund the outstanding workers' compensation liabilities?

- Actuarial Basis
- Cash Flow Basis
- Fixed Amount in Agency Budget—Amount is: \$ \_\_\_\_\_
- Percentage Above Last Year's Losses—Percentage is: \_\_\_\_\_ %  
—Total Amount Available is: \$ \_\_\_\_\_
- Agency Does Not Fund Workers' Compensation Liabilities
- Other: \_\_\_\_\_

2. Does your agency fund for incurred but not reported workers' compensation claims in addition to known or reported claims?

- Yes       No      If yes, Amount: \$ \_\_\_\_\_

3. Is the workers' compensation funding restricted or set aside solely to pay the agency's workers' compensation liabilities?

- Yes       No
- If yes, what was the amount set aside as of June 30, 2000? \$ \_\_\_\_\_

4. Does your agency have an outside, independent claims auditor review your case reserve practices and general claims management?

- Yes       No
- If yes, what was the date of the last such audit? \_\_\_\_\_

5. Does your agency have an outside, independent actuary to review future liability funding?

- Yes       No
- If yes, what was the date of the last such review? \_\_\_\_\_

### LIST OF OPEN INDEMNITY CASES

AS OF \_\_\_\_\_  
(Date)

Reporting Location No.: \_\_\_\_\_

All Cases on this Page are

Certificate Number: \_\_\_\_\_

For the Year \_\_\_\_\_

NAME OF MASTER CERTIFICATE HOLDER: \_\_\_\_\_

Name of Insured or Deceased (Last) (First Initial)	Date of Injury	Labor Code Section 4850 Salary	Description of Injury	Paid to Date		Estimated Future Liability	
				\$ Indemnity	\$ Medical	\$ Indemnity	\$ Medical
(List Alphabetically within year)							