2020 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

COMPANY FEIN

STREET ADDRESS

CITY/STATE/ZIP

MAILING ADDRESS

CITY/STATE/ZIP

CONTACT NAME

TELEPHONE

FACSIMILE

E-MAIL

COMPLAINT CONTACT NAME

COMPLAINT CONTACT MAILING ADDRESS

COMPLAINT E-MAIL ADDRESS

COMPLAINT TELEPHONE

COMPLAINT FACSIMILE NUMBER

☐ Self-Administered Insurance Company or Group

☐ Third-Party Administrator

☐ Self-Administered Self-Insured 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
- ☐ Self-Administered Self-Insured Employer
- ☐ Third-Party Administrator

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 Regulationstitle 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

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E-MAIL

CHECK ONE:

☐ Insurance Company

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

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Complete and attach additional sheets if necessary.

Form DWC-857 Rev. 9/2019