

COMMONWEALTH OF VIRGINIA
VIRGINIA WORKERS' COMPENSATION COMMISSION
1000 DMV DRIVE, RICHMOND VA 23220

ANNUAL SURVEY OF INDIVIDUAL SELF-INSURERS

January 2, 2014

Self-Insurance Number: _____

Self-Insured Company Name: _____

2014 Update to Virginia Workers' Compensation Commission Records

In order to update Commission records, we are asking you to provide the following information to us. This information is essential in ensuring that the Commission meets its responsibilities under Virginia law for the certification of individual self-insurers for workers' compensation.

Once you have completed the survey, check off the lines below, sign and date this top sheet, and return the survey and the necessary additional materials **by March 3, 2014** to Self-Insurance Program, Attn: Judy K. Brooks, Virginia Workers' Compensation Commission, 1000 DMV Drive, Richmond, Virginia 23220. If you have any questions, please contact Judy Brooks at (804) 205-3599 or at judy.brooks@workcomp.virginia.gov.

- _____ The survey is completed and enclosed.
- _____ A copy of the current excess insurance certificate is enclosed (if provided earlier, give date mailed).
- _____ All claims information is completed including the requested information on claims of \$100,000 or more (see page 5, section j).
- _____ The list of subsidiaries and locations is enclosed.
- _____ The Employer Identification Number (EIN), also known as the Federal Employer Identification Number (FEIN), is listed for **ALL** companies, subsidiaries, or operating entities with operations in Virginia.
- _____ The most recent annual report is enclosed (if provided earlier, give date mailed).

I certify that all information provided is correct to the best of my knowledge.

My typed name below shall have the same force and effect as my written signature for all purposes under Virginia law including the Virginia Workers' Compensation Act, and any Rule or Regulation of the Virginia Workers' Compensation Commission.

Preparer's Signature _____ Title _____ Date _____

1. Contacts: corporate, claims processing, and designated representative

The #1 address is for the person we will contact regarding basic issues of self-insurance, the #2 address is the address to which all routine mail regarding claims will be sent, and the #3 address is for the in-state designated representative. The #3 address must be a **street address** within Virginia.

#1 Corporate representative:

PHONE:

FAX:

E-Mail Address:

#2 Claims processing contact(s):

PHONE:

Change from 2013 Survey? Yes No

If yes: Date of Change _____
Will Handle Previous Claims? Yes No

#3 Designated representative (**street address in Virginia is required**):

PHONE:

Change from 2013 Survey? Yes No

If yes: Date of Change _____
Will Handle Previous Claims? Yes No

2. Parent Corporation and Subsidiaries

A. List the name and the **Employer Identification Number (EIN)** of **all** companies, subsidiaries, or operating entities with operations in Virginia that are **included** under the Virginia certificate of Self-Insurance (use separate sheet of paper if needed). Include the name of the **parent corporation** even if the parent has no operations in Virginia.

B. List the name and the **Employer Identification Number (EIN)** of **all** parent corporation, subsidiary company, or other operating entity with operations in Virginia that are to be **excluded** from the Virginia Certificate of Self-Insurance for your company (use separate sheet of paper if needed).

C. Has any state rejected, revoked, or not renewed Self-Insurance privileges in the past 5 years? Yes No If answered yes, list the state and give explanation and date of action.

3. Securities and guarantees

In addition to providing the information below, you should provide copies of certificates of insurance for excess coverage.

Excess coverage

Effective date: Expiration date:

Carrier:

Policy Number:

Limits: **Specific** **Aggregate**

Retention level

Limit of indemnity

Deductible

4. Virginia Claims Experience

Complete the claim forms attached (pages 4 and 5). The current year is not considered a complete year.

5. Locations and employees grouped by Employer Identification Number (EIN)

A. For all locations list the name, address, nature of operations, and number of employees. Attach separate sheets of paper if needed.

Example:

1. ABC Variety EIN # 12-3456789

<u>Name/Address</u>	<u>Nature of Operations</u>	<u>Number of Employees</u>
Some Store 123 ABC Street Anytown, VA 12345	Retail Sales	15 employees

2. XYZ Variety EIN # 87-6543210

<u>Name/Address</u>	<u>Nature of Operations</u>	<u>Number of Employees</u>
Another Store 234 XYZ Street Anothertown, VA 54321	Retail Sales	25 employees

B. If you have closed a location since the last annual survey and have not advised the Virginia Workers' Compensation Commission of the closure, list the location and give the closing date for that location on this report (use separate sheet of paper if needed).

Valuation Date / /
mm/dd/yy

	____/2009 (month)	____/2010 (month)	____/2011 (month)	____/2012 (month)	____/2013 (month)
Number of Claims					
a) Closed Claims					
b) Open Claims					
c) Total Claims (a + b)					
d) Lost Time Cases					
Payments					
e) Compensation					
f) Medical					
g) Other					
h) Total (e + f + g)					
Reserves					
i) Compensation					
j) Medical					
k) Other					
l) Total (i + j + k)					
IBNR Reserves					
m) Total IBNR Reserves					
Total Incurred					
n) Total (h + l + m)					
Virginia Payroll, Locations, Employees					
Payroll in VA					
Number of VA Locations					
Number of VA Employees					

Virginia Claims Experience
Open claims in years prior to years reported on page 4

Valuation Date / /
mm/dd/yy

	year								
Number of Claims									
a) Open Claims									
Payments									
b) Compensation									
c) Medical									
d) Other									
e) Total (b + c + d)									
Reserves									
f) Compensation									
g) Medical									
h) Other									
i) Total (f + g +h)									

j) On a separate sheet of paper, include detailed information of claims that are paid and/or reserved at \$100,000 or more for 1) open claims that occurred in 2008 and prior years and 2) both open and closed claims that occurred from 2009 to date. The information should include:

- ◆ name of claimant
- ◆ date of accident
- ◆ location of accident
- ◆ amounts paid and reserved (in above format)
- ◆ narrative detail on the cause of the accident and resulting injury. Include only the claims that occurred while self-insured.