COMMONWEALTH OF VIRGINIA

VIRGINIA WORKERS' COMPENSATION COMMISSION
333 E. FRANKLIN ST, RICHMOND VA 23220

ANNUAL SURVEY OF INDIVIDUAL SELF-INSURERS

Date _____

Self-Insurance Number: _____

Self-Insured Company Name: _____

Year _____ 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** _____ to Self-Insurance Program, Attn: Mechelle Esparza-Harris, Insurance Financial Examiner, Virginia Workers' Compensation Commission, 333 E. Franklin St., Richmond, Virginia 23219. If you have any questions, please contact Mechelle Esparza-Harris at (804) 205-3599 or at Mechelle.Esparza-Harris@workcomp.virginia.gov.

_____ The survey is completed and enclosed.

_____ A copy of the current excess insurance certificate is enclosed. The certificate displays the sixty (60) day advance notice of cancellation condition (if provided earlier, give date mailed).

_____ All claims information is completed. For claims of $100,000, information should include:

- Name of claimant
- Date of accident
- Location of accident
- Amounts paid and reserved
- Narrative detail on the cause of the accident and resulting injury
- VWC claim number

_____ 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 audited financial statement or 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:

Name of corporate representative:
Title of corporate representative:
Address:

PHONE:
FAX:
E-Mail Address:

#2 Claims processing contact(s):

Name of designated adjuster (if applicable):
Name of company:
Address of company:

PHONE:
FAX:
E-Mail Address:

Change from prior year Survey? ❑ Yes ❑ No
If yes: Date of Change _____
Will Handle Previous Claims? ❑ Yes ❑ No

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

Name of designated representative:
Name of company (if applicable):
Address of In-State Designated representative

PHONE:
FAX:
E-Mail Address:

Change from prior year 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. List and explain any changes to your core operation since the last survey (as an example, if your business is a retail store front and you enter into food manufacturing provide the new operation).

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

A. For all locations list the name, address, nature of operations, and number of employees. Page 5 of the survey includes form "2015 List of Subsidiaries and Locations" for your use.

Example:

Federal Tax ID	Location Name	Street Address	City	State	Zip Code	Nature of Operations	Number of Employees
54-1111111	**ABC Variety**	**123 ABC Street**	**Anytown**	**VA**	**12345**	**Retail sales**	**15**

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).

4. 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		
Sixty (60) day advance notice of cancellation		___ Yes

5. Virginia Claims Experience

Complete the claim forms attached;

Page 6: Claim Summary Addendum for 2015 Annual Survey

Page 7: Detailed Claims Addendum for Claims in excess of $100,000

The current year is not considered a complete year.