STATE OF MARYLAND
WORKERS' COMPENSATION COMMISSION
10 E. Baltimore Street
Baltimore, MD 21202

INFORMATION REPORT - June 30, 2017 ***All Questions Must be Answered***
(Under LE § 9-405(e) of Maryland Workers' Compensation Commission Law) ***Please print or type***

Insurer ID:_____ (Commission use only)

SECTION I - Corporate or Organization Data Federal I.D. No: _____

Name of Self-Insurer: _____

Corporate Address: _____

_____ _____ _____

Contact Person for Self-Insurance Program at Corporate Headquarters: _____

Phone No: ( )_____Fax No: ( )_____

Email address: _____ Toll Free Phone No: ( )_____

Type of Organization: Corporation ( ) Partnership ( ) Other ( ) Specify:_____

Fiscal Year Ends:_____

Organization's Contact Person in Maryland *(do not provide the name of a service company or attorney. If none, explain):*

Name: _____

Address: _____

Phone No: ( )_____Fax No: ( )_____

Email address: _____

Organization's In-house Legal Counsel:

Name: _____

Address: _____

Phone No: ( )_____ Fax No: ( )_____

Email address: _____

Organization's Chief Financial Officer:

Name: _____

Address: _____

Phone No: ( )_____ Fax No: ( )_____

Email address: _____

SECTION II - Workers' Compensation Commission Representative (as required by LE Sec. 9-405(d), Annotated Code of Maryland)

Service Company or In-house Administrator:

Name of Contact Person: ______________________________

Firm Name: ______________________________

Address: ______________________________

Phone No: (   )______________________ Fax No: (   )______________________

Email address: ______________________

(***NOTE***: **The above information will be changed on the Commission's records only upon written notification to the Commission by the self-insured employer**.)

SECTION III – Participating Payroll Office (List all payroll offices writing payroll for employees covered under this plan. If the name on the check is different than the self-insured, indicate if it is a subsidiary, affiliate, division, plant or office; include the effective date when each became self-insured. If additional space is needed, please attach exhibit.)

This report includes payroll of the following:

Business Name: ______________________ Federal I.D. No: ______________________

Address: ______________________________

Phone No: (   )______________________ Fax No: (   )______________________

Self-Insured ( ) Subsidiary ( ) Affiliate ( ) Division ( ) Plant ( ) Office ( ) Effective date of self-insurance: ____________

Principal Classification____________ No. Employees__________ No. All Other Employees ____________

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Business Name: ______________________ Federal I.D. No: ______________________

Address: ______________________________

Phone No: (   )______________________ Fax No: (   )______________________

Subsidiary (   ) Affiliate (   ) Division (   ) Plant (   ) Office (   ) Effective date of self-insurance: ____________

Principal Classification____________ No. Employees__________ No. All Other Employees ____________

****

Business Name: ______________________ Federal I.D. No: ______________________

Address: ______________________________

Phone No: (   )______________________ Fax No: (   )______________________

Subsidiary (   ) Affiliate (   ) Division (   ) Plant (   ) Office (   ) Effective date of self-insurance: ____________

Principal Classification____________ No. Employees__________ No. All Other Employees ____________

****

Business Name: ______________________ Federal I.D. No: ______________________

Address: ______________________________

Phone No: (   )______________________ Fax No: (   )______________________

Subsidiary (   ) Affiliate (   ) Division (   ) Plant (   ) Office (   ) Effective date of self-insurance: ____________

Principal Classification____________ No. Employees__________ No. All Other Employees ____________

****

Business Name: ______________________ Federal I.D. No: ______________________

Address: ______________________________

Phone No: (   )______________________ Fax No: (   )______________________

Subsidiary (   ) Affiliate (   ) Division (   ) Plant (   ) Office (   ) Effective date of self-insurance: ____________

Principal Classification____________ No. Employees__________ No. All Other Employees ____________

SECTION IV - Payroll Data

a. Annual period covered by this report: From: ______________________ To: ______________________

b. Number of employees covered: _____ c. Annual Maryland Payroll: (To the nearest dollar)_____

Types of work performed: _____

SECTION V - Claims Data

a. How many accidents occurred during this period (SF-1)? _____

b. How many accidents resulted in claims to the Commission during this period (Received Comm. Claim #)? _____

c. How many accidents occurred during the current reporting period for which costs were incurred or paid? _____

Section VI Reserves

a. **Ultimate loss net of payments** (for all years), including IBNR net of any expected excess carrier payments (indemnity, medical, vocational rehab. and all other).
$_____

b. **Total value of open claims/case reserves** (for all years). This amount should agree with Total Reserves on Loss Run. If not, please attach an explanation.
$ _____

Section VII Incurred Losses

Workers' Compensation claims incurred by year (paid and case reserves) by this organization in the past three years (including medical, vocational rehab., indemnity and all other direct claim costs). Please provide a detailed listing of claims that comprise the adjustments to prior year incurred losses:

Reporting Period	Originally Reported	Adjustments To Prior Year	Total Incurred As Adjusted
1. Current Year			
2. First Prior Year			
3. Second Prior Year			

SECTION VIII - Excess Coverage and Security Deposit Information

a. Amount of risk retained by self-insurer: $_____

b. Excess workers compensation policy limits: $_____

c. Does your excess insurance provide for an annual aggregate limit? Yes ( ) No ( )
If so, what is the annual aggregate amount? $_____

d. Name of Excess Carrier: _____

e. Do you have umbrella coverage applicable to workers' compensation? Yes ( ) No ( )

Amount $_____

f. Amount of surety bond: $_____
-OR-
Amount of security on deposit: $_____
-OR-
Amount of letter of credit: $_____

g. Issuer of security instrument: _____

SECTION IX. Additional Information (please provide the following by attachment or exhibit):

a. Loss Runs (in detail for the immediate past 5 years and in annual summary for up to an additional 15 years not to exceed the period of self-insurance).

b. Employee Locations (list worksites where the number of employees is greater than 10)

c. Copy of contract with Third Party Administrator, if any. **Note: Not required if TPA has not changed since 2015 reporting**.

d. Listing of claims which issues were filed with the Commission requesting penalties.

e. Listing of claims with penalties assessed (may be combined with f. above).

f. A statement whether there has been any change (in the reporting period) in accounting for Workers' Compensation costs as a result of audit or internal recommendations.

g. Listing of the states in which you are self-insured for Workers' Compensation; the number of states in which you have employees but are not self-insured.

h. Certificate of Status (Good Standing) for Third Party Administrator, if applicable. The Certificate should be from the State of Maryland.

i. Number of independent contractors (and associated payroll) covered by the self-insurance program. Is the payroll, if any, included in Section IV?

SECTION X - Certification

I certify that to the best of my knowledge and belief the information contained in this report and any attachments thereto is true and correct.

IN WITNESS WHEREOF, I have hereunto subscribed my name and caused the official seal to be affixed this _____day

of _____, 2017.

_____
Name of Self-Insured Employer

By:_____
Print Your Name in Full

Signature:_____

Title:_____

Phone No: ( )_____

Notary:

State of _____
City or County of _____

I hereby certify that on this _____ day of _____, 2017, before me the subscriber, a resident of the State of _____, in and for said County, personally appeared _____, (title) _____ of (Self-Insured Employer) _____ and made oath in due form of law that the matters and facts set forth in the foregoing reporting form and attached documents are true.

_____

(seal)

My Commission Expires: _____

NOTES