**State of Nevada**

**Department of Business & Industry**

##### Division of Industrial Relations

**WORKERS’ COMPENSATION SECTION**

FY16 INSURER INFORMATION FORM

(July 1, 2015 through June 30, 2016)

**Workers’ Compensation Insurers (Active and Inactive)**

## ANNUAL DUE DATE: FEBRUARY 28, 2017

(ALSO within 30 days of any changes/updates during the year)

Email: [wcsra@business.nv.gov](mailto:wcsra@business.nv.gov)

Mail: State of Nevada

Division of Industrial Relations

# Workers’ Compensation Section

# 1301 North Green Valley Parkway, Suite 200

##### Henderson, NV 89074

#### Attention: Research and Analysis

**Fax:** (702) 990-0364

|  |  |  |  |
| --- | --- | --- | --- |
| INSURER INFORMATION: | | | |
| Check One:  Private Carrier  Self-Insured Employer  Association of Self-Insured Employers | | | |
| Insurer Name (As listed on NV Certificate of Authority): | | | |
| Address: | | | |
| City: | | State: | Zip: |
| NV Certificate of Authority No.: | FEIN: | | |
| Date Certified: | Date Decertified (if applicable): | | |
| NCCI Carrier Code (Private Carriers): | NCCI Group Code (Private Carriers): | | |
| Did this carrier write WC business in NV in FY16? | YES  NO | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CURRENT IN-STATE NEVADA CLAIMS OFFICE(S)/TPAs: Attach additional page for multiple TPAs. This information will be used on our online Coverage Verification Service.** | | | | |
| Name of Administrator: | | | Effective Date: | |
| Address: | | | | |
| City: | | State: | | Zip: |
| Contact Person: | | | | |
| Telephone #: | C-4/Claims Fax #: | | | |
| Email Address: | | | | |

|  |  |  |
| --- | --- | --- |
| PREVIOUS NEVADA CLAIMS OFFICE(S)/TPAs DURING FY16: | | |
| Previous Administrator(s) | Effective Date(s) | Date(s) Through |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| **LOCATION OF RECORDS OTHER THAN CLAIMS OFFICE(S)/TPAs:** | | |
| Location of Records: | | |
| Address: | | |
| City: | State: | Zip: |
| Contact Person: | Title: | |
| Telephone: | | |
| Email Address: | Contract Expiration Date: | |

**State of Nevada**

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Division of Industrial Relations

**WORKERS’ COMPENSATION SECTION**

|  |  |  |  |
| --- | --- | --- | --- |
| **\*CORPORATE/WORKERS’ COMPENSATION REGULATORY CONTACT**  **(For issues relating to home office, legal, audit findings and reports, complaints, etc.):** | | | |
| Contact Name: | | | |
| Title: | Email Address: | | |
| Company Name: | | | |
| Address: | | | |
| City: | | State: | Zip: |
| Telephone: | | Fax: | |

|  |  |  |  |
| --- | --- | --- | --- |
| **COVERAGE VERIFICATION/CLAIM REPORTING CONTACT**  **(For issues relating to routing claims, employer policy/coverage status, etc.):** | | | |
| Contact Name: | | | |
| Title: | Email Address: | | |
| Company Name: | | | |
| Address: | | | |
| City: | | State: | Zip: |
| Telephone | | Fax: | |

|  |  |  |  |
| --- | --- | --- | --- |
| **PROOF OF COVERAGE/POLICY REPORTING CONTACT (Private Carriers Only)**  **(For issues relating to policy reporting to NCCI, proof of coverage reporting violations, etc.):** | | | |
| Contact Name: | | | |
| Title: | Email Address: | | |
| Company Name: | | | |
| Address: | | | |
| City: | | State: | Zip: |
| Telephone: | | Fax: | |

|  |  |  |  |
| --- | --- | --- | --- |
| **\*STATE STATUTORY REPORTING CONTACT**  **(For issues relating to the FY Activity Report, statistical reporting, data calls, etc.):** | | | |
| Contact Name: | | | |
| Title: | Email Address: | | |
| Company Name: | | | |
| Address: | | | |
| City: | | State: | Zip: |
| Telephone: | | Fax: | |

**\*These contacts will be placed on our data call email list.**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Individual Completing Form: | | | |
| Company: | Title: | | |
| Address: | | | |
| City: | | State: | Zip: |
| Telephone: | | Fax: | |
| Email Address: | | | |
| Signature: | | Date: | |