

STATE OF NEVADA
Department of Business and Industry
Division of Industrial Relations

Summary of Premium Earned and Claims Expenditures
Workers' Compensation Premiums Earned
And Workers' Compensation Claims Expenditures
July 01, 2024 through December 31, 2024

(1) * Insurer: _____

Earned Premiums Information:

(Please round all amounts to the nearest dollar)	Non-Mining:	Mining:	Total:
	(2)	(3)	(4)
July 01, 2024 through December 31, 2024 (Earned Premiums)	\$ _____	\$ _____	\$ _____

Claims Expenditure Information:

New: The insurer must submit claims information for each decertified self-insured employer or association of self-insured employers that this insurer has entered into or is a party to a loss portfolio transfer. Separate out the data below for claims expenditures under this insurer as a private carrier versus claims expenditures for each decertified self-insured employer or association of self-insured employers that this insurer assumed through a loss portfolio transfer. Place one decertified insurer on each line. Attach an additional sheet if more rows are needed.

(Please round all amounts to the nearest dollar)	Non-Mining:	Mining:	Total:	
	(5)	(6)	(7)	
Private Carrier Name: _____	July 01, 2024 through December 31, 2024 (For injuries on or after 7/1/99 for this insurer)	\$ _____	\$ _____	\$ _____
Decertified Self-Insured Employer Name: _____	July 01, 2024 through December 31, 2024 (For injuries on or after 7/1/99) for claims for a decertified self-insured employer assumed through a loss portfolio transfer	\$ _____	\$ _____	\$ _____
Decertified Association of Self Insurer Employers Name: _____	July 01, 2024 through December 31, 2024 (For injuries on or after 7/1/99) for claims for a decertified association of self-insured employers assumed through a loss portfolio transfer	\$ _____	\$ _____	\$ _____

(8) Does this report include all entities covered under the Certificate of Insurance for the insurer listed above?

() YES () NO

(9) Insurer's Federal Tax I.D. Number: _____

(10) Nevada Certificate of Authority Number: _____

Please complete and return this form
No later than **February 28, 2025** to:

Division of Industrial Relations
1830 College Pkwy, Suite 100
Carson City, NV 89706
Attn: WCS Safety Assessment

Or at e-mail address
WCAssessment@business.nv.gov

Compiled and approved on behalf of the above
Insurer by:

Insurer or Third-Party Administrator

Signature Date

Name (Please type or print) Phone #

Address (For questions related to this summary)

City, State, ZIP

Email (For questions related to this summary)