



**STATEMENT OF SPECIFIC AND AGGREGATE EXCESS INSURANCE COVERAGE**

(To Be Filed By Self-Insured)

P.O. Box 58  
Jefferson City, MO 65102-0058  
labor.mo.gov/DWC

**Name of Approved Self-Insured:** \_\_\_\_\_

**Other Named Insureds on Policy:** \_\_\_\_\_  
*(Please attach separate sheet if necessary)*

**Address of Self-Insured:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Insurance Company Issuing Policy:** \_\_\_\_\_

**Policy No.** \_\_\_\_\_

**Named State:** Missouri

**1) Policy period:**

From: \_\_\_\_\_  
To: \_\_\_\_\_

**2) Specific retention level:**

Each accident: \_\_\_\_\_  
Each employee for disease: \_\_\_\_\_

**3) Specific limit each accident:**

Policy Part One, Workers' Compensation: \_\_\_\_\_  
Policy Part Two, Employers Liability: \_\_\_\_\_

**4) Specific limit each employee for disease:**

Policy Part One, Workers' Compensation: \_\_\_\_\_  
Policy Part Two, Employers Liability: \_\_\_\_\_

**5) Aggregate excess retention:**

Normal premium multiplied by: \_\_\_\_\_  
Minimum retention: \_\_\_\_\_

**6) Aggregate excess limit:** \_\_\_\_\_

**7) Check here if aggregate excess coverage is not purchased.** \_\_\_\_\_

To remain in compliance with *The Rules Governing Self-Insurance* 8 CSR 50-3.010 (3)(B)3 or 8 CSR 50-3.010 (5)(B)2, the insurance company must:

- A. Be AM Best rated A- or better,
- B. Be an admitted carrier by the Missouri Department of Insurance, Financial Institutions and Professional Registration, and
- C. Provide the division, by certified mail, notice of cancellation or nonrenewal sixty (60) days before actual termination.

**I swear the above information is true under penalty of perjury.**

\_\_\_\_\_  
**Signature**  
*(Representative of self-insured entity or insurance company only)*

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Company Name and Address**