DIVISION OF WORKERS' COMPENSATION

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

INDIVIDUAL SELF-INSURED EMPLOYER INFORMATION

P.O. Box 58
Jefferson City, MO 65102-0058
573-751-4231
labor.mo.gov/DWC

1. EMPLOYER (legal entity holding Missouri self-insurance authority)

Name of Self-Insured Employer	
FEIN Number	SIC/NAICS Code
Name and Title of Principal Contact for Self-Insurance (Officer or Manager in your organization responsible for maintaining your self-insurance authority)	
Email	Phone Number
Mailing Address	Fax Number
City, State, ZIP Code	
Street Address	
City, State, ZIP Code	

2. OTHER NAMES (d/b/a's) – Do you operate under any registered fictitious names in Missouri? Please list all.

1)	2)
3)	4)

3. PRIMARY CONTACT FOR SELF-INSURANCE (person responsible for day-to-day issues involving self-insurance and the reporting of injuries to your claim administrator)

Name and Title of Contact	
Email	Phone Number
Address	Fax Number
City, State, ZIP Code	

4. FINANCIAL CONTACT (the Comptroller, Treasurer, or Chief Financial Officer)

Name and Title of Contact	
Email	Phone Number
Address	Fax Number
City, State, ZIP Code	

Missouri Division of Workers' Compensation is an equal opportunity employer/program.
Auxiliary aids and services are available upon request to individuals with disabilities.

5. SELF-INSURANCE ANNUAL REPORT CONTACT (person responsible for responding to information contained in the Annual Reports submitted to the Division)

Name and Title of Contact	
Email	Phone Number
Address	Fax Number
City, State, ZIP Code	

6. SAFETY – In-House Contact

Name and Title of Safety Manager/Administrator	
Email	Phone Number
Address	Fax Number
City, State, ZIP Code	

Do you use an outside safety consultant certified by the Missouri Workers' Safety Program? ☐ Yes ☐ No (If Yes, please fill in the following information.)

Name and Title of Safety Consultant	
Email	Phone Number
Address	Fax Number
City, State, ZIP Code	

7. ULTIMATE PARENT COMPANY

Name of Parent Company	
FEIN Number	Phone Number
Address	
City, State, ZIP Code	

Does the self-insured employer have any subsidiaries? ☐ Yes ☐ No
Attach an organizational chart if there are any subsidiaries or other related companies.

8. CORPORATE LEGAL COUNSEL (in-house counsel for the self-insured employer)

Name and Title of Contact, Firm Name (if applicable)	
Email	Phone Number
Address	Fax Number
City, State, ZIP Code	

9. CLAIMS ADMINISTRATION – Please list the location where claims are being handled for Missouri, NOT the office where the contract was signed.
Has there been a change from the previous year? ☐ Yes ☐ No

Please check if claims are or by ☐ **SELF-ADMINISTERED (IN-HOUSE)** ☐ **THIRD-PARTY ADMINISTRATOR (TPA)** **EFFECTIVE DATE _____/_____/_____.**

Name of Claims Administrator Company	
FEIN Number	
Contact Name and Title	
Email	Phone Number
Address	Fax Number
City, State, ZIP Code	

Is the current TPA handling all previous and new claims? ☐ Yes ☐ No

10. INSURANCE CONSULTANT OR BROKER
Change from previous year? ☐ Yes ☐ No

Company Name	
Contact Name and Title	
Email	Phone Number
Address	Fax Number
City, State, ZIP Code	

11. ADMINISTRATIVE TAX AND SECOND INJURY FUND SURCHARGE CONTACT (person within your organization that handles Admin tax and SIF assessment)
Change from previous year? ☐ Yes ☐ No

Name and Title	
Email	Phone Number
Address	Fax Number
City, State, ZIP Code	

12. PLEASE INDICATE ANY SIGNIFICANT CHANGES IN YOUR OPERATIONS IN THE LAST YEAR (i.e., ownership, locations open/closed, product or operations) Attach additional sheets, if necessary.
