MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

3315 West Truman Blvd.
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www.labor.mo.gov/DWC

# STATEMENT OF SPECIFIC AND AGGREGATE EXCESS INSURANCE COVERAGE

(To Be Filed By Self-Insured)

**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** **Date**
*(Representative of self-insured entity or insurance company only)*

______________________________
**Company Name and Address**

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