



MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
**INDIVIDUAL SELF-INSURED EMPLOYER
 INFORMATION**

3315 W. Truman Blvd.
 P.O. Box 58
 Jefferson City, MO 65102-0058
 573-751-4231

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

Change from previous year? Yes No

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 <u>responsible</u> for maintaining your self-insurance authority.)	
E-mail	Telephone 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.

Change from previous year? Yes No

1)	2)
3)	4)

3. PRIMARY CONTACT FOR SELF-INSURANCE (person responsible for day-to-day issues involving self-insurance)

Change from previous year? Yes No

Name and Title of Contact	
E-mail	Telephone Number
Address	Fax Number
City, State, ZIP Code	

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

Change from previous year? Yes No

Name and Title of Contact	
E-mail	Telephone 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)

Change from previous year? Yes No

Name and Title of Contact	
E-mail	Telephone Number
Address	Fax Number
City, State, ZIP Code	

6. SAFETY – In-House Contact

Change from previous year? Yes No

Name and Title of Safety Manager/Administrator	
E-mail	Telephone Number
Address	Fax Number
City, State, ZIP Code	

Do you use an outside safety consultant? Yes No (If “Yes,” please fill in the following information.)

Name and Title of Safety Consultant	
E-mail	Telephone Number
Address	Fax Number
City, State, ZIP Code	

7. ULTIMATE PARENT COMPANY – If applicable. (Attach an organizational chart if there are intermediate companies.)

Change from previous year? Yes No

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

8. 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 SELF-ADMINISTERED (IN-HOUSE) or by THIRD-PARTY ADMINISTRATOR (TPA) EFFECTIVE DATE ____/____/____.

Name of Claims Administrator Company	
FEIN Number	
Contact Name and Title	
E-mail	Telephone Number
Address	Fax Number
City, State, ZIP Code	

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

9. INSURANCE CONSULTANT OR BROKER

Change from previous year? Yes No

Company Name	
Contact Name and Title	
E-mail	Telephone Number
Address	Fax Number
City, State, ZIP Code	

10. ADMINISTRATIVE TAX AND SECOND INJURY FUND SURCHARGE CONTACT

Change from previous year? Yes No

Name and Title	
E-mail	Telephone Number
Address	Fax Number
City, State, ZIP Code	

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