

**COMMONWEALTH OF VIRGINIA**  
VIRGINIA WORKERS' COMPENSATION COMMISSION  
1000 DMV DRIVE, RICHMOND VA 23220

***ANNUAL SURVEY OF INDIVIDUAL SELF-INSURERS – PUBLIC***

Date \_\_\_\_\_

**Public Self-Insured Number:** \_\_\_\_\_

**Public Self-Insured Name:** \_\_\_\_\_

**Year \_\_\_\_\_ Update to Virginia Workers' Compensation Commission Records**

In order to update Commission records, we are asking you to provide the following information to us. This information is essential in ensuring that the Commission meets its responsibilities under Virginia law for the certification of individual self-insurers for workers' compensation.

Once you have completed the survey, check off the lines below, sign and date this top sheet, and return the survey and the necessary additional materials by \_\_\_\_\_ to Self-Insurance Program, Attn: Mechelle Esparza-Harris, Insurance Financial Examiner, Virginia Workers' Compensation Commission, 1000 DMV Drive, Richmond, Virginia 23220. If you have any questions, please contact Mechelle Esparza-Harris at (804) 205-3599 or at [Mechelle.Esparza-Harris@workcomp.virginia.gov](mailto:Mechelle.Esparza-Harris@workcomp.virginia.gov).

\_\_\_\_\_ The survey is completed and enclosed.

\_\_\_\_\_ The list of locations is enclosed.

\_\_\_\_\_ The Employer Identification Number (EIN), also known as the Federal Employer Identification Number (FEIN), is listed for ALL public agencies, departments, or operating entities with operations in Virginia.

I certify that all information provided is correct to the best of my knowledge.

**My typed name below shall have the same force and effect as my written signature for all purposes under Virginia law including the Virginia Workers' Compensation Act, and any Rule or Regulation of the Virginia Workers' Compensation Commission.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

**1. Contacts: corporate, claims processing, and designated representative**

The #1 address is for the person we will contact regarding basic issues of self-insurance, the #2 address is the address to which all routine mail regarding claims will be sent, and the #3 address is for the in-state designated representative. The #3 address must be a **street address** within Virginia.

#1 Corporate representative:

PHONE:

FAX:

E-Mail Address:

#2 Claims processing contact(s):

PHONE:

Change from prior year Survey?  Yes  No

If yes: Date of Change \_\_\_\_\_

Will Handle Previous Claims?  Yes  No

#3 Designated representative (street address in Virginia is required):

PHONE:

Change from prior year Survey?  Yes  No

If yes: Date of Change \_\_\_\_\_

Will Handle Previous Claims?  Yes  No

**2. Excess insurance coverage (if applicable):**

Effective date:

Expiration date:

Carrier:

Limits:

**Specific**

**Aggregate**

Retention level

Limit of indemnity

Deductible

**3. Locations and employees grouped by Employer Identification Number (EIN)**

A. For all locations list the name, address, nature of operations, and number of employees. Page 4 of the survey includes form "2015 Public List of Subsidiaries and Locations" for your use.

**Example:**

<b>Federal Tax ID</b>	<b>Location Name</b>	<b>Street Address</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>	<b>Nature of Operations</b>	<b>Number of Employees</b>
54-1111111	ABC Variety	123 ABC Street	Anytown	VA	12345	Retail sales	15

B. If you have closed a location since the last annual survey and have not advised the Virginia Workers' Compensation Commission of the closure, list the location and give the closing date for that location on this report (use separate sheet of paper if needed).

