Self-Insurer's Records Update Form

Name of Self-Insured: _____

FEIN #: _____ Carrier ID # W _____

Primary Contact

Name of Primary Contact Person at Self-Insured: _____

Title of Contact Person: _____ Telephone #: _____

E-Mail Address: _____ Fax #: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Assessment Contact (if different than Primary.) If none, please enter "N/A"

Name of Contact Person at Self-Insured: _____

Title of Contact Person: _____ Telephone #: _____

E-Mail Address: _____ Fax #: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Claims Contact (if different than Primary.) If none, please enter "N/A"

Name of Contact Person at Self-Insured: _____

Title of Contact Person: _____ Telephone #: _____

E-Mail Address: _____ Fax #: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Additional Contact (if desired) If none, please enter "N/A"

Name of Contact Person at Self-Insured: _____

Title of Contact Person: _____ Telephone #: _____

E-Mail Address: _____ Fax #: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Active Subsidiaries in self-insurance program:

Name: _____ FEIN#: _____
Name: _____ FEIN#: _____
Name: _____ FEIN#: _____
Name: _____ FEIN#: _____
Name: _____ FEIN#: _____
Name: _____ FEIN#: _____
Name: _____ FEIN#: _____
Name: _____ FEIN#: _____

(Attach list if additional subsidiaries are included.)

☐ Claims are self-administered by the Self-Insured Employer

☐ Claims are administered by a TPA - Please complete back of form with TPA information

Return this form to the WCB Office of Self Insurance via e-mail: selfinsurance@wcb.ny.gov

Self-Insurer's Records Update Form

TPA – Claims Administrator Information

Claims Administrator: ______________________ T#: __________

Contact Person for your account: ______________________

Title of Contact Person: __________ Telephone #: __________

E-Mail Address: ______________________ Fax #: __________

Mailing Address: ______________________

City: __________ State: __________ Zip: __________

This TPA is handling all cases for our entire period of self-insurance? ☐ Yes ☐ No

If no, answer below.

The following is a breakdown of Claims Administrators:

Dates of Accident from __________ to __________

Claims Administrator: ______________________ T#: __________

Contact Person for your account: ______________________

Title of Contact Person: __________ Telephone #: __________

E-Mail Address: ______________________ Fax #: __________

Mailing Address: ______________________

City: __________ State: __________ Zip: __________

Dates of Accident from __________ to __________

Claims Administrator: ______________________ T#: __________

Contact Person for your account: ______________________

Title of Contact Person: __________ Telephone #: __________

E-Mail Address: ______________________ Fax #: __________

Mailing Address: ______________________

City: __________ State: __________ Zip: __________

Dates of Accident from __________ to __________

Claims Administrator: ______________________ T#: __________

Contact Person for your account: ______________________

Title of Contact Person: __________ Telephone #: __________

E-Mail Address: ______________________ Fax #: __________

Mailing Address: ______________________

City: __________ State: __________ Zip: __________

Form Completed By: __________ **Date:** __________

Return this form to the WCB Office of Self Insurance via e-mail: selfinsurance@wcb.ny.gov