INDUSTRIAL COMMISSION OF ARIZONA
800 W WASHINGTON STREET
PHOENIX, ARIZONA 85007
(602) 542-4661

WORKERS' COMPENSATION LIABILITY FORM

1. **NAME OF SELF-INSURER:**

2. **SECURITY DEPOSIT CALCULATION**
(Number of Claims, Incurred Liability and Paid amounts must be calculated from the ***Effective Date of Self-Insurance Authority to the present date***):

A	B	C	D	E	F	G	H
Total Amount of Open Claims	**Incurred Medical**	**Paid Medical**	**Total Medical Owed (B – C = D)**	**Incurred Comp.**	**Paid Comp.**	**Total Comp. Owed (E – F = G)**	**TOTAL ALL CLAIMS (D + G = H)**
			$ 0.00			$ 0.00	$ 0.00

Total Owed from Column H:	$ 0.00
Excess insurance reimbursement amount expected:	
Net remaining liability:	$ 0.00
Multiply by 125%:	$ 0.00
Calculated Security Deposit: (minimum security deposit $100,000.00)	$ 100,000.00

Please submit Loss Run report in Excel format to selfinsurance@azica.gov

3. **Name of Excess Insurance Carriers providing reimbursement:** (attach detailed report with carrier name, SIR amount, claimant names, DOI and claim number, reimbursement amount requested, policy year(s) of reimbursement taken)

I, _____ attest that there is no affiliate relationship between the self-insurer and the excess insurance carrier and to the truthfulness of the above information.

4. . **EMPLOYEE COUNT**
Total Employee Count from prior anniversary date to current (include all full & part time employees that worked regardless of whether or not they are still employed.) Attach explanation of decrease.

Self-Insurers Authorized Representative Signature: _____

Submitter First Name:

Submitter Last Name:

Submitter Title:

Submitter Email Address:

Date: *** Must be signed by Designated Officer**