INDUSTRIAL COMMISSION OF ARIZONA
WORKERS' COMPENSATION LIABILITY FORM

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

2. **EMPLOYEE COUNT _____ Total Employee Count from prior anniversary date to current (W-2 count to include all full & part time employees that worked regardless of whether or not they are still employed). Explain decrease from prior year on separate cover.**

3. **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)**

Total Owed from Column H: **$**_____

Excess insurance reimbursement amount expected: **$**_____

Net remaining liability: **$**_____

Multiply by 125%: **$**_____

Calculated Security Deposit: (minimum security deposit $100,000.00) **$**_____

4. **Name of Excess Insurance Carriers providing reimbursement:** (provide detailed report with carrier name, SIR amount, claimant names, DOI and claim number, reimbursement amount requested)

(List the 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.

Self-Insurers Authorized Representative Signature: _____

Printed Name/Title: _____

DATE: _____ *** Must be signed by Designated Officer**