

(Company Name Exactly As It Should Appear on the Certificate of Exemption)

MINNESOTA 2016 STATUS REPORT

Required of ALL Active Workers' Compensation Self-Insurers Licensed  
Under Minnesota Statutes 79A.01 - .18

General Instructions. The Status Report should be completed using the most recent information available. Wherever necessary, attach additional pages, clearly indicating the question to which they refer. Self-insured groups, may consolidate the information. THE REPORT, ALONG WITH THE \$500 ANNUAL RENEWAL FEE PAYABLE TO THE MINNESOTA DEPARTMENT OF COMMERCE, MUST BE RETURNED TO THE ADDRESS BELOW\* BY APRIL 1, 2016.

Mid-Year Updates. The completion of this report does not constitute sufficient notice to the Department. Any changes in the information requested in this report which occur after the submission of this report must be reported promptly under separate cover to the **\*Minnesota Department of Commerce, Attention: Eva Crawford, 85 Seventh Place East, Suite 500, St. Paul, MN 55101-2198. Phone: (651) 539-1741 Fax: (651) 539-1550**  
E-Mail: [eva.leonard@state.mn.us](mailto:eva.leonard@state.mn.us)

1. Name, Mailing Address. List the name and mailing address of the named self-insured.

2. Parent Companies. List the names, addresses and ownership relationships of the self-insured's parent companies, if any, up to and including the ultimate parent. Designate by asterisk (\*) any companies which have filed Assumption of Liability or Guarantee of Payment agreements for the name self-insured.

Name/Address

Relationship/% of Ownership



**2016 Status Report - \_\_\_\_\_**  
**(Company Name)**

If you are an **Individual** Self-Insurer, please name **Primary Contact at self-insured's location, Title, Address, Phone/Fax:**

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Title: \_\_\_\_\_ Phone #: \_\_\_\_\_  
\_\_\_\_\_ FAX #: \_\_\_\_\_  
E-Mail: \_\_\_\_\_

If you are a **Group** Self-Insurer, please attach a list of the Group Board of Directors to include: Name, Office Held, Member Company represented, Title, Address, Phone and Fax Numbers.

Identify **Group's Fiscal Agent** Name/Address and activities and responsibilities **on separate sheet** per Minnesota Rules Chapter 2780.4300.

**Mandatory:** If the group has entered into **a new** service agreement or a renewal agreement with a Third Party Administrator **after July 1, 2001**, you must enclose a copy of the contract with this report. (Per Minnesota Statutes 60A.23 Subd. 4 (4).

Who will be the **PRIMARY CONTACT** between the self-insured and the Minnesota Department of Commerce. **This will be the person to whom ALL correspondence relating to your self-insurance authority will be sent by the Minnesota Department of Commerce.**  
**(Note: This could be your TPA or a person at your company)**

Company (above)       TPA (above)       Other (fill out below)

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Company: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Address: \_\_\_\_\_ E-Mail: \_\_\_\_\_

6. Have you received written approval for "In-House" Claims Administration by the Department of Commerce?    Yes \_\_\_\_                      No \_\_\_\_

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

E-mail: \_\_\_\_\_

**2016 Status Report - \_\_\_\_\_**  
**(Company Name)**

7. A Minnesota law does not allow you to purchase Specific Excess Workers' Compensation insurance from anyone other than the WCRA for operations in Minnesota. If you do, Minnesota should be deleted from that policy. (For exceptions to this, refer to the WCRA Website: www.WCRA.BIZ)

\*8. Do you purchase a "Buffer Layer" Specific Workers Compensation policy other than from the WCRA?

\_\_\_\_ Yes      \_\_\_\_ No      If Yes, from which insurance company: \_\_\_\_\_

Policy Limit: \_\_\_\_\_ Retention Limit: \_\_\_\_\_ Policy Dates: \_\_\_\_\_

\*9. Do you purchase Aggregate Excess Workers' Compensation insurance which covers your operations in Minnesota?

\_\_\_\_ Yes      \_\_\_\_ No      If Yes, from which Insurance Co.: \_\_\_\_\_

Policy Limit: \_\_\_\_\_ Retention Amount: \_\_\_\_\_ Policy Dates: \_\_\_\_\_  
(Attachment Point)

10. What is your current retention limit with the **WCRA**?

A) \_\_\_\_ Low    B) \_\_\_\_ High    C) \_\_\_\_ Super

**\*If yes, to either 8 or 9 you must attach copies of the pertinent pages of the policy(ies).**

\_\_\_\_\_  
Name of Person Completing Report

\_\_\_\_\_  
Title

\_\_\_\_\_  
Company

\_\_\_\_\_  
Date