COMMERCE DEPARTMENT

__________________________________________

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

# MINNESOTA 2023 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, 2023.**

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: Marie Douglas, 85 Seventh Place East, Suite 280, St. Paul, MN 55101-2198. Phone: (651) 539-1743 Fax: (651) 539-1550**

**E-Mail: marie.douglas@state.mn.us**

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

**2023 Status Report - ______________________________**
**(Company Name)**

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 named self-insured.

Name/Address Relationship/% of Ownership

3. A) Legal entities INCLUDED within Self-Insurance Authority. List the names, addresses and ownership relationships of separate legal entities with Minnesota operations that the self-insured is including within their self-insurance authority, if any. Indicate the percentage of ownership or include other details of relationship.

Name/Address Relationship/% of Ownership

**NOTE: The entities named in 3A) must concur with Attachment "A" of your Self-Insurance Authority, if one has been issued for you. Please do not list Divisions or Departments. Please contact Eva Crawford at the Department of Commerce if there are any discrepancies on your current license or Attachment "A".**

B) Employee Leasing companies and PEOs must report the name and address of any client company to which it provides employees for 30 days or more during the year, using the Employee Leasing Report found on the website at: http://mn.gov/commerce/industries/insurance/licensing/self-insurance/

**2023 Status Report ______________________________**
**(Company Name)**

4. (A) Total number of employees ____________

   (B) Total number of Minnesota employees _____________

5. Third Party Administrator. For each administrator (if any) under contract with the self-insured, list the items mentioned below. It is possible to have contracts with more than one administrator since not all are authorized to provide all services. If different persons at the administration company(ies) are responsible for different services (e.g. claims handling, loss control), list the primary person responsible for the account.

Name: ____________________ Address: ________________________

Title: _____________________ Phone #: ________________________

_____________________ FAX #: _________________________

E-Mail: _________________________

**Note: Your TPA MUST BE LICENSED IN Minnesota and maintain an office in the State of Minnesota.** Commerce must be notified in writing if there is a change in your TPA during the year.

**2023 Status Report - ______________________________**
**(Company Name)**

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

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, and emails.

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, you must enclose a copy of the contract with this report. (Per Minnesota Statutes 60A.23 Subd. 4 (4).

**2023 Status Report - ______________________________**
**(Company Name)**

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 ____

(If "yes", please provide contact information for your in-house claims manager):

Name: ______________________________________

Phone Number: ___________________

Fax Number: _____________________

E-mail: __________________________

**2023 Status Report - ______________________________**

**(Company Name)**

7. Minnesota law does not allow you to purchase Specific Excess Workers' Compensation insurance below certain limits 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)

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

**2023 Status Report - ______________________________**
**(Company Name)**

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

    A) ____ Low B) ____High C) ____Super D) ____Jumbo

11. Is this entity or any affiliated entity the subject of a bankruptcy proceeding? Yes ____ No _____

    If "Yes", provide full details on a separate attachment.

_____________________________________

Name of Person Completing Report

_____________________________________

Title

_____________________________________

Company

_____________________________________

Date