pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

SUPPLEMENTAL INFORMATION ADDENDUM TO GROUP SELF-INSURANCE FUND ANNUAL REPORT

1. Name of fund _____

2. Insurer code _____

FUND ADMINISTRATOR

Company name _____
Contact person _____
Address _____
Address _____
City/Town _____ State ____ ZIP _____
Telephone _____
Email _____

FISCAL AGENT (if different from Fund Administrator)

Company name _____
Contact person _____
Address _____
Address _____
City/Town _____ State ____ ZIP _____
Telephone _____
Email _____

APPLICATION CONTACT (if different from Fund Administrator)

Company name _____
Contact person _____
Address _____
Address _____
City/Town _____ State ____ ZIP _____
Telephone _____
Email _____

3. Excess Insurance
Provide the following information about the Fund's excess insurance coverage:

	Specific		Aggregate (if applicable)	
Retention amount:	$ _____		$ _____	
Liability limit:	$ _____	☐ Statutory	$ _____	☐ Statutory

Cash Flow Protection (if applicable)

First Year: $ _____
Second Year: $ _____
Third Year: $ _____

Insurer _____

Policy number _____

Effective period: From ☐☐ - ☐☐ - ☐☐☐☐ To ☐☐ - ☐☐ - ☐☐☐☐
MM DD YYYY MM DD YYYY

4. Fidelity Coverage
Provide the following information about the Fund's fidelity insurance coverage:

Type of coverage	Deductible	Liability limit
_____	$ _____	$ _____
_____	$ _____	$ _____
_____	$ _____	$ _____
_____	$ _____	$ _____

Insurer _____

Policy number _____

Effective period: From [ ][ ] - [ ][ ] - [ ][ ][ ][ ] To [ ][ ] - [ ][ ] - [ ][ ][ ][ ]
MM DD YYYY MM DD YYYY

5. Provide the following information about the Board of Trustees (attach additional sheets if necessary).

Name of Trustee	Company	Title or Position

6. Aggregate Financial Information
If the members are private employers, provide the following (calculated according to generally accepted accounting principles):

Aggregate working capital $ _____

Aggregate net worth $ _____

Attach a list that provides each member's working capital and net worth.

ACKNOWLEDGEMENTS AND AGREEMENTS

The undersigned fund has been approved to operate as a fund under the Workers' Compensation Act. It acknowledges that the above facts and documents have been submitted under oath to the Bureau of Workers' Compensation of the Department of Labor & Industry to enable the bureau to decide if the fund continues to qualify to operate as a fund under the Act. This report must be submitted to the bureau no later than five (5) months following the end of each annual fund year.

The fund hereby confirms its agreement to fairly administer the Workers' Compensation Act in accordance with the rules and regulations of the Department of Labor & Industry and not circumvent the law for the purpose of avoiding or reducing the compensation liability.

The fund acknowledges that it understands and accepts that following the submission of the report or at other times determined by the bureau, the bureau may revise the conditions previously set for the issuance of the fund's permit. The fund's permit may be revoked if the revised conditions are not met in the time prescribed by the bureau.

This report must be signed by an officer of the Board of Trustees of the fund and attested to as set forth below.

I verify that the facts set forth in this Group Self-Insurance Fund Report are true and correct to the best of my knowledge, information and belief. This verification is made subject to the penalties of 18 Pa.C.S.§4904, relating to unsworn falsification to authorities.

By _____
Signature

Date signed
__ __ - __ __ - __ __ __ __
MM DD YYYY

_____ _____ _____
First name (typed/printed) M Last name

_____
Title (typed/printed)