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)

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program