INDUSTRIAL COMMISSION OF ARIZONA

WORKERS' COMPENSATION LIABILITY FORM

EMPLOYER NAME:

NUMBER OF W2 FORMS ISSUED IN LAST CALENDAR YEAR

AMOUNT OF PAYROLL REPORTED IN LAST CALENDAR YEAR

REPORTING DATE: (the cut off date for data entered on this Form)

SECURITY DEPOSIT CALCULATION

The Number of Claims, Incurred Liability & Paid amounts must be calculated from the Authorization Date of Self-Insurance Authority to the Reporting Date listed above.

A	B	C	D	E	F	G	H
Total Amount of Open Claims	Incurred Medical	Paid Medical	Total Medical Owed (B–C=D)	Incurred Indemnity	Paid Indemnity	Total Indemnity Owed (E – F = G)	Total Medical and Indemnity Owed (D+G)
			$ 0			$ 0	$ 0

Apportionment Reimbursement Expected - A.A.C. § R20-5-1520 (C) (must subtract from indemnity reserves and incurred:

Excess Insurance Reimbursement amount expected - A.A.C. § R20-5-1520 (D): _____

Net Remaining Liability (Column H - Apportionment Reimbursement - Excess Reimbursement): $ 0

Multiply Net remaining liability by 125% - A.A.C § R20-5-1520 (A)(2) $ 0

Calculated Security Deposit: (minimum security deposit $100,000 A.R.S. § 23-961) **$ 100,000**

Note: The Commission may require a different security amount pursuant to A.A.C. § R20-5-1509 (C).

Pursuant to A.A.C. § R20-5-1506 (D)(3), a loss run of all open claims incurred on or after the Authorization Date **MUST BE SUBMITTED**. The loss run must include the following information for each claim: Payroll Classification Code, Commission claim number, employee name, date of injury, total paid medical, medical reserves, total paid indemnity (including death benefits), indemnity reserves, excess insurance carrier name (if applicable), amount of excess credit expected (if applicable), and excess insurance self-insured retention amount per occurrence (if applicable), Excess Insurance carrier name, and Excess Insurance Policy number (can only claim an excess credit for medical and indemnity) (excess insurance cannot offset the minimum security deposit of $100,000 pursuant to A.R.S. § 23-961).

Attach Loss Run Here

I, _____, _____
attest there is no affiliate relationship between the self-insurer and the excess insurance carrier, the amount of apportionment reimbursement expected and to the truthfulness of the above information.

Self-Insured Authorized Representative Signature: _____

Submitter First Name: _____

Submitter Last Name: _____

Submitter Title: _____

Submitter Email Address: _____

Phone Number of Submitter:_____Date: _____