Self-Insurer's Records Update Form

Name of Self-Insured:					
FEIN #:	Carrier ID # W				
Primary Contact					
Name of Primary Contact	Person at Self-Insured:				
itle of Contact Person:		Telephone #:			
E-Mail Address:	Mail Address:				
Mailing Address:					
	State:		Zip:		
	different than Primary.) If none				
Name of Contact Person a					
		Telephone #:			
		·			
	State:		Zin:		
	ent than Primary.) If none, plea		Zip:		
Name of Contact Person a		ase citter IVA			
		Tolophono #:			
Title of Contact Person:					
	State:		Zip:		
Additional Contact (if de	<u>sired)</u> If none, please enter "N	/A"			
Name of Contact Person a	at Self-Insured:				
Title of Contact Person:		Telephone #:			
E-Mail Address:		Fax #:			
Mailing Address:					
City:	State:		Zip:		
	Active Subsidiaries in self	f-insurance program:			
Name:		FEIN#:			
Name:		FEIN#:			
Name:		FEIN#:			
Name:		FEIN#: FEIN#:			
Namo:					
Namo:		EEINI#:			
N.I.					
(Attac	ch list if additional subsidiaries ar	e included.)			
Claims are s	elf-administered by the Self-Insu	red Employer			
Claims are a	dministered by a TPA - Please c	omplete back of form with	TPA information		
	•	•			

Return this form to the WCB Office of Self Insurance via e-mail: selfinsurance@wcb.ny.gov

Self-Insurer's Records Update Form

TPA – Claims Administrator Information

Claims Administrator:			T#:
Contact Person for your account	::		
Title of Contact Person:			
E-Mail Address:			
Mailing Address: ————			
City:	State:		Zip:
This TPA is handling all cases for	or our entire period o	of self-insurance?	Yes No
	If no,	answer below.	<u> </u>
The following is a breakdown of	Claims Administrate	ors:	
Dates of Accident from		to _	
			T#:
Contact Person for your account	t:		
Title of Contact Person:			phone #:
E-Mail Address:			
City:	State:		Zip:
Dates of Accident from		to _	
Claims Administrator:			T#:
Contact Person for your account	i:		
Title of Contact Person:			phone #:
E-Mail Address:			
Mailing Address:			
City:	State:		Zip:
Dates of Accident from		to _	
Claims Administrator:			T#:
Contact Person for your account	t:		
Title of Contact Person:			phone #:
E-Mail Address:			
Mailing Address:			
City:	State:		Zip:
Form Completed By:			Date: