Washington State Department of Labor & Industries

Self-Insurance Annual Attestation

Self-Insurance
PO Box 44890
Olympia WA 98504-4890

Please provide an updated list of contacts for your workers' compensation program. Complete each question. If the question does not apply to your company, write "N/A" in the space provided.

Failure to provide this information may result in a penalty under Revised Code of Washington (RCW) 51.48.080.

Part A. Injury Reporting	
Claim Filing Process Contact Information	
A.1.	Identify the person or entity responsible for obtaining, maintaining, and distributing Self-Insurance Accident Report Forms (SIF-2s).
A.2.	Who is the designated person or persons on premises at each location to whom report of injury shall be made?
A.3.	Identify the person (or position) available at each location who can answer employee questions about workers' compensation and will assist workers in filing claims.
A.4.	Who will be responsible for completing the employer's portion of the SIF-2?

Part B. Authorization of Medical Care (Washington Administrative Code [WAC] 296-15-330)	
B.1.	Does the applicant have any location where medical treatment is provided to employees on the premises (an on-site medical facility)?

If “Yes”, please identify the locations.

(a) For each location that has an on-site medical facility, please list the operating hours and staffing levels. What are the credentials of the individuals providing treatment to workers?

B.2. Identify the position(s) within your claims management organization responsible for treatment authorization and describe their qualification (i.e. training, years of Washington claims experience, etc.).

B.3. Identify the position(s) responsible for payment of bills and describe their qualifications (i.e. training, years of Washington claims experience, etc.).

Part C. Payment of Compensation (WAC 296-15-340)

C.1. Identify the position(s) responsible for the calculation and payment of time loss compensation benefits and describe their qualifications (i.e. training, years of Washington claims experience, etc.).

Part D. Qualification of Personnel (WAC 296-15-360)

D.1. How many certified claims administrators will be responsible for managing the applicant’s claims?

D.2. In additional to department-approved claims administrators, who else on staff will provide support on the applicant’s claims? Describe the role of these other staff members.

D.3.	We certify that we have a business representative as the point of contact or manager for the following systems: SICATS, SIEDRS, and EDI.

Part E. Changes in Business (WAC 296-15-221)

E.1.	Provide a list of all physical locations in Washington. Include addresses.
E.2.	Provide a list of all Uniform Business Identifier (UBI) numbers and business names for subsidiaries in Washington.

Part F. Other Contact Information

F.1.	Provide the name and address of the entity responsible for administering claims (the work location where self-administered by the applicant or for the third party administrator hired for this purpose).
F.2.	Identify the person who is the primary point of the contact for your business. Include the name, phone number, and email address. In addition, please include any further individuals you would like included on the Certification Services distribution list.
Primary Name:	
Primary Phone Number:	
Primary Email:	
Additional Distribution Emails:	

I certify that the information provided in this form is complete and accurate to the best of my knowledge.

I understand that any falsification, omission, or concealment of material fact may subject me to penalty under RCW 51.48.080.

Name	Title	Date
Name	Title	Date

Thank you for taking the time to provide the information. Please be aware that the department keeps this information on file and relies on its accuracy.

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