

**DIVISION OF WORKERS' COMPENSATION  
BUREAU OF MONITORING AND AUDIT  
SELF-INSURANCE SECTION**

**SERVICE COMPANY ANNUAL REPORT FORM**

1. Name of business \_\_\_\_\_

2. Address of home office \_\_\_\_\_

3. Please note if your home office is not the location of your records, indicate the address of such records

\_\_\_\_\_

Please complete the following items only if there has been a change from that reported on your application or on your last annual report. If there has been no change, please write "No Change". Attach additional sheets if necessary.

4. Address of your Florida branch offices \_\_\_\_\_

\_\_\_\_\_

5. Your business is a Corporation ( ) Partnership( ) Individual Proprietorship( )  
Other( ) \_\_\_\_\_

6. Name and addresses of owners, partners or corporate officers: \_\_\_\_\_

\_\_\_\_\_

7. Is your business a subsidiary? Yes( ) No( ). If yes, give the name and address of your parent company:

\_\_\_\_\_

For items 8 and 9, please note any changes from your last annual report or from your original application. Please include residence and business addresses for all new personnel submitting a resume. If your answer is "yes" to any of these questions, attach summary data on the size and composition of the appropriate staff; include resumes on any new individuals with administrative or professional responsibilities.

8. Have there been any changes in your claims staff: Yes( ) No( )

9. Have there been any changes in your underwriting staff: Yes( ) No( )

10. Have there been any changes in your safety engineering staff? Yes( ) No( )

11. If you have made substantial changes in your safety program, have they been approved by the Division of Workers' Compensation? Yes( ) No( )

12. Do you wish to name a new person to act for your business in Florida? Yes( ) No( ) If yes, list the name, address and telephone number of that

person: \_\_\_\_\_

\_\_\_\_\_

Finally, please supply the following information:

13. Attach a list of all the self-insured employers and self-insurers funds for which you are currently providing service. Please indicate the extent of the services being performed (e.g., claims, underwriting, safety or all). Please limit your response to Florida Workers' Compensation Self-Insurers. Indicate if the services being provided are for a current contract or for claims run-off of an expired contract.

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This form must be returned to us no later than March 1 each year. If your report is satisfactorily completed, you should receive notice of recertification within sixty (60) days. Please send your completed report to:

Division of Workers' Compensation  
Self-Insurance Section  
200 East Gaines Street  
Tallahassee, FL 32399-4224

I certify that the information contained in and accompanying this annual report form is true and correct to the best of my knowledge.

Date: \_\_\_\_\_

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(Name of Service Company)

By: \_\_\_\_\_  
(Signature)

Title: \_\_\_\_\_