CLAIMS RESERVED IN EXCESS OF SELF-INSURED RETENTION valued as of 1/1/ (year)

Self-Insured:

Worker's name *Last name, first name*	**Date of injury**	**Future liability covered by excess insurance** *Amount*	**Self-insured retention (SIR)** *Amount*	**Have claim payments exceeded SIR?** *Yes or no*	**Excess insurer name/ policy number**	**Is self-insured receiving reimburse-ment?** *Yes* * *or no*	**Excess insurer notified?** *Yes or no*	****Check here if copy of written notification attached**

* *If yes, also provide percentage of claim costs being reimbursed.*

** *Not required if previously submitted to the department, or if receiving reimbursement*

FAILURE TO SUBMIT THIS FORM MAY RESULT IN THE AMOUNT OF THE SECURITY DEPOSIT BEING DETERMINED WITHOUT REGARD TO EXCESS INSURANCE REIMBURSEMENT.

If you have questions regarding this form, please contact Jody Howatt at (503) 947-7699 or Dianna Janowski at (503) 947-7716.

Prepared by: _____

Telephone no.: _____

Return form to: Department of Consumer and Business Services
WCD/Compliance Section/Benefits and Certifications Unit
PO Box 14480
Salem, OR 97309-0405