

December 1, 2011

**VIA CERTIFIED MAIL**

TO: Members of the Georgia Self-Insurers Guaranty Trust Fund

FROM: John P. Reale, Administrator

Attached please find a copy of the 2012 Member Information Update form. This form must be completed to retain self-insured status in Georgia and will be used to update our files and compute your company's assessment in 2012. A COPY OF YOUR COMPLETED FORM WILL BE FORWARDED TO THE STATE BOARD OF WORKERS' COMPENSATION UPON RECEIPT BY THIS OFFICE.

**The 2012 Member Information Update Form must be postmarked no later than MARCH 31, 2012.** Failure to return your form as required will result in an automatic penalty of \$50.00 for each day the form is delinquent, or 10 percent of the assessment, whichever is greater. **Extensions will not be granted after MARCH 23, 2012. Facsimiles are not permitted.**

Return your completed form to:

Georgia Self-Insurers Guaranty Trust Fund  
P. O. Box 7159  
Atlanta, Georgia 30357-0159  
OR  
880 West Peachtree Street, N.W.  
Atlanta, Georgia 30309

If you have any questions, please call us at (404) 872-6184. Thank you for your cooperation.

GEORGIA SELF-INSURERS GUARANTY TRUST FUND  
2012 MEMBER INFORMATION UPDATE

December 1, 2011

VIA CERTIFIED MAIL

TO:

PLEASE PROVIDE THE FOLLOWING INFORMATION. SIGN AND RETURN THIS FORM TO:

GEORGIA SELF-INSURERS GUARANTY TRUST FUND  
P. O. BOX 7159  
ATLANTA, GEORGIA 30357-0159

OR

880 WEST PEACHTREE STREET NW  
ATLANTA, GEORGIA 30309

**The 2012 Member Information Update form must be postmarked no later than MARCH 31, 2012. Failure to return your form as required will result in an automatic penalty of \$50.00 for each day the form is delinquent, or ten percent (10%) of the assessment, whichever is greater. Extensions will not be granted after MARCH 23, 2012. Facsimiles are not permitted. ALL QUESTIONS MUST BE ANSWERED COMPLETELY. INCOMPLETE FORMS WILL BE CONSIDERED DELINQUENT.**

1. **STATE THE COMPANY NAME IN WHICH YOUR SELF-INSURANCE IS REGISTERED. STATE THE NAME OF THE PERSON WHO IS OUR PRIMARY CONTACT PERSON AT THE MEMBER COMPANY, ALONG WITH HIS/HER ADDRESS AND TELEPHONE NUMBER.** (THE PERSON WHOSE NAME IS STATED HERE MUST BE AN EMPLOYEE OF THE MEMBER COMPANY.)

MEMBER COMPANY NAME		
SBWC ID #		FEIN:
CONTACT PERSON		
TITLE		
MAILING ADDRESS		
CITY, STATE, ZIP		
PHYSICAL ADDRESS		
CITY, STATE, ZIP		
TELEPHONE NUMBER		
FACSIMILE NUMBER		
E-MAIL ADDRESS		

**ALSO, PLEASE LIST A SECONDARY CONTACT, ALONG WITH HIS/HER ADDRESS AND TELEPHONE NUMBER.**

MEMBER COMPANY NAME	
SECONDARY CONTACT PERSON	
TITLE	
<b>MAILING ADDRESS</b>	
CITY, STATE, ZIP	
<b>PHYSICAL ADDRESS</b>	
CITY, STATE, ZIP	
TELEPHONE NUMBER	
FACSIMILE NUMBER	
E-MAIL ADDRESS	

2. **STATE THE NAME OF THE THIRD-PARTY ADMINISTRATOR (TPA must be licensed in Georgia), ALONG WITH HIS/HER COMPANY, ADDRESS, AND TELEPHONE NUMBER. LIST ONE OFFICE ONLY.** If your program is self-administered, state the name, address and telephone number of the person at your company who is responsible for administering your claims. If your program is self-administered, the company named will be the same as the member company in Item 1. If you have a question regarding claim handling/administration, please contact the State Board of Worker’s Compensation at (404) 656-4893 or [mcmillanm@sbwc.ga.gov](mailto:mcmillanm@sbwc.ga.gov). Please refer to Board Rule 127. **PLEASE NOTE: If more than one location handles your claims, you must select one office as your designated office.**

CLAIMS COMPANY \_\_\_\_\_

CLAIMS COMPANY FEIN \_\_\_\_\_

CONTACT PERSON \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

TELEPHONE (toll-free number,  
if available) \_\_\_\_\_

FACSIMILE \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_

**PLEASE ATTACH A COPY OF THE FOLLOWING:**

- 2a. **YOUR THIRD-PARTY ADMINISTRATOR’S CERTIFICATE OF ERRORS & OMISSIONS INSURANCE COVERAGE.**
- 2b. **YOUR THIRD-PARTY ADMINISTRATOR’S GEORGIA TPA LICENSE .** Please note, such license can be obtained by contacting the Office of Insurance and Safety Fire Commissioner at (404) 656-2056. If your TPA is exempt from licensure, please provide a copy of the signed formal exemption letter. For an example of the exemption letter, please visit our website at [www.gaguaranty.com](http://www.gaguaranty.com).
- 2c. If both the **self-insurer** and the **claims** office are located outside the State of Georgia, please designate a GEORGIA AGENT located in the State of Georgia who shall be authorized to execute instruments for the payment of compensation. See Board Rule 127.

COMPANY \_\_\_\_\_

CLAIMS COMPANY FEIN \_\_\_\_\_

CONTACT PERSON \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

TELEPHONE (toll-free number,  
if available) \_\_\_\_\_

FACSIMILE \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_

3. **IS THE SELF-INSURED COMPANY A SUBSIDIARY? \_\_\_\_\_ IF SO, NAME THE PARENT OR HOLDING COMPANY ALONG WITH ITS ADDRESS.**

If the member company (the company stated in Item 1) is a subsidiary of another company, type “yes” and state the name and address of the parent company.

NAME OF PARENT CO.	ADDRESS, CITY, STATE, ZIP

4. **LIST THE SUBSIDIARIES OF THE MEMBER COMPANY (NAMED IN ITEM 1) WHICH ARE COVERED BY ITS SELF-INSURANCE PROGRAM AND ARE PRESENTLY DOING BUSINESS IN GEORGIA.** List the subsidiaries of the member company (the company stated in Item 1) along with the primary address of each subsidiary. List only the subsidiaries doing business in Georgia which are covered under the member company's self-insurance. Do not list divisions of the member company. Do not list individual locations of the member company.

NAME OF SUBSIDIARIES	ADDRESS, CITY, STATE, ZIP

5. **LIST THE AFFILIATES OF THE MEMBER COMPANY (NAMED IN ITEM 1) WHICH ARE COVERED BY ITS SELF-INSURANCE PROGRAM AND ARE PRESENTLY DOING BUSINESS IN GEORGIA.** List the affiliates of the member company (the company stated in item 1) along with the primary address of each affiliate. List only the affiliates doing business in Georgia which are covered under the member company's self-insurance. Do not list divisions of the member company. Do not list individual locations of the member company. (In order for an affiliate to be included in the member company's self-insurance, there must be 51% common ownership with the member company.)

NAMES OF AFFILIATES	ADDRESS, CITY, STATE, ZIP

6. **IF YOUR COMPANY IS DOING BUSINESS IN GEORGIA, USING NAMES OTHER THAN THOSE LISTED IN YOUR RESPONSES TO ANY PREVIOUS QUESTIONS, PLEASE LIST THOSE COMPANIES.** If your company is doing business in Georgia using a trade name, the name of a division, etc., list those names. Your response to this question will be used in determining coverage at the State Board of Workers' Compensation.

TRADE NAME OR DBA	ADDRESS, CITY, STATE, ZIP

7. **IF YOUR COMPANY OPERATES FRANCHISES, WHICH ARE COVERED BY ITS SELF-INSURANCE PROGRAM AND ARE PRESENTLY DOING BUSINESS IN GEORGIA, PLEASE LIST THE NAME AND ADDRESS OF EACH FRANCHISE LOCATION.**

NAME OF FRANCHISE	ADDRESS

8. **WAS THERE A CHANGE IN OWNERSHIP OF YOUR COMPANY LAST YEAR, OR DID YOU BUY OR SELL SUBSIDIARY COMPANIES LAST YEAR? IF SO, PLEASE EXPLAIN.**

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**ITEMS 9 THROUGH 28 MUST INCLUDE 12 MONTHS OF DATA**

In order for your company to be assessed in 2012, you must provide twelve months of data for items 9 through 28. If your company was not self-insured for all of 2011, you must contact the insurance carrier with which you were insured prior to commencing your self-insurance to determine what was paid on your company's behalf in 2011 and add it to what was paid while self-insured.

9. **AVERAGE NUMBER OF EMPLOYEES IN GEORGIA IN 2011**

State the average number of total employees in Georgia in 2011 (self-insured only), including the employees of a subsidiary and/or affiliate of the company which were covered by your self-insurance.

\_\_\_\_\_

10. **AVERAGE PROJECTED NUMBER OF EMPLOYEES IN GEORGIA IN 2012**

State the projected average number of total employees in Georgia in 2012 (self-insured only).

\_\_\_\_\_

11. **AVERAGE NUMBER OF EMPLOYEES OUTSIDE GEORGIA IN 2011**

State the average total number of out-of-state employees of the member company who were not located in Georgia in 2011 and not self-insured in Georgia.

\_\_\_\_\_

12. **AVERAGE PROJECTED NUMBER OF EMPLOYEES OUTSIDE GEORGIA IN 2012**

State the projected average total number of out-of-state employees of the member company not located in Georgia in 2012 and not self-insured in Georgia.

\_\_\_\_\_

13. **GEORGIA PAYROLL IN 2011**

State the payroll of the Georgia employees covered by self-insurance in 2011. Please include the W-2 earnings of the GA employees covered by self-insurance in 2011.

\$ \_\_\_\_\_

14. **ESTIMATED GEORGIA PAYROLL IN 2012**

State the estimated payroll of the employees which will be covered by self-insurance in Georgia in 2012.

\$ \_\_\_\_\_

15. **TOTAL MEDICAL PAID IN GEORGIA IN 2011**

(regardless of date of injury)

State the **total** amount of all medical payments made by or on your company's behalf to Georgia employees or medical providers in 2011, regardless of the date of injury.

The response to this item should include medical payments made in conjunction with both lost-time and medical-only claims.

\$ \_\_\_\_\_

**(Exclude from the above amount any claims for which you have executed agreements with the SITF for full reimbursement and/or are currently receiving 100% reimbursement from the excess carrier.) Additionally for those claims excluded, please identify, by name, those claims excluded and attach confirmation from SITF or Excess of 100% acceptance of the claim.**

**PLEASE NOTE: THE ACCURACY OF YOUR RESPONSE TO THIS QUESTION CAN SIGNIFICANTLY AFFECT YOUR SECURITY REQUIREMENTS.**

16. **TOTAL INDEMNITY PAID IN GEORGIA IN 2011**

(regardless of date of injury)

State the **total** amount of all indemnity payments made by or on your company's behalf to Georgia employees in 2011, regardless of the date of injury. The response to this item should include indemnity payments made in conjunction with lost-time and indemnity-only claims, as well as any settlements.

\$ \_\_\_\_\_

**(Exclude from the above amount any claims for which you have executed agreements with the SITF for full reimbursement and/or are currently receiving 100% reimbursement from the excess carrier.) Additionally for those claims excluded, please identify, by name, those claims excluded and attach confirmation from SITF or Excess of 100% acceptance of the claim.**

**PLEASE NOTE: THE ACCURACY OF YOUR RESPONSE TO THIS QUESTION CAN SIGNIFICANTLY AFFECT YOUR SECURITY REQUIREMENTS.**

17. **TOTAL OUTSTANDING (NET) RESERVES FOR ALL SELF-INSURED CLAIMS IN GEORGIA AS OF 12/31/2011**

(regardless of date of injury)

State the **total** outstanding reserves for all Georgia employees as of 12/31/11. The response to this item should include both medical and indemnity reserves.

\$ \_\_\_\_\_

**Exclude from the above amount any self-insured claims for which you have executed agreements with the SITF for full reimbursement and/or are currently receiving 100% reimbursement from the excess carrier. Please note, any cases that have been accepted by SITF or Excess should be reserved at their corresponding amount. For instance, if SITF or Excess fully reimburses a claim, the reserves should be set at \$0. Likewise, if SITF or Excess reimburses a claim 50%, the reserves should be reduced by 50%.**

**PLEASE NOTE: THE ACCURACY OF YOUR RESPONSE TO THIS QUESTION CAN SIGNIFICANTLY AFFECT YOUR SECURITY REQUIREMENTS.**

**PLEASE SUBMIT A LOSS RUN OF ALL OPEN CLAIMS AS OF 12/31/2011, FOR YOUR COMPANY, AND A SEPARATE LOSS RUN FOR YOUR SUBSIDIARIES AND AFFILIATES (IF ANY).** PLEASE INCLUDE THE FOLLOWING: CLAIMANT'S NAME, THE LAST FOUR DIGITS OF THE CLAIMANT'S SOCIAL SECURITY NUMBER, DATE OF INJURY, TYPE OF INJURY, MEDICAL PAID-TO-DATE, INDEMNITY PAID-TO-DATE, AND UNPAID MEDICAL AND INDEMNITY RESERVES.

**PLEASE NOTE: SUBMISSION OF THE LOSS RUN FOR YOUR COMPANY MAY BE MADE BY THUMB DRIVE OR CD.**

**PLEASE NOTE: ONCE DATA IS SUBMITTED, NO CHANGES MAY BE MADE. PLEASE ENSURE ACCURACY OF DATA BEFORE SENDING.**

18. Please attach a **written** explanation of any variance of 20% (only if the variance is equal to \$20,000 or more) or more in the total medical, indemnity, and/or reserve data that you reported on last year's Update Form, when compared to what you are reporting on this year's Update Form. If you are unable to provide specifics related to the variance, please summarize the reason for the variance to the best of your knowledge, pointing out any significant claims that contributed to the variance. **NOTE: the accuracy of your response to this question can significantly affect your security requirements.**

19. **PLEASE ATTACH A LIST OF ALL CLAIMS DESIGNATED TO BE CATASTROPHIC ALONG WITH THEIR RESPECTIVE RESERVES.**  
**IF NONE, PLEASE INDICATE N/A HERE:** \_\_\_\_\_

20. **PLEASE ADVISE IF YOUR COMPANY HAS A CAPTIVE AND HOW THE RESERVES ARE FUNDED.**

**Yes**, we have a captive. Reserves are funded as follows: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**No**, we do not have a captive.

**PLEASE NOTE: IN THE EVENT OF THE MEMBER COMPANY'S BANKRUPTCY, YOUR CAPTIVE MUST AGREE TO REIMBURSE THE GSIGTF FOR PAYMENTS MADE BY THE FUND ACCORDING TO THE SAME TERMS AS THE CAPTIVE WOULD HAVE REIMBURSED THE MEMBER COMPANY FOR PAYMENTS MADE ON ANY CLAIM.**

21. **IF YOU INDICATED YOUR COMPANY HAS A CAPTIVE, PLEASE FORWARD THE FOLLOWING PAGE TO YOUR CAPTIVE FOR COMPLETION AND RETURN TO US.** Please note, the captive endorsement and the bankruptcy/cancellation endorsement for excess are two separate endorsements.

If you have any questions, please contact us at (404) 872-6184, or the State Board of Workers' Compensation at (404) 656-4893.

**CAPTIVE ENDORSEMENT NO. \_\_\_\_\_**  
**USED FOR CAPTIVE INSURANCE**

**NAMED INSURED:** \_\_\_\_\_

**POLICY NUMBER:** \_\_\_\_\_

**It is hereby understood and agreed that the following condition is added to the policy.**

**IN THE EVENT OF THE BANKRUPTCY OR INSOLVENCY OF THE NAMED INSURED:** If the Georgia Self-Insurers Guaranty Trust Fund is called upon to expend monies on behalf of the insolvent or bankrupt member in order to pay workers' compensation benefits, medical expenses, or other costs pursuant to O.C.G.A. 34-9-1, et seq., we will reimburse the Georgia Self-Insurers Guaranty Trust Fund for those amounts paid on behalf of the insolvent or bankrupt member per the terms of our insurance policy issued to the employer. The Georgia Self-Insurers Guaranty Trust Fund will be treated as the insured for purposes of reimbursement pursuant to this endorsement and payments made by the bankrupt insolvent named insured will be credited towards the retention for the benefit of the Georgia Self-Insurers Guaranty Trust Fund.

This endorsement applies to \_\_\_\_\_, and self-insured subsidiaries and affiliates, if any.

By: \_\_\_\_\_  
(Authorized Representative of the Company)

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

22. **IF A CAPTIVE INSURANCE COMPANY IS USED TO FUND ANY PART OF THE SELF-INSURANCE LIABILITY OF THE EMPLOYER, PLEASE PROVIDE A COPY OF THE MOST RECENT CERTIFIED FINANCIAL STATEMENT OF THE CAPTIVE AS WELL AS THE FOLLOWING INFORMATION REGARDING THE CAPTIVE MANAGER.**

NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY, STATE, ZIP \_\_\_\_\_  
TELEPHONE \_\_\_\_\_  
DOMICILE \_\_\_\_\_

23. **TOTAL NUMBER OF OPEN MEDICAL ONLY CLAIMS COVERED BY SELF-INSURANCE IN GEORGIA AS OF 12/31/2011.** \_\_\_\_\_

24. **TOTAL NUMBER OF OPEN INDEMNITY CLAIMS COVERED BY SELF-INSURANCE IN GEORGIA AS OF 12/31/2011** \_\_\_\_\_

25. **STATE THE NUMBER OF GEORGIA CLAIMS FILED IN 2011, WHICH HAVE NOT BEEN CONTROVERTED BUT HAVE NOT BEEN INCLUDED IN QUESTION 23 OR 24.** \_\_\_\_\_

26. **NUMBER OF DEATHS IN GEORGIA IN 2011** \_\_\_\_\_

27. **NUMBER OF DISMEMBERMENTS IN GEORGIA IN 2011** \_\_\_\_\_

28. **NUMBER OF INJURIES IN GEORGIA IN 2011 WHICH ALLOWED AN EMPLOYEE TO COLLECT WEEKLY INDEMNITY BENEFITS, including: TEMPORARY TOTAL, TEMPORARY PARTIAL, PERMANENT PARTIAL, AND PERMANENT TOTAL.** \_\_\_\_\_

29. **ENCLOSE A COPY OF THE CERTIFICATE OF INSURANCE ASSOCIATED WITH YOUR EXCESS INSURANCE COVERAGE.**

You are required to furnish a copy of the certificate of insurance for the excess policy currently in place which includes the effective date, expiration date, specific retention level, workers' compensation limits, the insurance company that issued the policy, and companies covered by the policy. The certificate must state the policy is a specific excess workers' compensation policy. If we already have a copy of your current certificate of insurance, you do not need to include a copy with your update form. DO NOT DELAY SENDING YOUR UPDATE FORM BECAUSE PROOF OF EXCESS INSURANCE IS NOT AVAILABLE. PROOF OF EXCESS INSURANCE MAY BE SENT UNDER SEPARATE COVER. (FOR ADDITIONAL INFORMATION, PLEASE REFER TO OUR WEB SITE [www.gaguaranty.com](http://www.gaguaranty.com)).

30. **PLEASE ADVISE WHO IS RESPONSIBLE FOR NOTIFYING YOUR EXCESS CARRIER OF CLAIMS ELIGIBLE FOR REIMBURSEMENT.**

(1)

COMPANY NAME \_\_\_\_\_  
CONTACT PERSON \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY, STATE, ZIP \_\_\_\_\_  
TELEPHONE NO. \_\_\_\_\_  
FACSIMILE NO. \_\_\_\_\_  
E-MAIL ADDRESS \_\_\_\_\_

**PLEASE ADVISE WHO IS RESPONSIBLE FOR NOTIFYING THE SITE OF CLAIMS ELIGIBLE FOR REIMBURSEMENT.**

(2)

COMPANY NAME \_\_\_\_\_  
CONTACT PERSON \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY, STATE, ZIP \_\_\_\_\_  
TELEPHONE NO. \_\_\_\_\_  
FACSIMILE NO. \_\_\_\_\_  
E-MAIL ADDRESS \_\_\_\_\_

31. **DIRECTORS AND OFFICERS INSURANCE COVERAGE**

You are required to provide the following information, if applicable:

INSURED'S NAME	
LIMITS OF COVERAGE	
ISSUING COMPANY	
POLICY	

32. **ENCLOSE AN ORIGINAL BOUND COPY OF YOUR MOST RECENT AUDITED FINANCIAL STATEMENTS, OR NOTE WEB ADDRESS OF FINANCIAL STATEMENTS BELOW:**

**Website**

**Address:** \_\_\_\_\_

Each employer is required to furnish a copy of their full audit to us each year. If we do not have a copy of your most recent audit on file, please attach a copy of your audited financial statement for the recently completed calendar year with the update form or, if not yet available, please advise when same is produced. If you are on a fiscal year, please advise when your most recent fiscal year will be completed, and when your financial statement for the said year will be available. (We prefer to receive original bound copies of your financial statements or annual report, instead of photocopies.) **DO NOT DELAY SENDING YOUR UPDATE FORM BECAUSE AUDITED FINANCIAL STATEMENTS ARE NOT AVAILABLE. THE FINANCIAL STATEMENTS MAY BE SENT UNDER SEPARATE COVER.** If it is necessary to submit financial statements separately from the update form, you are required to forward the enclosed affidavit entitled "Certification of Financial Statements" (#37) which is to be executed by the owner, a partner, or a corporate officer, preferably the President or CFO, of the member company.

*Please note that the State Board of Workers' Compensation may rely on the information contained herein; therefore, the attached affidavit requires an officer of the member company, preferably the President or the CFO, to certify that the most recent audited financial statements are attached, and that there are no material changes in the members' financial status between the previous and current year. As a member of the self-insurance program, you are required to notify the Georgia Self-Insurers Guaranty Trust Fund and the State Board of Workers' Compensation if any material changes do occur in said financial statement status.*

Please note for question 32a, if your company has already submitted financials for the previous year prior to the submission of the 2012 update form, please indicate when the next calendar/fiscal year audited financial statements will be available.

32a. **Please advise when your most recent fiscal year will be completed here:** \_\_\_\_\_

32b. **If your most recent audited financial statements are *not* available, please state the date of their availability here:** \_\_\_\_\_

33. **NAME, ADDRESS AND TELEPHONE NUMBER OF THE PERSON COMPLETING THIS FORM.**

State the name, address and telephone number of the person we should contact if there are questions about your responses on this form. The person named does not have to be an employee of the member company.

NAME

ADDRESS

CITY, STATE, ZIP

TELEPHONE NO.

FACSIMILE NO.

E-MAIL ADDRESS

34. **CERTIFICATION BY THE MEMBER COMPANY:**

The update form must be signed by the owner, partner, or corporate officer, preferably the President or CFO, of the member company. It cannot be signed by your third-party administrator. In addition, the signature must be notarized and, where applicable, the corporate seal must be affixed.

The undersigned, after being duly sworn does hereby depose and state under oath, and certify under penalty of law, that I am thoroughly familiar with the operation and affairs of the above-named company; that I have read and studied the statements above, attachments, including the most recent audited financial statements, if currently available, and exhibits, and know the contents thereof; that I am authorized by said company to execute and submit the foregoing information with all attachments including the most recent audited financial statements, if currently available, exhibits and supporting documents, as well as to individually execute this affidavit. I hereby certify that, after a thorough and diligent search, said statements and representations contained herein, together with all supporting attachments, including the most recent audited financial statements, if currently available, exhibits and documents are true and correct to the best of my knowledge, information and belief.

SUBSCRIBED AND SEALED THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, 2012.

\_\_\_\_\_  
SIGNATURE OF OWNER, PARTNER, OR CORPORATE OFFICER  
(PRESIDENT OR CFO) AS AFFIANT

\_\_\_\_\_  
TYPED NAME AND OFFICIAL POSITION

Attest (If a Corporation)

\_\_\_\_\_  
Signature of Corporate Secretary

\_\_\_\_\_  
Name of Corporate Secretary (Typed or Printed)

**(PLACE CORPORATE SEAL HERE)**

SWORN TO AND SUBSCRIBED BEFORE ME BY ABOVE  
AFFIANT, THIS THE DATE SHOWN ABOVE:

\_\_\_\_\_

ADDRESS AND TELEPHONE NUMBER OF NOTARY PUBLIC:

SIGNATURE OF NOTARY PUBLIC

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

MY COMMISSION EXPIRES \_\_\_\_\_

(SEAL OF NOTARY PUBLIC HERE)

**35. CERTIFICATION BY CLAIMS COMPANY, ADJUSTER OR THIRD PARTY ADMINISTRATOR**

If a claims company, adjuster or third party administrator provided information regarding claims, payments and reserves which were used in the preparation of this form, the claims company, adjuster or third party administrator must certify the data provided herein.

**PLEASE ATTACH A BRIEF DESCRIPTION OF YOUR RESERVING METHODOLOGY OR FORMULAS USED TO REACH THE RESERVE FIGURES YOU ARE CERTIFYING, SPECIFICALLY OUTLINING HOW OFTEN RESERVES ARE ADJUSTED, WHAT INPUT THE SELF-INSURED EMPLOYER PROVIDED, *if any*, AS WELL AS ANY OTHER INFORMATION YOU BELIEVE TO BE PERTINENT TO YOUR RESERVING PRACTICES.**

I hereby certify that, after a thorough and diligent search, the information provided in this form regarding claims, payments and reserves are true and correct to the best of my knowledge.

SUBSCRIBED THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, 2012.

\_\_\_\_\_  
SIGNATURE OF DESIGNATED OFFICIAL OF THE  
ADJUSTER, CLAIMS COMPANY OR THIRD  
PARTY ADMINISTRATOR

\_\_\_\_\_  
TYPED NAME AND OFFICIAL POSITION OF THE  
DESIGNATED OFFICIAL OF THE ADJUSTER, CLAIMS  
COMPANY OR THIRD PARTY ADMINISTRATOR

**NAME OF THE ADJUSTER, CLAIMS COMPANY OR THIRD PARTY ADMINISTRATOR'S PLACE OF BUSINESS**

\_\_\_\_\_

SWORN TO AND SUBSCRIBED BEFORE ME BY ABOVE  
AFFIANT, THIS THE DATE SHOWN ABOVE:

\_\_\_\_\_  
SIGNATURE OF NOTARY PUBLIC

ADDRESS AND TELEPHONE NUMBER OF NOTARY  
PUBLIC:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

MY COMMISSION EXPIRES \_\_\_\_\_  
(SEAL OF NOTARY PUBLIC HERE)

36. **CERTIFICATION BY MEMBER COMPANY SUBMITTING FINANCIAL STATEMENTS  
SEPARATE FROM THE UPDATE FORM:**

This certification must be signed by the owner, partner, or corporate officer, preferably the President or CFO, of the member company. In addition, the signature must be notarized and, where applicable, the corporate seal must be affixed.

The undersigned, after being duly sworn, does hereby depose and state under oath, and certify under penalty of law, that I am thoroughly familiar with the operation and affairs of the above-named company; that I am authorized by said company to execute and submit, **under separate cover**, the most recent audited financial statements, as well as to individually execute this affidavit.

SUBSCRIBED AND SEALED THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, 2012.

\_\_\_\_\_  
SIGNATURE OF OWNER, PARTNER, OR CORPORATE  
OFFICER (PRESIDENT OR CFO) AS AFFIANT

\_\_\_\_\_  
TYPED NAME AND OFFICIAL POSITION

Attest (If a Corporation)

\_\_\_\_\_  
Signature of Corporate Secretary

\_\_\_\_\_  
Name of Corporate Secretary (Typed or Printed)

(PLACE CORPORATE SEAL HERE)

SWORN TO AND SUBSCRIBED BEFORE ME BY ABOVE  
AFFIANT, THIS THE DATE SHOWN ABOVE:

\_\_\_\_\_  
SIGNATURE OF NOTARY PUBLIC

ADDRESS AND TELEPHONE NUMBER OF NOTARY PUBLIC:

MY COMMISSION EXPIRES \_\_\_\_\_

(SEAL OF NOTARY PUBLIC HERE)

**This certification refers to Item 32**

**BEFORE YOU MAIL YOUR 2012 MEMBER INFORMATION UPDATE**

- \* Please ensure you have responded to **each** item. **If any question is left unanswered, the form will be returned to you.**
- \* Please complete the corresponding update form mailed to member company with regard to self-insurance status (i.e. active or cancelled).
- \* Only original certifications will be accepted regarding questions #35 through #37.
- \* Regarding the submission of current financial statements, if you have **not** submitted a copy of your most recent audited financial statements, please send a copy with your update form. If your company's year ending date for the most current financial statements has not passed, resulting in your need to submit current financial statements at a later date, please complete questions numbered 31 and 37 regarding this later submission to us.
- \* If we do not have a current certificate of insurance for your excess insurance policy, please include a copy with your update form.
- \* Do **not** send copies of your letter of credit, surety bond or OSHA reports.
- \* If you have any questions, please visit our website at [www.gaguaranty.com](http://www.gaguaranty.com).

**IMPORTANT**

**FAILURE TO RETURN THIS FORM, WITH A POSTMARK OF MARCH 31, 2012 OR BEFORE WILL RESULT IN AN AUTOMATIC PENALTY OF \$50.00 FOR EACH DAY THE FORM IS DELINQUENT, OR 10 PERCENT OF THE ASSESSMENT, WHICHEVER IS GREATER. EXTENSIONS WILL NOT BE GRANTED AFTER MARCH 23, 2012.**

**DO NOT DELAY SENDING YOUR UPDATE FORM BY MARCH 31, 2012 BECAUSE YOUR FINANCIAL STATEMENTS AND/OR EXCESS CERTIFICATE ARE NOT AVAILABLE. YOUR FINANCIAL STATEMENTS AND EXCESS CERTIFICATE CAN BE SENT UNDER SEPARATE COVER.**

**FACSIMILES ARE NOT PERMITTED.**