Wisconsin Worker's Compensation Information Update For Self-Insurance

INSTRUCTIONS: The following is the information presently on our information system. If any of the information requested is missing, please provide the information in the space provided. If the requested information is incorrect, please change it by writing the correct information in the space next to the incorrect information. If you have any questions related to the information on this form, please call Mike Tomsyck at (608) 266-8961.

Employer Name: City of Milwaukee **Political Subdivision** 139

Section A: Employer Information

Only the information in this Section with an "X" in front of it is considered public information. This will be published on our web site and available to the public when requested.

X **Exact Legal Name of Employer:** City of Milwaukee

Mailing Address:

X **Address Line 1** 701 City Hall

X **Address Line 2** 200 E WELLS ST

X **City, State, Zip** MILWAUKEE WI 53202 - 3515

X **Voice Telephone Number:** (414) 286-2935

Fax Telephone Number: (414) 286-2106

Internet Home Page Address: http://www.ci.mil.wi.us

Unemployment Insurance No.: 692137

FEIN: 39-6005532

State Incorporated In:

Section B: Employer's Top Responsible Official

Mayor John O. Norquist

c/o or Attention

Street Address 200 E WELLS ST RM 701 Rm 201

City, State, Zip MILWAUKEE WI 53202-3515

Voice Telephone Number: (414) 286-2200

Section C: Designated Contact Person

(The Designated Contact Person MUST be an employee of this political subdivision.)

Contact Person Name: Ms. Burma Hudson

Contact Person Title: Worker's Compensation/Safety Administrator

Mailing Address:

Address Line 1

Address Line 2 200 E WELLS ST RM 701

City, State, Zip MILWAUKEE WI 53202 - 3515

Voice Telephone Number: (414) 286-2935

Fax Telephone Number: (414) 286-2106

Internet Email Address: bhudso@ci.mil.wi.us

Form: WKC-7210 (R. 12/2000)

Update Year: 2001

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Employer Name: City of Milwaukee — Political Subdivision 139

Section D: Claims Handling Information

(Complete this section in its entirety. However if you do not use a TPA, leave blank the TPA Company Name and the TPA FEIN.)

TPA Company Name:

TPA FEIN:

Mailing Address:

Address Line 1

Address Line 2 200 E WELLS ST RM 701

City, State, Zip MILWAUKEE WI 53202 - 3515

Claims Handling Person:

Name: Richard J. Reiter

Title: Claims Adjuster Specialist

Voice Telephone Number: (414) 286-3546

Fax Telephone Number: (414) 286-2106

Internet Email Address:

Claims Pending Person: It is strongly recommended that all self-insured employers designate a person to be responsible for regularly monitoring their "Pending Reports" on the Department's web site. This will enable the employer to know the status of their claims and to timely respond to the Department with information that is being requesting.

Name: Richard Reiter

Voice Telephone Number: (414) 286-3546

Fax Telephone Number: (414) 286-2106

Internet Email Address: rreite@ci.mil.wi.us

Section E: Security and Excess Insurance Information

Security is not applicable, and Excess coverage is not required but highly recommended.

If Bond, Name of Bond Company:

Bond Number:

Type of Security Required:

Required Amount of Security:

Date Security Expires:

NOTE: Please submit a copy of the continuation certificate for the surety bond when submitting this Information Update form, only if the above expiration date is in the past.

Excess Requirements

Type of Excess Required: None

Date Excess Expires:

Required Retention:

Required Upper Limits:

NOTE: Please submit a copy of the declarations / information page of the excess policy(ies) when submitting this Information Update form, only if the above expiration date is in the past.

Form: WKC-7210 (R. 12/2000)

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Employer Name: City of Milwaukee — Political Subdivision 139

Section F: Assessment Information

Person to whom Assessment should be mailed: (This person must be an employee of the parent corporation or an affiliate.)

Name: Burma Hudson

Title: Worker's Compensation/Safety Administrator

Mailing Address:

Address Line 1

Address Line 2 200 E WELLS ST RM 201 Rm 701

City, State, Zip MILWAUKEE WI 53202 - 3515

Voice Telephone Number: (414) 286-2935

Fax Telephone Number: (414) 286-2106

Internet Email Address: bhudso@ci.mil.wi.us

The employer and the person completing this form attest that the information contained herein is deemed to be correct unless otherwise noted.

The following information is needed about the person completing this form:

Signature: Burma Hudson **Date:**

Printed name and title: Burma Hudson, Worker's Compensation/Safety Administrator

Voice telephone number: (414) 286-2935

Employer name of person completing this form: City of Milwaukee

Form: WKC-7210 (R. 12/2000)

Update Year: 2001

NOTE: THE SECTIONS THAT FOLLOW REQUIRE YOU TO SUPPLY US WITH SPECIFIC INFORMATION. BECAUSE THIS INFORMATION CHANGES OR IS NOT PRESENTLY CAPTURED IN OUR INFORMATION SYSTEM, WE REQUIRE THAT YOU SUPPLY US THIS INFORMATION ON AN ANNUAL BASIS OR AS SOON AS ANY CHANGES ARE MADE, WHICHEVER OCCURS FIRST.

Section G: Employer's Claim History Information

[*Information provided in this section shall be for the most recently completed calendar year, January 1 through December 31.*]

Please provide the following information for self-insured Wisconsin worker's compensation claims.

1. Medical only claims:

Number of medical only claims incurred during past year (*i.e. date of injury: Jan. 1 to Dec. 31*)	2,697
Number of medical only claims closed during past year (*no matter when incurred*)	2,637
Number of medical only active claims as of December 31	528
Expenses of medical only claims actually paid during past year (*No matter what year incurred; do not include any employer overhead or TPA expenses.*)	$ 727,595.23

2. Indemnity claims:

Number of indemnity claims incurred during past year (*i.e. date of injury: Jan. 1 to Dec. 31*)	862
Number of indemnity claims closed during past year (*no matter when incurred*)	964
Number of indemnity active claims as of December 31	868
Expenses of indemnity claims actually paid during past year (*No matter what year incurred; do not include any employer overhead or TPA expenses; include medical costs of the indemnity claims.*)	$ 5,221,326.45

Section H: Wisconsin Location Information (SI)

For **each Wisconsin location to be self-insured**, please provide the following information:

You may send us printouts for any of the requested information in this Section rather than filling out our form, provided you supply us with the information that we are requesting.

- Business or Trade Name: City of Milwaukee
- Street Address: 200 East Wells Street
- City: Milwaukee
- State and Zip Code: WI 53202
- Product or Service: City Government

Please make additional copies of this page as needed, with one page for each location.

Section I: Wisconsin Operations not Self-Insured

- Do you intend for all Wisconsin locations to be Self-Insured? (Yes) No

If "No", please provide the following information for each Wisconsin location or portions of employer's operations that are NOT to be self-insured in Wisconsin:

- Business or Trade Name _____
- Street Address _____
- City _____
- State and Zip Code _____ _____
- Product or Service _____
- Number of employees _____
- Total number of hours worked by employees in the most recently ended calendar year _____
- Annual Payroll at Location _____

- Is entire location excluded? Yes No (circle one please)
  [*If "**NO**", please describe that portion and its location on an attached separate sheet of paper.*]

- Insurance Company information
  Provide a copy of the Declaration page of your present Wisconsin Worker's Compensation policy.
  [This should include: *Name of insurance company; policy number; and date policy expires*]

Please make additional copies of this page as needed, with one page for each location.

Section J: Employer Information

The following information should not be itemized by location, but summed-up by employer.

Employer name: City of Milwaukee

- Number Wisconsin of employees: 7,930
- Total number of hours worked by Wisconsin employees in the most recently ended calendar year: 14,392,005.28
- Annual Wisconsin payroll: 279,047,340.28

Section K. TPA/Claims Handling Office History

The following information is needed for each claims handling office or third party administrator (TPA) that an employer is using to handle claims. This includes past as well as present claims.

An employer can have only one TPA/claims handling office for its current claims, but may have several TPA/claims handling offices that are handling past claims over various periods of time.

Each employer needs to specify what applies. If an employer has only one TPA/claims handling office that handles all past as well as present claims of the employer, it is not necessary to complete this form, since the same information is contained in Section D. However, the employer must still indicate such on this form by checking the appropriate box below.

[The Department strongly encourage all employers to have only one TPA/claims handling office for all past as well as current claims. This makes for easier claims administration for all parties.]

If an employer has different TPA/claims handling offices covering various time periods, the employer is to make copies of this form, one for each time period that a different TPA/claims handling office is responsible for.

Legal Name of Employer	City of Milwaukee
FEIN	39-6005532
UI	692137

Legal name of TPA (if applicable)	
TPA FEIN (if applicable)	

Please provide the address to which claims related correspondence should be sent.

Address Line 1	
Address Line 2	
City	
State	
Zip Code	
Name of claims processing person	
Title of claims processing person	
Voice telephone number	
Facsimile number	
Internet email address	

For what period of time is the above TPA/claims handling office responsible for claims?:

Begin Date: _____ End Date: _____

☑ **Check this box if**:
You as an employer have only one TPA/claims handling office that handles all past as well as present claims. The information contained in Section D of the Update form has been completed and is accurate. Please see Section D for our current TPA/claims handling office information.

The below shaded area is for DWD office use only:		
☐ Update ICMS:		
	Date of Update	Printed name of person updating ICMS
☐ Update Access:		
	Date of Update	Printed name of person updating Access

Please include this document when your return your annual update packet. Thank you.

AGREEMENT AND STIPULATIONS

For: City of Milwaukee
FEIN: 39-6005532

Employer agrees to the conditions and stipulations below to maintain their exemption privileges granted by the State of Wisconsin Department of Workforce Development (DWD). For corporations this statement must be signed by a corporate officer, authorized to enter into said agreement by the corporation, and have applicant's corporate seal affixed before consideration for exemption privileges will be given. Applications by organizations other than corporations shall be signed by one or more persons possessing authority to execute this application. DWD requires verification of authority of person(s) executing said agreement.

Failure to meet any conditions or stipulations indicated in this document or the Department's Order shall constitute grounds for revocation.

GENERAL CONDITIONS

In consideration of exemption from the insurance requirements of 102.28(2) Wisconsin Statutes, the employer agrees that it will:

A. Meet the conditions and stipulations which become part of the Department's exemption Order upon approval of DWD.

B. Discharge its liability to injured employees, their dependents and the State of Wisconsin in accordance with the requirements of all Wisconsin laws, including Chapter 102 and Administrative Code DWD 80.

C. Abide by Chapter 102 of the Wisconsin Statutes and DWD 80 of the Administrative Code, including the promptly furnishing of all reports to the DWD.

D. Notify DWD in any case of contemplated liquidation, sale or transfer of ownership, or material reduction in Wisconsin operation. Subject to DWD approval, the employer will arrange for the payment of all existing liability and any liability arising thereafter for which it may become legally liable, by guaranty bond, deposit of securities, or as otherwise required by DWD.

E. Notify DWD promptly and in writing of any of the following changes: change in corporate parent and/or subsidiary name; change in corporate and/or subsidiary address; change in corporate parent and/or subsidiary telephone numbers; changes related to corporate parent and/or subsidiary designated contact person, including name, address and telephone numbers, both voice and facsimile numbers; any unfavorable turn it its financial condition which is reasonably material to a reduced ability to carry its own risk under the Act, which shall include, but not be limited to, any of the following conditions:
   lowering of any bond rating
   notification by EPA (or similar state or federal agency) of any liability
   change in any of the following: parent and/or subsidiary corporate officers: CEO; President; CFO; COO; and Treasurer; and any change in the parent and/or subsidiary operating structure

F. Notify DWD promptly and in writing of any change in: claims handling person; claims processing location address; claims processing telephone and facsimile numbers; change in TPA (if applicable); and changes in excess or insurance companies that cover any entities of the company; changes of location addresses, location telephone numbers, location claims processing person(s) and their address and corresponding telephone numbers, both voice and facsimile..

G. Allow any injured employee to select a health care practitioner in accordance with the statutes.

H. Insure timely reporting of injuries and prompt payment of first indemnity so that both of these will be at or above the minimums required by Wisconsin Statute and Administrative Code.

I. Comply with all other Administrative Code, rules and orders of DWD.

J. If a publicly traded company, provide the DWD with a copy of its annual report to shareholders when published.

K. If a privately held company, provide the DWD with unaudited quarterly financial reports within 45 days of the end of its quarter and an audited annual financial report within 120 days from the end of its fiscal year.

L. Provide all security documents required in the exemption order.

AGREEMENT AND STIPULATIONS

EXCESS INSURANCE

DWD requires excess worker's compensation insurance. It must be procured from a licensed worker's compensation carrier. Policy form and rates must be on file with, and approved by, the Wisconsin Compensation Rating Bureau, PO Box 3080, Milwaukee, Wisconsin 53201-3080.

Paragraph 102.28(2)(d) provides "an employer who procures an exemption under par. (b) and thereafter enters into any agreement for excess insurance coverage with an insurer not authorized to do business in this state shall report that agreement to the Department immediately. The placing of such coverage shall not by itself be grounds for revocation of the exemption." This notification should be sent to DWD Worker's Compensation Division, Bureau of Insurance Programs, 201 East Washington Avenue, Post Office Box 7901, Madison, Wisconsin 53707-7901.

ASSUMPTION OF LIABILITY FOR FULLY INSURED UNITS

The employer assumes full responsibility under the Act to immediately make all compensation and medical expense payments as required by DWD pending determination of liability should a dispute arise between the insurance carrier and the employer as to responsibility in any injury case.

SIGNATURE

The employer makes this application with the knowledge that: self-insurance ends on the date specified in the Order; DWD may rescind (not renew) an exemption from the duty to insure by giving 60 days written notice to the employer; DWD may revoke the exemption from the duty to insure after giving 10 days written notice to the employer. The revocation can be initiated when the Department determines that: the employer's financial condition is inadequate to pay its employee's claims for compensation; the employer has received an excessive number of claims for compensation; the employer has failed to faithfully discharge its obligations according to the agreement and information provided in the application for exemption; the employer has provided false or misleading information in any documents attached to or associated with the Initial/Renewal Application for Self-Insurance; the employer fails to comply with any other terms or conditions listed in the Agreement and Stipulations. The revocation orders by the Department can be appealed as outlined in Section 102.28(2)(c) of the Statutes. Rescinding or not renewing an employer's exemption from the duty to insure is discretionary action by DWD and is not appealable.

_____
(Employer Name)

Place Corporate Seal Here

If no seal, write "none"

SIGNED BY: _____
(Corporate Officer)

_____
(Official Position)

STATE OF _____)
)SS.
_____COUNTY)

(The person signing the application above and subscribing the affidavit below must be the corporate President, Vice President, Secretary or Treasurer, or the corporation Assistant Secretary or Assistant Treasurer Treasurer if authorized by articles of incorporation to make this application.)

AFFIDAVIT

_____, being duly sworn, says that he/she is the person who signed this application, and that he/she is acquainted with the affairs of the applicant employer, to which the statements set forth in the application relate. He/she has read the application, understands its contents and certifies that all statements contained in the application are true to the best of his/her knowledge, information and belief.

_____ _____
(Affiant's Signature) (Official Position)

Subscribed and Sworn to before me at _____, _____

on this date: _____.

_____
(Notary Public)

Place Seal Here

_____
(Date Commission Expires)