Annual Report to State Risk Manager HW

Individual Health & Welfare Self-Insurance Programs
Form B - Financial Information

Instructions to **INDIVIDUAL health & welfare self-insurance programs only**

To complete the State Risk Manager's - Health & Welfare annual report Form B, please:

1. Complete sections of Form A as instructed.
2. After completing, please submit Form A as an **email attachment** to Shannon.stuber@des.wa.gov.
3. **Individual programs ONLY** - Continue to Form B and complete as instructed.
4. After completing Form B, please submit by clicking on the "Submit by Email" button at the bottom of Form B. **Do not send as an email attachment.**
5. No other information is required.
6. If questions, please contact Shannon Stuber, 360-280-4280.

Program information:

Entity Name (City, County, etc.):

Entity Type (select one):

Entity Type (if Other):

Street Address:

City:

State: WA

Zip Code:

Person responsible for program:

Last Name:

First Name:

Phone Number:

Email:

Fiscal year end date:

Individual programs: Submit the end of year financial information for all benefits offered. Programs should report on an accrual basis (include expenses incurred during the period, regardless of whether they are paid after the year ends). ***Amounts reported should coincide with the financial reports and notes as provided to the State Auditor's Office annually.***

Benefit Program Type		Medical	Dental	Vision	RX	Other
		Please enter amounts to the nearest dollar.				
1. Beginning Program Deposits/Assets (balance at end of prior year)	$					
2. *List the annual program contributions:*						
2.a Employer Contributions	$					
2.b Employee Contributions	$					
2.c Other Revenues	$					
2.d Other Reimbursements	$					
3. Total Projected Annual Contributions/ Revenues/Reimbursements (2.a to 2.d)	$					
		Medical	**Dental**	**Vision**	**RX**	**Other**
4. *List the annual program expenses:*						
4.a Claim Payments	$					
4.b TPA Expenses	$					
4.c Broker Fees	$					
4.d Stop Loss Insurance	$					
4.e Wellness Program Expenses	$					
4.f Other Expenses	$					
5. Total Annual Expenses (4.a to 4.f)	$					
		Medical	**Dental**	**Vision**	**RX**	**Other**
6. Interest Income Earned	$					
7. Funds transferred into program from other sources	$					
8. Funds transferred from program for other purposes	$					
9. Program Reserves/Assets at End of Year (1 plus 3 less 5, then add 6 and 7 minus 8)	$					
10. Does entity purchase aggregate stop loss policy coverage for medical program?		◯ Yes	◯ No			
10.a If so, what is the percent of expected claims at which the aggregate stop loss insurance begins to pay claims?	%					
10.b Average number of employees enrolled per month in program						
10.c Average number of dependents enrolled per month in program						

Certification (To be completed by ***all*** self-insurance programs submitting this report)

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

Name of Local Government Representative Completing Report

Position

Entity Represented

Submit by Email

Print form for your records