OKLAHOMA INSURANCE DEPARTMENT

Insurance Commissioner, Glen Mulready

400 NE 50th Street
Oklahoma City, OK 73105
405.522.2828
oid.ok.gov

Pursuant to Title 40 Section 600.4(1) "***Each PEO or PEO Group required to be registered under the Oklahoma Professional Employer Organization Recognition & Registration Act shall provide the Insurance Commissioner with information required by the Commissioner on forms prescribed by the Commissioner".***

PEO Name: ____

1. How does your organization satisfy the Oklahoma statutory Workers' Compensation requirement for your PEO clients pursuant to Title 40 O.S. 600.7(C)(4)? ____
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2. If the answer to Question No. 1 is "purchase of insurance", whether subject to the Oklahoma Administrative Workers' Compensation Act (AWCA) or as a Qualified Employer under the Oklahoma Employee Injury Benefit Act (OEIBA) please provide the following information:

   a. Name of Insurer: ____
   b. Policy Effective and Expiration Dates: ____
   c. Policy Number: ____
   d. Additional Insured's, if any (**attach list**): ___________________________________
   ____
   ____

   (Oklahoma considers a PEO Client to be an additional insured or one who would be endorsed onto the PEO's Workers' Compensation Policy via an Alternate Employer Endorsement. This will be a list of clients whom your PEO is contractually obligated to maintain workers' compensation coverage for. If such responsibility is specifically allocated to the PEO Client by "agreement", please provide this information.)

   e. Claims Administrator, if other than Insurer: _______________________________________
   f. Experience Modifier: ____
   g. Deductible Amount and Collateral Requirements (provide specific details): _______________
   ____
   ____
   h. Annual Premium: ____
   i. Number of Co-Employers: ____
   j. Number of Covered Employees: ____

****Please furnish the OID with this same information as to each insurer that provided insurance to your covered employees for the past 3 years.**

3. If the answer to Question No. 1 was "self-insurance" or "self-funded", whether subject to the ASCA or the OEIBA, please provide the following information:

   a. Name of Principle Self Insured Employer: ____

   b. Effective Date and number of Self-Insured Permit issued by the Workers' Compensation Commission: ____________

   ____

   c. Additional Self-Insured, if any (**attach list**): ____

   ____

   d. Claims Administrator (name and contact information): ______________________________________

   ____

   e. Retention: ____

   f. Excess Insurer(s): ____

   g. Excess Coverage:____

   h. Annual Average of Total Compensation Claims Paid during the past 3 years: ___________________________

   ____

   i. Number of Co-Employers: ____

   ____

   j. Number of Covered Employees:____