



**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 Legal Name: \_\_\_\_\_ FEIN: \_\_\_\_\_

1. How does your organization satisfy the Oklahoma statutory Workers' Compensation requirement for your PEO clients pursuant to [Title 40 O.S. 600.7\(C\)\(4\)](#)?

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

2. If the answer to Question No. 1 is "purchase of insurance", subject to the Oklahoma Administrative Workers' Compensation Act (AWCA) please provide the following information (*furnish this same information for each insurer that provided insurance to your covered employees for the past 3 years and attach additional list if needed*):

a. Name of Insurer: \_\_\_\_\_ NAIC License #: \_\_\_\_\_

b. Policy Effective and Expiration Dates: \_\_\_\_\_

c. Policy Number: \_\_\_\_\_

d. Additional Insureds, if any (*attach additional list if needed*):

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

***(NOTE: 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 include 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: \_\_\_\_\_

3. If the answer to Question No. 1 was “self-insurance” or “self-funded”, subject to the ASCA, 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

[https://www.ok.gov/wcc/Permitting\\_Services/index.html](https://www.ok.gov/wcc/Permitting_Services/index.html):

\_\_\_\_\_

c. Additional Self-Insured if any (**attach additional list if needed**):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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: \_\_\_\_\_