

INSTRUCTIONS FOR FORM IC-211
SELF-INSURED EMPLOYER REPORT OF TOTAL UNPAID LIABILITY

The total unpaid liability on all open claims on which compensation is payable under the provisions of the Idaho Workers' Compensation Law, must be reported on this form semi-annually and submitted by the last day of January and the last day of July. Form IC-211 must provide the aggregate number of open claims, including indemnity with medical and medical only claims. In order to accurately report total unpaid liabilities as required by the rule, self-insured employers must maintain all claims with known unpaid future medical or indemnity benefits as open claims; with the anticipated unpaid liability amounts accounted for and reported in the total incurred and total unpaid columns of the report form. Please round amounts to the nearest dollar. The report must be filed even if there are **BC CD9B 7@5-AG**, and must be signed and certified by a corporate officer. The Form IC-211 is an interactive report found on the Industrial Commission website which may be completed, then printed and submitted.

HEADING: ENTER NAME OF SELF-INSURER EMPLOYER, YEAR AND SELECT SEMI-ANNUAL DATE

COLUMN 1: TOTAL NUMBER OF OPEN CLAIMS
Enter the number of all open claims as of the "snapshot" reporting date.

COLUMN 2: TOTAL INCURRED MEDICAL ONLY
Enter the total incurred liability on all Medical Only claims. Total incurred Medical Only amounts to be reported include all paid and anticipated unpaid liabilities including medical, and allocated expenses if incurred, as of the snapshot reporting date.

COLUMN 3: TOTAL PAID MEDICAL ONLY
Enter the total dollar amount paid on Medical Only claims reported in column 2 as of the snapshot reporting date.

COLUMN 4: TOTAL UNPAID MEDICAL ONLY
Enter the dollar amount of the unpaid portion of the total incurred liability reported in Column 2 (Column 2 minus Column 3).

COLUMN 5: TOTAL INCURRED INDEMNITY (INCLUDING MEDICAL)
Enter the total incurred liability on all Indemnity Claims. Total incurred Indemnity amounts to be reported include all paid and anticipated unpaid liabilities including both medical and indemnity, and vocational or allocated expenses if incurred, as of the snapshot reporting date.

COLUMN 6: TOTAL PAID INDEMNITY INCLUDING MEDICAL
Enter the total dollar amount paid on all Indemnity claims reported in column 5 as of the snapshot reporting date.

COLUMN 7: TOTAL UNPAID INDEMNITY INCLUDING MEDICAL
Enter the dollar amount of the unpaid portion of the total incurred liability reported in column 5 (Column 5 minus Column 6).

COLUMN 8: TOTAL UNPAID LIABILITY
Enter the total amount of unpaid liability for all Medical Only and Indemnity claims. (Column 4 plus Column 7).

TOTAL UNPAID LIABILITY FROM COLUMN 8

Enter the amount that was calculated on the interactive report form in column 8, above.

**INSTRUCTIONS FOR FORM IC-211
SELF-INSURED EMPLOYER REPORT OF TOTAL UNPAID LIABILITY (cont.)**

EXCESS INSURANCE CARRIER REIMBURSEMENT EXPECTED

If the self-insured employer has coverage under an excess/reinsurance policy for payment or reimbursement of any portion of the amount reported in Column 7 above, that expected reimbursement must be entered on this line. This amount should agree with the Total Amount from Column 8 below. A copy of the **full and complete** excess insurance policy must be submitted with the Form IC-211 for consideration of coverage credit toward the security deposit requirement.

NET REMAINING UNPAID LIABILITY

Enter the difference between the Unpaid Liability and the Excess Carrier Reimbursement Expected.

EXCESS CARRIER REIMBURSEMENT DETAIL:

The self-insured employer will complete this section of the Form IC-211 only if reimbursement is expected from an excess insurance carrier. Each claimant that receives benefits from the excess carrier must be listed individually in this section. In addition to the amounts reported, the self-insured employer may receive a credit toward the security deposit requirement for Total Unpaid Liability when a copy of the applicable excess insurance policy is also provided.

COLUMN 1: DATE OF INJURY

Enter the date the workers' compensation injury occurred.

COLUMN 2: EMPLOYEE'S NAME

Enter the full name of the injured worker.

COLUMN 3: TOTAL MEDICAL & INDEMNITY INCURRED

Enter the total dollar amount for incurred and anticipated unpaid liabilities relating to each employee's injury.

COLUMN 4: TOTAL MEDICAL & INDEMNITY PAID

Enter the total dollar amount that has been paid on behalf of each claim. This amount should include everything paid by both the self-insured employer and the excess insurance carrier.

COLUMN 5: EXCESS CARRIER NAME

Enter the name of the carrier that has written the excess insurance policy.

COLUMN 6: SPECIFIC RETENTION LIMIT

Enter the specific dollar retention limit from the excess insurance policy that covers this claim.

COLUMN 7: EXCESS REIMBURSEMENT OBTAINED

Enter the dollar amount of reimbursement that has been received from the excess insurance carrier on behalf of the injured workers' claim.

COLUMN 8: EXCESS REIMBURSEMENT EXPECTED

Enter the dollar amount that you expect the excess insurance carrier to pay on each claim. (Equals the sum of column 3 minus column 6 minus column 7.)

SELF-INSURED'S AUTHORIZATION AND VALIDATION

The IC-211 form must be signed and certified by a corporate officer. The signature does not require a notary. The preparer should be the contact person able to respond to follow-up questions regarding the information reported.

IC-211, SELF- INSURED EMPLOYER REPORT OF TOTAL UNPAID LIABILITY

(Name of Self-Insured Employer)

Calendar Year: _____

For Calendar Semiannual Period Ending and As Of: June December

(1) Total Number Of Open Claims	(2) Total Incurred Medical Only	(3) Total Paid Medical Only	(4) Total Unpaid Medical Only (2 - 3 = 4)	(5) Total Incurred Indemnity incl medical	(6) Total Paid Indemnity incl medical	(7) Total Unpaid Indemnity incl medical (5 - 6 = 7)	(8) Total Unpaid Liability (4 + 7 = 8)
	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

Note: Report Open Claim Totals for All Previous Periods of Self Insurance in Idaho.

Total Unpaid Liability from Column 8: \$ _____

Excess Insurance Carrier Reimbursement Expected: \$ _____

Net Remaining Unpaid Liability: \$ _____

Note: Credit for Excess Insurance is contingent upon meeting criteria acceptable to the Idaho Industrial Commission.

Excess Carrier Reimbursement Detail:

(1) Date Of Injury	(2) Employee's Name	(3) Total Medical & Indemnity Incurred	(4) Total Medical & Indemnity Paid	(5) Excess Carrier Name	(6) Specific Retention Limit	(7) Excess Reimbursement Obtained	(8) Excess Reimbursement Expected (3 - 6 - 7 = 8)

Total: \$ _____

Self-Insurer's Authorization and Validation

I, _____, certify that the above information is true and correct to the best of my knowledge.

Corporate Officer's Signature

Printed Name and Title

Date: _____

Report Preparer's Validation:

I, _____, attest that the above information is valid and truthful to the best of my knowledge

Company: _____

Telephone: _____

Address: _____

Send Original to: Fiscal Section, Industrial Commission, P.O. Box 83720, Boise, Idaho 83720-0041

Form IC-211
V3.0 11/20/15

If you need assistance, please contact one of the following Financial Specialists:

Alan Pace at (208) 334-6083 or Shelly Tudela at (208) 334-6026.