Commonwealth of Pennsylvania
Department of Labor & Industry
Bureau of Workers' Compensation
Health & Safety Division
Report Processing & Audit Section
1171 S. Cameron St, Rm 324
Harrisburg, PA 17104-2501
(717) 772-1636

COMMONWEALTH OF PENNSYLVANIA
INSURER'S INITIAL REPORT OF
ACCIDENT & ILLNESS PREVENTION SERVICES

This report must be included with the application for licensure to write Workers' Compensation in the Commonwealth of Pennsylvania.

An entry must be made for each question. Use an N/A or zero when appropriate.
(***Before*** completing, please refer to the accompanying instructions. Please print or type all information.)

Please note: this form may ***NOT*** be altered in any way

Report for Application Year 20____

FEIN: | | | | | | | | | | |

NAIC: | | | | | |

I. Insurer Name: (Please see instructions on Page 4)

II. Mailing Address: Street, P. O. Box, City, State, and Zip Code

III. Is the Insurer prepared to notify policyholders of the availability of accident & illness prevention services?

( ) Yes [If "Yes," attach sample copies of all notifications. Label as Item #3].

( ) No [If "No," indicate date when policyholders will be notified of the availability of accident & illness prevention services]

Date: _____

IV. Which of the following methods will be utilized in determining service commitments?

- ☐ a. Policyholder Request
- ☐ b. Loss History
- ☐ c. Loss Ratio
- ☐ d. Incurred Losses
- ☐ e. Paid Losses
- ☐ f. Underwriter Request
- ☐ g. Broker Request
- ☐ h. Standard Industrial Classification (SIC) Code/NAICS Code
- ☐ i. Experience Modification Factor
- ☐ j. Other (Explain – Identify as Item IV j on additional sheets)

V. Will policyholder on-site hazard surveys be conducted for the purpose of determining accident and illness prevention service(s) needs?

( ) Yes ( ) No [If "No", attach explanation as to how policyholder service needs will be determined.]

VI. Check (X) the types of accident & illness prevention services that will be made available and/or provided under Column I, and then check whether they will be made available and/or provided by Insurer's qualified service providers or qualified contracted service providers:

		COLUMN I	COLUMN II Insurer's Providers	COLUMN III Contracted Providers
a.	On-Site Surveys	_____	_____	_____
b.	Hazard Identification	_____	_____	_____
c.	Accident Cause Analysis	_____	_____	_____
d.	Safety Committee Certification Training	_____	_____	_____
e.	Industrial Hygiene Services	_____	_____	_____
f.	Industrial (Occupational) Health Services	_____	_____	_____
g.	Safety Training	_____	_____	_____
h.	Pre-Operational Process Reviews	_____	_____	_____
i.	Policyholder Program Review	_____	_____	_____
j.	Other [Explain – Identify as Item IV (j) on additional sheets]	_____	_____	_____

VII. Indicate the types of accident & illness prevention materials to be provided to policyholders: [check (x) all that apply]:

( ) a. Audiovisual Material
( ) b. Poster/Payroll Stuffers
( ) c. Booklets, Brochures, Pamphlets
( ) d. Regulations/Standards
( ) e. Sample Forms
( ) f. Sample Programs
( ) g. Awards
( ) h. Other [Explain – Identify as ITEM VII (h) on additional sheets]

VIII. Which of the following method(s) will be used to determine the effectiveness of the accident & illness prevention services: [check (x) the method(s) to be used]:

( ) a. Incidence Rate Comparison
( ) b. Recommendations Closed
( ) c. Incurred Losses
( ) d. Satisfaction Surveys
( ) e. Loss Ratio Comparison
( ) f. Experience Modification Factor
( ) g. Other [Explain – Identify as ITEM VIII (g) on additional sheets.

NOTE: The following *must* be filled out *completely*, signed and dated.

I, the undersigned, verify that the facts set forth in this report and any attachments are true and correct. This verification is made subject to the penalties of Section 4904 of the *Crimes Code*, 18 Pa.C.S. §4904, relating to unsworn falsification to authorities.

Point of Contact Name (Please Print) **	Title	( ) Telephone

Email address

Signature

Date

(Please attach additional sheets, where necessary, labeled with appropriate form, section number and letter)

Send this Completed Report along with other application package material to:

Mr. William A. Keefer, Manager
Pennsylvania Department of Labor & Industry
BWC – Health & Safety Division
Report Processing & Audit Section
1171 S. Cameron Street, Room 324
Harrisburg, PA 17104-2501
Telephone Number: (717) 772-1636

Contact Person Name and Telephone Number of Person Signing this Form is ***necessary* in case additional information is needed.

Please note: this form may ***NOT*** be altered in any way

Instructions for Completing Form LIBC-211I

INSURER'S INITIAL REPORT OF ACCIDENT & ILLNESS PREVENTION PROGRAM

This form ***must*** be filed with the Pennsylvania Insurance Department when submitting the application for licensure to write workers' compensation insurance in the Commonwealth of Pennsylvania. This form ***may not*** be altered.

NOTE: The term *Accident & Illness Prevention Services* as described in the Pennsylvania Workers' Compensation Act is synonymous with the terms *Safety and Health Program,* and *Loss Control Program.*

FEIN: (Federal Employer Identification Number), NAIC (National Association of Insurance Commissioners Code)

Enter the Federal Employers Identification Number (FEIN) and the National Association of Insurance Commissioners number assigned to your organization.

ITEM 1: Provide the full name of the insurance carrier. A separate report is required for each company applying for a license for Workers' Compensation authority from the Pennsylvania Insurance Department.

ITEM 2: Provide the complete **mailing address** of the Insurance Carrier.

ITEM 3: Mark with a (x) "Yes" or "No" regarding Policyholder Notification of Accident & Illness Prevention Services. If the insurer has a prepared Policyholder Notice of availability of Accident & Illness Prevention Services, "**YES**" should be checked. Identify the Notice as ITEM #3, and attach a copy of the Notice to the report. *(The Pennsylvania Workers' Compensation Act* [Section 1001 (d) requires that: "Insurers notify policyholders of the availability of Accident & Illness Prevention Services; that this notification be in at least **10 point bold print;** and that the notification accompany each workers' compensation insurance policy delivered or issued for delivery in the Commonwealth". If "**NO**" is checked, you must indicate when the Notice will be available. It is suggested that a copy of the Policyholder Notification be forwarded to the Health and Safety Division for review prior to issue.

ITEM 4: Mark with a (x) the method(s) to be utilized for determining Policyholder Accident & Illness Prevention Service(s) commitments. Method(s) could include, but not be limited to: (a) policyholder request; (b) loss history; (c) loss ratio (incurred losses/earned premium); (d) incurred losses; (e) paid losses; (f) request by underwriters as a component of coverage; (g) policyholder request; (h) request by brokers as an account agreement; (i) insurer schedule by policyholder SIC Code; (j) experience modification factor: a factor developed by the **P**ennsylvania **C**ompensation **R**ating **B**ureau that apportions the cost of workers' compensation insurance based upon losses reported, a modifier of <1 usually indicates favorable loss experience; or (k) other method, please use an attached sheet identified as ITEM #4(k).

ITEM 5: Respond "YES" or "NO" regarding the use of the on-site hazard identification surveys as the means to determine Policyholders Accident & Illness Prevention Service(s) needs. If "**NO**" is checked, you must attach an explanation as to how you will determine policyholder Accident & Illness Prevention Service(s) needs.

ITEM 6: Mark with a (x) under Column I, the types of Accident & Illness Prevention Services that you are in a position to **Maintain** or **Provide** for Policyholders. (The Accident & Illness Prevention Services listed under the "SERVICE" heading are the minimal that an Insurer must be in a position to maintain or provide for Policyholders as a prerequisite for a license to write Workers' Compensation Insurance within this Commonwealth.) Indicate in Column II and/or Column III, whether insurers in-house qualified employee services providers, or qualified contracted services providers, will provide these services.

ITEM 7: Mark with a (x) the type(s) of Accident & Illness Prevention material(s) that will be provided to policyholders.

ITEM 8: Mark with a (x) the internal method(s) to be utilized in determining the effectiveness of Accident & Illness Prevention Service(s). Methods could include, but are not limited to: (a) comparisons of incidence rates as calculated by the policyholder or insurer; (b) submitted recommendations that are considered closed; (c) comparisons of the number of incurred or paid losses for a specific period; (d) results of customer satisfaction surveys; (e) comparison of loss ratios for a specific period; (f) experience modification factor; (g) other method, please explain using an attached sheet identified as ITEM #8 (g).

(Please attach additional sheets, where necessary, labeled with the appropriate form, section number and letter.)