COMMONWEALTH OF KENTUCKY
Department of Insurance
P .O. Box 517
Frankfort, Kentucky 40602-0517

Property & Casualty Division
Workers' Compensation
Self-Insured Group
Face & Verification Form

WORKERS' COMPENSATION SELF-INSURED GROUP INFORMATION

NAME _____ **KOI #** _____ **LETTER DATE** _____

FILING INFORMATION AND STATEMENT

LINE OF INSURANCE E **TYPE OF FILING:** **RATE &/OR RULE** ☐ **FORM** ☐

FILING FEE: _____ **FILING BASIS:** **PRIOR APPROVAL** ☐ **USE & FILE** ☐

I CERTIFY THAT I HAVE BEEN AUTHORIZED TO MAKE THIS FILING AND THAT THE INFORMATION PROVIDED ON THE SYNOPSIS FORMS AND OTHER SUPPLEMENTARY AND SUPPORTING INFORMATION IS ACCURATE AND APPROPRIATE.

SIGNATURE _____ **TITLE** _____ **DATE** _____

ATTACH THIS FORM AS THE FIRST PAGE OF EACH DOCUMENT SET OF THE TWO DOCUMENT SETS REQUIRED. INCLUDE A THIRD COPY OF YOUR COVER LETTER WITH A SELF-ADDRESSED, STAMPED ENVELOPE FOR RETURN.

FOR DEPARTMENT USE ONLY

	REMARKS	ANALYST	CASHIER STAMP
ATTACH FILING FEE HERE		LOG-IN STAMP	
		ACTION STAMP	MAIL ROOM STAMP

WC SIG: F-1A P&C (3/2005)