



Group Fund: Submitting an Annual Report

This guide demonstrates the process of submitting an Annual Report for Group Fund users/organizations.

Select Self Insurance then Self Insurance Program.

Self-Insurance Program Summary

Group Fund: Example Organization

PROGRAM INFORMATION

Manage Program Applications and Reports Documents and Correspondences Program History Security and Funding Contact History

View SI Group Fund Profile

Applications and Reports In Progress (1)

Application Type ↑	Due Date ↓	Application Status ↑
Group Annual Report	05/31/2025	Not Started

Select the Group Annual Report link.



Annual Report Tab

Group Annual Report

PROGRAM INFORMATION

Group Fund: Example Organization [View SI Program Summary](#)

Status	Start Date	Fund Type	Insurer Code
Active	10/01/1992	Public Employers	5500

Note: The system navigates to the Annual Report tab and displays the SI Group Fund Member table.

Annual Report | Health & Safety | Certify

The table contains the active members of your Self-Insurance Group Fund. If you would like to modify your fund's membership, click [here](#) to access the Program Summary where you may add new members or terminate existing members from your program.

Member ↓	FEIN ↓
FIRST LAST	000000000
BUSINESS NAME LLC	123456789
SIGNAGE LLC	987654321
LOCAL BANK	111111111
COFFEE SHOP LLC	123123123

Showing 1 - 5 of 281

Complete the Required information.

Click [here](#) to access 34 Pa. Code, Chapter 125, Subchapter B, the regulations governing applications for and the operations of group self-insurance funds in Pennsylvania.

Annual Compensation Payment Data

Year of Payment: 2024

Total Indemnity Benefits Paid (required)
\$

Total Medical Benefits Paid (required)
\$

Total Compensation Paid

- Total Compensation Paid must equal sum of Indemnity Benefits Paid and Medical Benefits Paid (or differ by at most \$1 due to rounding).
- A calendar Year should include all payments from January 1st to December 31st.
- Compensation paid as part of a full wage or salary program must be separated and the applicable compensation rate included as Indemnity Benefits paid.
- The required 'Year of Payment' announced above will be the most recent calendar year if this application is due after April 30th, but will be the 2nd most recent calendar year if due before April 30th.



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Annual Report Tab (Cont'd)

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Application Attachments

Upload the following attachments:

1. Complete and upload the LIRC-365 Group Self Insurance Fund Annual Report, available here.
2. Complete and upload the LIRC-810 Claims Listing, available here.
3. Complete and upload the Claim Count Loss Year tables template, available here.
4. The Fund's audited financial statements for its prior year prepared by a certified public accountant in accordance with generally accepted accounting principles.
5. A report certified by an independent actuary projecting the value of the Fund's ultimate and outstanding liability by fund year.
6. Upload an excel spreadsheet which contains each dollar amount loss triangle and each of the claim count triangles from the independent actuarial report being submitted with this annual report. For each triangle, state the corresponding page location in the independent actuarial report. [A complete Guidelines for Group Self-Insurance Actuarial Valuations are available here.](#)
7. A schedule of the dividends which the fund plans to return to its members within the next year. Such a schedule must be accompanied by a recommendation from an independent actuary (which might be via exhibits) that the dividends proposed will not impair the fund's ability to meet its obligations and that the dividends will comply with the other requirements of Section 809 of the Workers' Compensation Act. If the fund is not planning to issue dividends at this time, a statement to that effect should be submitted as the attachment. The dividends which the fund proposes can be less than what the independent actuary recommended. Based upon changing facts and circumstances, the dividends which the fund later actually chooses to return to members can be less than what amount the Bureau approved.
8. Group Self-Insurance Fund Surplus Exhibit: [Click here for a sample of an acceptable surplus exhibit.](#)

Upload Documents

Upload Document

1. Select the **links (1, 2 & 3)** to download the documents. You will need to complete the documents outside of the system before uploading them back into WCAIS (Step 2).

Note: Additional documentation must also be provided as listed in numbers 4-8.

2. Press **Upload Document**.

3. Select the **Document Sub Category** from the dropdown

4. Select the **Document Type** from the dropdown.

5. Press **Browse** to locate file.

6. Press **Upload**. Repeat this process until all documents are uploaded.

Upload Document

Document Sub Category: Attachments

Document Type: - Select One -

Upload Document (Uploaded documents may not exceed 10MB)

No file selected | Browse

Document Description

0 / 500 characters

Upload



Annual Report Tab (Cont'd)

Press **Upload** to repeat this process from the previous page until all documents are uploaded.

Upload Documents

Document successfully uploaded! If this screen contains a Submit/Save/Continue button, please click button to finalize the upload. Scroll down to verify.

Upload Document

Note: The Uploaded Documents table displays each document that has been included into the report.

Uploaded Documents (7)

Document Type	Document Description	Submitted Date	Submitted By	Submission Method	Batch Number	Action
LIBC-810 Claims Listing Excel Template		06/27/2025	Last First	Online		
Actuarial Report		06/27/2025	Last First	Online		
Financial Statements		06/27/2025	Last First	Online		
Dollar Amount Loss Triangle		06/27/2025	Last First	Online		
LIBC-365 Group Self Insurance Fund Annual Report		06/27/2025	Last First	Online		
Surplus Exhibit		06/27/2025	Last First	Online		
Claims Loss Year Tables	Test description	06/27/2025	Last First	Online		

Showing 1 - 7 of 7

Associated Documents (0)

Document Type	Document Description	Submitted Date	Submitted By	Submission Method	Batch Number
There are no records to show					

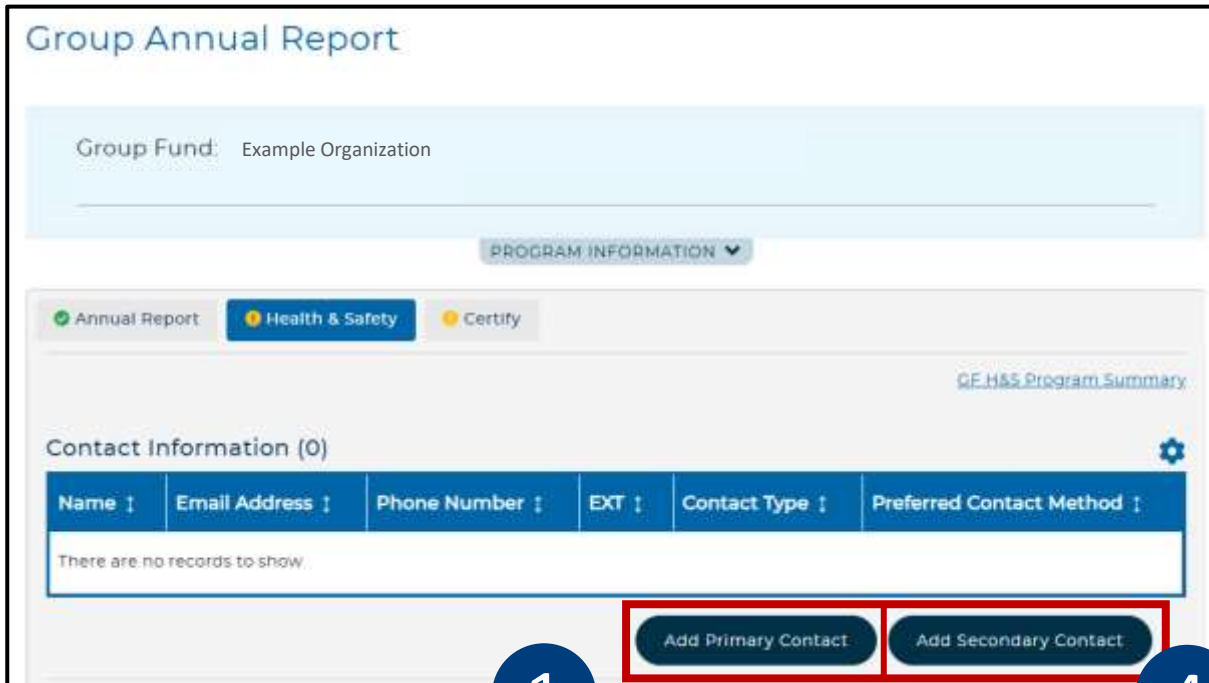
Cancel

Save As Draft

Save And Continue

Press **Save and Continue**.

Health & Safety Tab



Group Annual Report

Group Fund: Example Organization

PROGRAM INFORMATION

Annual Report | **Health & Safety** | Certify

[QE HSS Program Summary](#)

Contact Information (0)

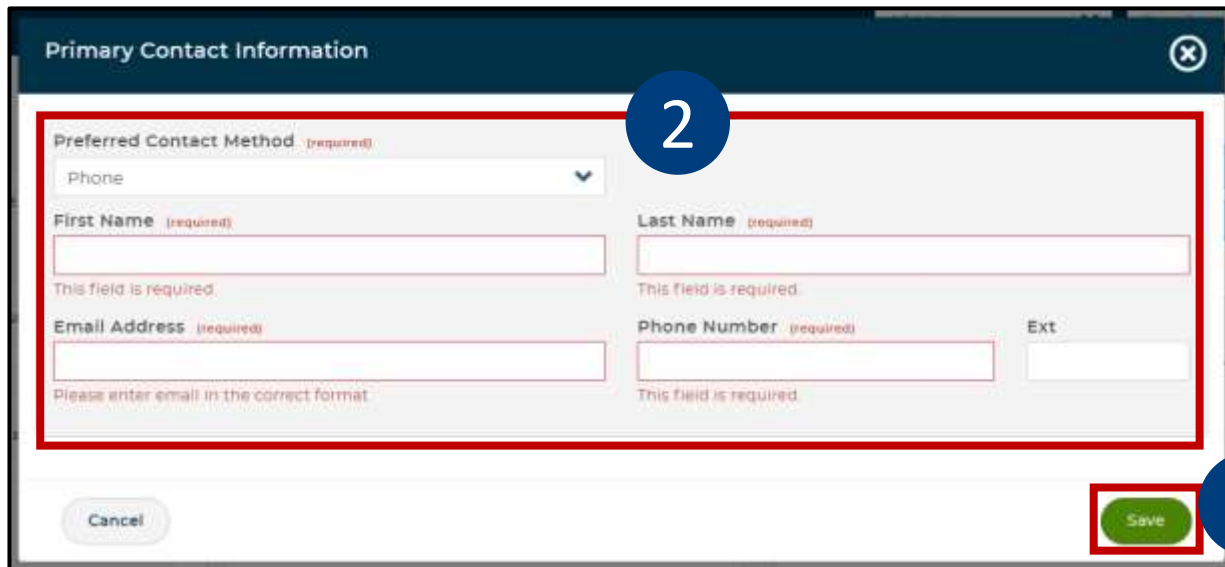
Name	Email Address	Phone Number	EXT	Contact Type	Preferred Contact Method
There are no records to show.					

Add Primary Contact | Add Secondary Contact

1. Press **Add Primary Contact**.

1

4



Primary Contact Information

Preferred Contact Method (required)
Phone

First Name (required)
This field is required.

Last Name (required)
This field is required.

Email Address (required)
Please enter email in the correct format

Phone Number (required)
This field is required.

Ext

Cancel | Save

2

3

2. Complete the **Required** information.

3. Press **Save**.

4. Repeat the process for the **Secondary Contact**.



Health & Safety Tab (Cont'd.)

Contact Information (2)

Name	Email Address	Phone Number	EXT	Contact Type	Preferred Contact Method	Actions
Penn, William	firstlast@email.com	(321) 555-5555		Primary	Phone	
Franklin, Benjamin	testertestington@test.com	(321) 555-0000		Secondary	Email	

Showing 1 - 2 of 2

1. Member Information

1a. Total Number of Members Affiliated with the Group Self-Insurance Fund (required)

1b. Total Number of Members Receiving Accident & Illness Prevention Services (required)

1c. Total Amount Spent on Accident & Illness Program Services (required)

\$

1

- 1. Complete the **Required Member Information.**
- 2. Complete the **Required Service Request Information.**
- 3. Select the applicable **checkbox(es).**

2. Service Request Information

2a. Total Number of Requests for Program Services Received (required)

2b. Total Number of Service Requests that were Fulfilled (required)

2c. Number of Member Service Requests Fulfilled Via Service Visits (required)

If 2b is less than 2a, please explain

0 / 3000 characters

2

3. Program Services Commitments Information

Methods utilized for determining program services commitments (at least one required)

- a. Member Contributions (%)
- b. Member Request
- c. Loss History
- d. Incidence Rate
- e. First Report Rate
- f. Incurred Losses
- g. Paid Losses
- h. Fund Administrator Request
- i. Annual Inspection
- j. Other

Please describe Other methods.

3



Health & Safety Tab (Cont'd)

4. On-Site Inspection Information

Number of On-Site Inspections performed (Include follow-up inspections) (required)

Complete the
Required
information.

5. Accident & Illness Prevention Program Elements and Services Information

Select the Elements/Services Contained within your Accident and Illness Prevention Program that are developed, implemented, and monitored by the fund. Elements 1 through 13 are considered mandatory by the Pennsylvania Workers' Compensation Act. The procedures and activities described in item 14, i through xi, are applicable only on an individual employer need basis.

Elements and Services

- 1. Safety Policy Statement (required)
- 2. Designated A&IP Program Coordinator (required)
- 3. Assignment of Responsibilities for Developing, Implementing, and Evaluating the A&IP Program (required)
- 4. Program Goals and Objectives (required)
- 5. Employee Involvement Methods (required)
- 6. Employee Accident & Illness Prevention, Suggestion and Communications Program (required)
- 7. Methods for Accident Investigation and Reporting and Recordkeeping (required)
- 8. Onsite Surveys to Identify Existing or Potential Accident and Illness Hazards or Safety Program Deficiencies (required)
- 9. Analyses of the Causes of Accidents and Illnesses at the Members' Worksite (required)
This field is required.
- 10. Providing or Proposing Corrective Actions in the Area of Industrial Hygiene Services (required)
This field is required.
- 11. Providing or Proposing Corrective Actions in the Area of Industrial Health Services (required)
This field is required.
- 12. Accident and Illness Prevention-Training Programs (required)
This field is required.
- 13. Consultations Regarding Specific Safety and Health Problems and Hazard Abatement Programs and Techniques (required)
This field is required.

Select each
checkbox (1-13).



Health & Safety Tab (Cont'd)

Select the applicable
checkbox(es).

Protocols and Standard Operating Procedures

14. Protocol or Standard Operating Procedures, when applicable to the Workplace and Workplace Environments for

- i. Electrical and Machine Safeguarding ⓘ
- ii. Personal Protective Equipment ⓘ
- iii. Hearing and Sight Conservation ⓘ
- iv. Lockout/Tagout Procedure ⓘ
- v. Hazardous Material Handling, Storage and Disposal Procedures ⓘ
- vi. Confined Space Entry ⓘ
- vii. Fire Prevention and Control ⓘ
- viii. Substance Abuse Awareness and Prevention Policies and Programs ⓘ
- ix. Control of Exposure to Bloodborne Pathogens ⓘ
- x. Preoperational Process Review ⓘ
- xi. Other. Other protocols as may be Appropriate for the Group Self-Insurance Fund's Operations ⓘ

6. Accident & Illness Prevention Materials Information

State the Types of Accident & Illness Prevention Materials Provided to Members. (at least one required)

- a. Audio-Visual Material
- b. Posters/Payroll Stuffers
- c. Booklets, Brochures, Pamphlets
- d. Regulations/Standards
- e. Sample Forms
- f. Sample Programs
- g. Awards
- h. Other

Description of Other Materials



Health & Safety Tab (Cont'd)

i. What is the Cost of these Materials

\$

7. Accident & Illness Prevention Program Effectiveness Measures

6. Which of the following method(s) are used to determine the effectiveness of the Program?

Your North American Industry Classification System (NAICS) Code (required)

PRIOR FISCAL YEAR [View Historical Data](#)

I. OSHA/BLS incidence rate comparison related to your Employer North American Industry Classification System (NAICS) Code

1. Complete the **Required** information.
2. Select the **checkbox**.

1

2

3

PRIOR FISCAL YEAR [View Historical Data](#)

I. OSHA/BLS incidence rate comparison related to your Employer North American Industry Classification System (NAICS) Code

Incidence Rate Represents (required)

Total Recordable Cases

Total cases with days away from work; job transfer or restriction

Cases with or without job transfer or restriction

Cases with job transfer or restriction

Other recordable cases

Please state your Incidence Rate (required)

II. Experience Modification Factor (E-Mod Factor) ⓘ

Please state your experience modification factor

III. Other ⓘ

Any other methods used by the organization to determine the effectiveness of the Accident & Illness Prevention Program including the Loss Ratio & Comparison of Statistics Derived from the First Reports.

Include in the explanation how it is calculated or derived, and how it is used to determine program effectiveness.

3. Select the **radio button**, if applicable.

4. Select the applicable **radio buttons**.

5. Complete the **Required** field.

6. Select the **radio button**, if applicable, then fill out the **field**.

7. Select the **radio button**, if applicable, then complete the **available textbox**.

4

5

6

7



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Health & Safety Tab (Cont'd)

8. Qualified Provider/In-Service Request

[View Current List of Bureau Accepted Credentials](#)

Please provide at least one Qualified Provider.

Qualified Provider (0)

Qualified Provider First Name	Qualified Provider Middle Name	Qualified Provider Last Name	Hiring Status	Credential Code	Actions
There are no records to show					

1

Add Qualified Provider

1. Press **Add Qualified Provider**.
2. Complete the **Required** information.
3. Press **Add In-Service Provider**, if applicable. If not applicable, skip to page 12.

Add Qualified Provider

Qualified Provider First Name (required)

Qualified Provider Middle Name

Qualified Provider Last Name (required)

Hiring Status (required)

Credential Code (required)

Cancel

Save

2

Please provide at least one Qualified Provider.

Qualified Provider (1)

Qualified Provider First Name	Qualified Provider Middle Name	Qualified Provider Last Name	Hiring Status	Credential Code	Actions
Jane		Doe	Contractor	(CHMM) Certified Hazardous Materials Manager	

Showing 1 - 1 of 1

Add Qualified Provider

You may also provide In-Service Providers.

In-Service Provider (0)

In-Service Provider First Name	In-Service Provider Middle Name	In-Service Provider Last Name	Hiring Status	Date Provider Initially Reported	Associated Qualified Provider	Status	Actions
There are no records to show							

Provider Comments

Add In-Service Provider

3



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Health & Safety Tab (Cont'd)

Add In-Service Provider

Search Criteria

First Name Middle Name

Last Name

Clear Search

Select One	In-Service Provider First Name	In-Service Provider Middle Name	In-Service Provider Last Name	Hiring Status	Date Provider Initially Reported	Associated Qualified Provider	Status
There are no records to show							

Cancel

Note. Adding an In-service Provider is optional. To do so:

1. Complete applicable search fields, then press **Search**.
2. Press the **gear icon** then select the filter checkbox to filter the results, if desired.

Note: Search result(s) appear based on how broad or narrow the search criteria entered is.

Search Results (140)

Last

Filter Results

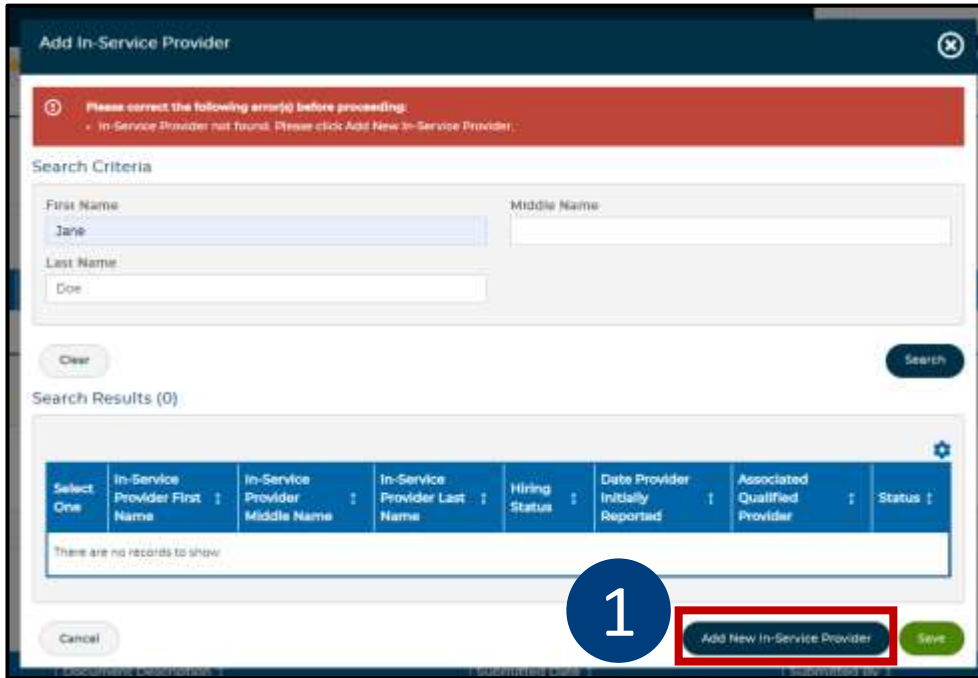
Select One	In-Service Provider First Name	In-Service Provider Middle Name	In-Service Provider Last Name	Hiring Status	Date Provider Initially Reported	Associated Qualified Provider	Status
<input type="checkbox"/>	First	Middle	Last	Employee	04/18/200		Active
<input type="checkbox"/>	Last		Last	Employee	02/01/2006		
<input type="checkbox"/>	Last		Last	Employee	12/04/1984		
<input type="checkbox"/>	John		Last	Contractor	01/01/2007		
<input type="checkbox"/>	First		Last	Contractor	03/12/2007		

Showing 1 - 5 of 140

3. Select the **checkbox** next to their name.

4. Select an **Associated Qualified Provider** from the dropdown.

Health & Safety Tab (Cont'd)



Add In-Service Provider

Please correct the following error(s) before proceeding:
• In-Service Provider not found. Please click Add New In-Service Provider.

Search Criteria

First Name: Jane
Middle Name:
Last Name: Doe

Clear Search

Search Results (0)

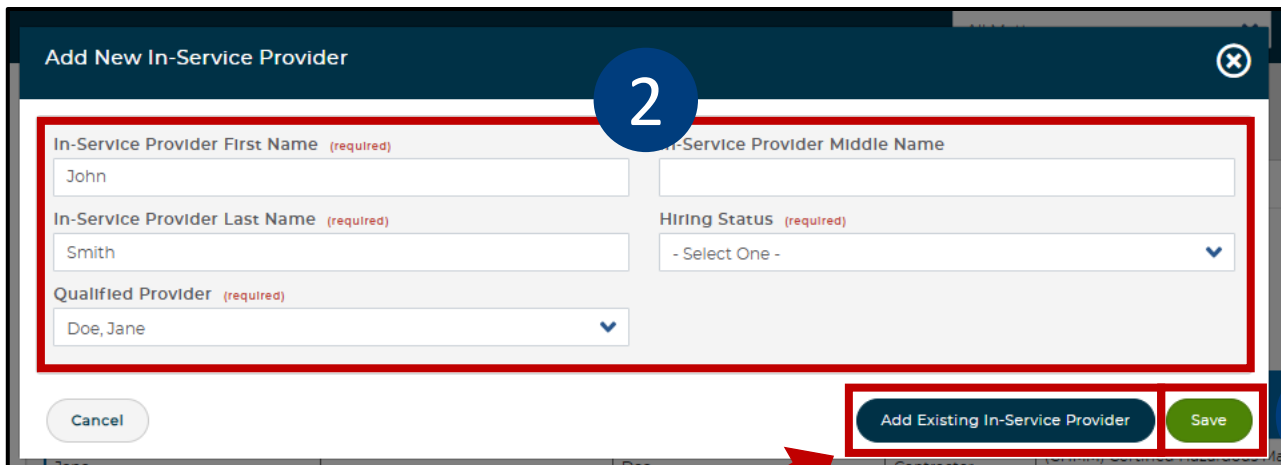
Select One	In-Service Provider First Name	In-Service Provider Middle Name	In-Service Provider Last Name	Hiring Status	Date Provider Initially Reported	Associated Qualified Provider	Status
There are no records to show.							

Cancel Add New In-Service Provider Save

1

Note: If the system cannot find the Provider, an error message will appear.

1. Press **Add New In-Service Provider**.
2. Complete the **Required** information
3. Press **Save**.



Add New In-Service Provider

In-Service Provider First Name (required): John
In-Service Provider Middle Name:
In-Service Provider Last Name (required): Smith
Hiring Status (required): - Select One -
Qualified Provider (required): Doe, Jane

Cancel Add Existing In-Service Provider Save

2

3

Note: To re-complete the search process for a different, existing in-service provider and repeat the steps on Page 11, press **Add Existing In-Service Provider**.

Health & Safety Tab (Cont'd)

In-Service Provider (1)

In-Service Provider First Name	In-Service Provider Middle Name	In-Service Provider Last Name	Hiring Status	Date Provider Initially Reported	Associated Qualified Provider	Status	Actions
John		Smith	Employee		Doe,Jane	Active	

Showing 1 - 1 of 1

Provider Comments

0 / 3000 characters

Upload Documents

1 Upload Document

Upload Document

Upload Document

No file selected **2** Browse

Description

3 Upload

Uploaded Documents (1)

Document Title	Uploaded Date	Uploaded By	Description	Action

4 Save

Associated Documents (1)

Document Type	Document Description	Submitted Date	Submitted By	Submission Method
MS Document	document (1)	06/27/2025	LAST FIRST	Online

Showing 1 - 1 of 1

Save and Continue **5**

1. Optional documents can be uploaded by pressing **Upload Document**.
2. Press **Browse** to locate the file.
3. Press **Upload**.
4. Press **Save**.
5. Press **Save and Continue**.



Certify Tab

Group Annual Report

Group Fund: Example Organization

PROGRAM INFORMATION

Annual Report Health & Safety **Certify**

Certify

The undersigned Fund has been approved to operate as a fund under the Workers' Compensation Law. You acknowledge that this report has been submitted under oath to the Bureau of Workers' Compensation of the Department of Labor and Industry to enable the Bureau to continue to qualify to operate as a fund under the Act. This report must be submitted to the office no later than five (5) months after the end of the reporting period.

The Fund hereby confirms its commitment to fairly administer the Workers' Compensation Law in accordance with the rules and regulations of the Department of Labor and Industry and not to circumvent the law for the purpose of avoiding or reducing compensation liability.

The Fund acknowledges that it understands and agrees that after the submission of this report at other times determined by the Department of Labor and Industry, the conditions previously established for the issuance of the Fund's permit. The Fund's permit may be revoked if the revised conditions are not met as prescribed by the office.

This report must be signed by an official of the Board of Directors of the Fund and certified as set forth below.

I verify that the facts set forth in this Collective Self-Insurance Fund Report are true and correct to the best of my knowledge and belief. This verification is subject to the penalties of 18 Pa.C.S. 4904, relating to unsworn falsification to authorities.

I hereby certify that I am a corporate officer, partnership principal or otherwise authorized to sign this application. (required)

Date of Signature (required) Signature Full Name (required)

Cancel Back Print Application **Submit**

1. Select the **checkbox**.
2. Select the **current date** from the **calendar**.
3. Enter your **Full Name**.
4. Press **Submit**.

Confirmation

Thank you for your application submission.

Your application number is SI-202507011

Your application will not be processed until payment is received.

Payment options are as follows:

- **Electronic Payments:** Pay electronically via a secure ACH / EFT transfer using the Bureau's secure payment portal.

An email will be sent the following business day providing instructions for using this preferred secure payment option. Please note you will need your company's bank routing number and account number to complete the online payment.

Partial payments will not be accepted.

- **Check:** Made payable in the amount below to the Commonwealth of Pennsylvania. Please mail this to the Self-Insurance Division.

Payment Details:

Total Amount Due : \$1,000.00

Any questions or concerns, please email ra-libwc-si@pa.gov

To print the confirmation information for your records, please select Print Confirmation Details button. You will receive a copy of this application in the Documents and Correspondence tab of the application or Program Summary.

Return to Dashboard **Print Confirmation Details**

5. Press **Return to Dashboard** to return to your WCAIS Dashboard.
6. Press **Print Confirmation** if you wish to print and/or save the Submission Receipt.