Completes this page on ALL reports

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
SELF INSURANCE PLANS
2265 Watt Avenue, Suite 1
Sacramento, CA 95825
Web site http://sip.dir.ca.gov
E-mail:sip@dir.ca.gov

RECEIVED
JUL 05 2005
RISK MANAGEMENT

YEAR ENDING June 30, 2005

PUBLIC SELF INSURER'S ANNUAL REPORT
(Non-JPA Member)

I. GENERAL

1. CERTIFICATE NUMBER: 4-7000-03-218
   Status Active

2. PERIOD OF REPORT: [X] Full Year
   [ ] Interim Report For The Period of:
   07/01/04 (Mo Day Yr) to 06/30/05 (Mo Day Yr)

3. NAME OF MASTER CERTIFICATE HOLDER:

   County of Fresno (NAME)
   2220 Tulare Street, 21st Floor (ADDRESS OF MAIN HEADQUARTERS)
   Fresno CA 93721 (CITY, STATE ZIP+4)

   Federal Tax Identification No: 94-404803

4. TYPE OF PUBLIC AGENCY: COUNTY

   [ ] CITY/COUNTY [ ] HOSPITAL
   [ ] SCHOOL [ ] TRANSIT
   [ ] POLICE/FIRE [ ] OTHER

5. DURING THE PERIOD OF THIS REPORT, HAS THERE BEEN ANY OF THE FOLLOWING WITH RESPECT TO THE MASTER CERTIFICATE HOLDER, SUBSIDIARY OR AFFILIATE CERTIFICATE HOLDER?

   A MERGER OR UNIFICATION? [ ] Yes [X] No
   CHANGE IN NAME OR IDENTITY? [ ] Yes [X] No
   ANY ADDITION TO SELF INSURANCE PROGRAM? [ ] Yes [X] No

6. ARE THERE ANY AGENCY EMPLOYEES **NOT** INCLUDED IN YOUR WORKERS' COMPENSATION

   [ ] Yes [ ] No

   IF YES, WHAT EMPLOYEES ARE NOT INCLUDED? _____

   ARE THESE EMPLOYEES COVERED BY AN INSURANCE POLICY? [ ] Yes [ ] No
   ARE THESE EMPLOYEES COVERED BY ANOTHER SELF INSURANCE CERT. OR JPA? [ ] Yes [ ] No

7. TO WHOM DO YOU WANT CORRESPONDENCE ADDRESSED?

   NAME Gregory Borboa
   TITLE Senior Personnel Analyst
   COMPANY NAME County of Fresno
   ADDRESS 2220 Tulare Street, 21st Floor
   Fresno, CA 93721-2104
   TELEPHONE (559)488-3360 FASCIMILE (FAX) NUMBER (559)488-6766

8. CERTIFICATION BY AGENCY OFFICIAL:
   I declare under the penalty of perjury that I have examined this Self Insurer's Annual Report and to the best of my knowledge and belief it is true, correct and complete.

   Signature: _____ Date: _____
   Original Signature Only

   Typed Name: _____

   Agency Name: _____

   Street Address: _____

   City: _____ State: _____ ZIP+4: _____

   Telephone: (____)_____-_____ Fax: (____)_____-_____

Fiscal Year 04/05

Annual Report is Due October 1, 2005

II. LIABILITIES BY REPORTING LOCATION

v3.1\SelectBy-E\Extract-P

Reporting Location Nos.: 4-7000-03-218

Name/Identification of Location: COUNTY OF FRESNO

Name of Master Certificate Holder: COUNTY OF FRESNO

Type of Report:

☒ Original Report (07/01/2004 to 06/30/2005) ☐ Amended Year End Report ☐ Amended Due to Audit ☐ Interim Report

From Date: 07 (Month) 01 (Day) 04 (Year) To Date: 06 (Month) 30 (Day) 05 (Year)

A. CASES AND BENEFITS (to nearest dollar)

	Number	Incurred Liability		Paid to Date		Future Liability	
		$ Indemnity	$ Medical	$ Indemnity	$ Medical	$ Indemnity	$ Medical
1. Cases open as of 06/30/2005 reported prior to FY 2000-01	374	21,394,159	26,742,009	16,562,376	18,274,007	4,831,783	8,468,002
2. Open & Closed Cases:							
a. FY 2000-01 Total cases reported	916	5,758,302	4,547,581	4,957,027	3,357,080	801,275	1,190,501
FY 2000-01 Cases Open	95	3,968,804	3,247,621	3,167,529	2,057,120		
b. FY 2001-02 Total cases reported	925	7,187,775	5,335,573	5,066,988	3,322,032	2,120,786	2,013,540
FY 2001-02 Cases Open	123	5,833,310	4,236,892	3,712,523	2,223,352		
c. FY 2002-03 Total cases reported	923	5,711,279	5,380,918	4,053,933	2,885,401	1,657,345	2,495,517
FY 2002-03 Cases Open	153	4,858,154	4,643,621	3,200,808	2,148,104		
d. FY 2003-04 Total cases reported	817	3,372,109	3,828,330	2,333,558	2,432,691	1,038,551	1,395,640
FY 2003-04 Cases Open	187	2,968,447	2,634,303	1,929,895	1,238,663		
e. FY 2004-05 Total cases reported	836	2,379,970	2,233,399	1,329,758	839,695	1,050,212	1,393,704
FY 2004-05 Cases Open	437	2,156,873	2,015,844	1,106,661	622,140		

3. ESTIMATED FUTURE LIABILITY (Indemnity plus Medical)	$ Indemnity	$ Medical
SUBTOTAL	11,499,953	16,956,904
TOTAL	28,456,857	

	$ Indemnity	$ Medical
4. Total Benefits paid during FY 2004-05 (including all case expenditures):	6,519,464	4,898,898

5. Number of MEDICAL-ONLY cases reported in FY 2004-05:	372
6. Number of INDEMNITY cases reported in FY 2004-05:	464
7. TOTAL of 5 and 6 (also entered in 2e above):	836
8. TOTAL number of open indemnity cases (all years):	1,239
9. Number of Fatality cases reported in FY 2004-05:	0
10. (a) Number of FY 2004-05 claims for which the employer or administrator was notified of representation by an attorney or legal representative in FY 2004-05:	32
10. (b) Number of non-FY 2004-05 claims for which the employer or administrator was notified of representation by an attorney or legal representative in FY 2004-05:	67

B. TOTAL EMPLOYMENT AND WAGES PAID IN FISCAL YEAR 2004-2005 FOR THIS SELF INSURER:

(a) NUMBER OF EMPLOYEES _____
(Number of individual employees listed on the DE-6 for year ending June

(b) TOTAL WAGES AND SALARIES PAID $ _____
(As reported on EDD Form DE-6 Line M for all four quarters)

Fiscal Year

04/05

A. NAME OF ADMINISTRATOR(S)/ADMINISTRATING AGENCY(IES) SUBMITTING THIS REPORT.

1. Name (Person) Shelly Isaak

Agency Name Pegasus Risk Management

Address 2547 W. Shaw Ste. 113

City Fresno State CA Zip+4 93711-3321

Administrative Agency's Certificate No.: 2 1 8

or ☐ Self Administered

B. HAS THERE BEEN A CHANGE IN ADMINISTRATOR/ADMINISTRATIVE AGENCY DURING THE PERIOD OF THIS REPORT PERIOD? ☐ YES ☒ NO

IF YES: DATE OF CHANGE: ☐☐☐☐☐☐ Month Day Year

TYPE OF CHANGE: ☐ Change in Administrative Agency

☐ Change to or from Self Administration

NAME OF NEW ADMINISTRATOR(S)/ADMINISTRATIVE AGENCY(IES):

Name _____

Agency Name _____

Address _____

City _____ State _____ Zip+4 _____

CERTIFICATION

I declare under penalty of perjury that I have prepared or caused this report to be prepared and I have examined this liabilities report of this self insurer's workers' compensation liabilities. To the best of my knowledge and belief this report is true, correct and complete with respect to the workers' compensation liabilities incurred and paid. I further declare under the penalty of perjury that the estimates of future liability of workers' compensation claims made in this report reflect the administrator's best judgment astothe future liability of claims, using prevailing industry standards, and the signatory intends Self Insurance Plans to rely upon the representation.

Original Signature of Administrator (Qualified Person)

Date 9/27/05

Shelley Isaak
Typed Name of Administrator

Pegasus Risk Management
Name of Administrative Agency or Employer

Claims Manager
Title

2547 W. Shaw Ste. 113
Street Address

Fresno, CA 93711-3321
City State Zip+4

Phone No. of Administrator (559) 230-2800
area code

Fax No. (559) 241-6055
area code

E-mail Address of Administrator sisaak@pegasusrisk.com

Fiscal Year
04/05

IV. RECORDS STORAGE

1. Are claim records stored at any location other than with the current administrator?

[X] Yes [ ] No **If yes, Where?** _____

A. Agency Name Derrel's Mini Storage
Address 4441 W. Herndon
City Fresno **State** CA **Zip+4** 93772
Phone (559)436-1495

B. Agency Name Bekin's
Address 301 Van Ness
City Fresno **State** CA **Zip+4** 93721
Phone (559) 233-4274

C. Agency Name _____
Address _____
City _____ **State** _____ **Zip+4** _____
Phone ( ) _____

D. Agency Name _____
Address _____
City _____ **State** _____ **Zip+4** _____
Phone ( ) _____

V. INSURANCE COVERAGE

1. Are any of your workers' compensation liabilities in California during the reporting period covered by a standard workers' compensation insurance policy?

[ ] Yes [X] No **If Yes:**

1. Name of Insurance Company: _____
Policy Number: _____ **Policy Issue Date:** _____

2. Name of Insurance Company: _____
Policy Number: _____ **Policy Issue Date:** _____

2. Are any of your workers' compensation liabilities in California during the reporting period covered by a specific excess workers' compensation insurance policy?

[X] Yes [ ] No **If Yes:**

1. Name of Carrier: CSAC Excess Insurance Authority
Policy Number: _____ **Policy Issue Date:** _____
Retention Limit: $500,000

2. Name of Carrier: _____
Policy Number: _____ **Policy Issue Date:** _____
Retention Limit: _____

3. Do you carry an aggregate (stop loss) workers' compensation insurance policy?

[ ] Yes [ ] No **If Yes:**

1. Name of Carrier: _____
Policy Number: _____ **Policy Issue Date:** _____
Retention Limit: _____

2. Name of Carrier: _____
Policy Number: _____ **Policy Issue Date:** _____
Retention Limit: _____

VI. OPEN INDEMNITY CLAIMS

A. List of *ALL* Open Indemnity Claims by reporting location and by year reported and with claims in alphabetical order is attached immediately following page 6 of this report. (You may use the form attached or a computer prepared printout organized in the same format.)

Fiscal Year
04/05